PREFACE

Healthcare is a dynamic and demanding field that involves continuous human interaction. Successful leaders in this field are characterized by their ability to work well with others. This book is designed to help readers understand and apply the principles of organizational behavior and theory to improve their management abilities and skills.

This text examines theories of organizational design, leadership, and management and the social psychology of organizations as they apply to health services organizations. It provides students with tools and the framework to understand, structure, and change organizational behavior in our dynamic healthcare environment.

Specifically, this book approaches these concepts from a practical, applied perspective. Through the chapters and cases, the reader gains an understanding of not only theory but also the way the interactions and interrelationships of people, organizations, and structures affect the extent to which companies succeed or fail. Having spent many years as a healthcare administrator, I have sought to demonstrate real-world experiences in a useful and direct way. Each chapter contains cases, most of which are based on actual occurrences that either I or one of my associates experienced. In addition, short activities and chapter questions provoke the reader to realize the complexity and challenge of working with individuals in organizations.

Text Competencies

Our educational and professional environment, along with accrediting bodies, now strongly encourages—indeed, mandates—the use of competency-based learning models that seek to identify performance needs and demonstrate the value of learning. From an educational perspective, course curricula should provide students with the knowledge and skills required for future careers. Recognizing the wide variation of healthcare administration roles and professional settings, accrediting bodies such as the Commission on Accreditation

of Healthcare Management Education (CAHME) allow individual programs to develop their own unique competencies.

Likewise, several professional organizations propose different sets of competencies for healthcare leaders. The Healthcare Leadership Alliance (HLA)—a consortium of professional healthcare administration associations composed of the American Association for Physician Leadership, the American College of Healthcare Executives (ACHE), the American Organization of Nurse Executives, the Healthcare Financial Management Association, the Healthcare Information and Management Systems Society, and the Medical Group Management Association—has identified five domains of competencies as being valuable to healthcare executives, administrators, and managers: (1) communication and relationship management, (2) leadership, (3) professionalism, (4) knowledge of the healthcare environment, and (5) business skills and knowledge (Stefl 2008). ACHE (2015) has adapted the HLA competencies to offer its members the ACHE Healthcare Executive Competencies Assessment Tool, which helps healthcare administrators self-assess their areas of strength and areas needing improvement. ACHE updates the tool annually.

Given the wide variation of possible competencies, I have chosen the ACHE Healthcare Executive Competencies Assessment Tool to identify and develop competencies for inclusion in this book. Using the following list, instructors can quickly ascertain which competencies are covered in each chapter to appropriately develop their course and syllabus according to their competency-based curricula.

Competencies by Chapter

Chapter 1. Organizational Behavior, Organizational Theory, and Their Importance in Healthcare

Competencies:

- Knowledge of the healthcare environment
  - The community and the environment
    - Socioeconomic environment in which the organization functions
    - Healthcare trends
- Business skills and knowledge
  - Organizational dynamics and governance
    - Organization systems theories and structures
    - Governance structure
    - Principles and practices of management and organizational behavior

Chapter 2. Theories of Managing People

Competencies:

- Business skills and knowledge
  - Organizational dynamics and governance
    - Organization systems theories and structures
    - Governance theory
    - Principles and practices of management and organizational behavior
  - Strategic planning and marketing
    - Organizational mission, vision, objectives, and priorities

Chapter 3. Individual and Organizational Learning

Competencies:

- Leadership
  - Managing change
    - Explore opportunities for the growth and development of the organization on a continuous basis
    - Promote continuous organizational learning/improvement
- Professionalism
  - Professional development and lifelong learning
    - Acquire and stay current with the professional body of knowledge

Chapter 4. Individual and Organizational Ethics and Values

Competencies:

- Professionalism
  - Personal and professional accountability
    - Consequences of unethical actions
    - Organizational business and personal ethics
    - Professional standards and codes of ethical behavior
    - Uphold and act upon ethical and professional standards
    - Adhere to ethical business principles

Chapter 5. Individual and Organizational Motivation

Competencies:

- Leadership
  - Communicating vision
    - Create an organizational climate that facilitates individual motivation

- Business skills and knowledge
  - Human resource management
    - Employee satisfaction measurement and improvement techniques
    - Employee motivational techniques

Chapter 6. Emotions and Stress on the Job

Competencies:
- Professionalism
  - Professional development and lifelong learning
    - Time and stress management techniques
- Business skills and knowledge
  - Human resource management
    - Conflict resolution and grievance procedures

Chapter 7. Paradigms and Perceptions

Competencies:
- Knowledge of the healthcare environment
  - Healthcare personnel
    - Staff perspective in organizational settings
- Business skills and knowledge
  - Human resource management
    - Employee motivational techniques

Chapter 8. Power and Influence

Competencies:
- Leadership
  - Leadership skills and behavior
    - Incorporate and apply management techniques and theories into leadership activities
- Business skills and knowledge
  - Organizational dynamics and governance
    - Organizational dynamics, political realities, and culture

Chapter 9. Leadership Theories and Styles

Competencies:
- Leadership
  - Leadership skills and behavior
    - Leadership styles/techniques

        - Leadership theory and situational applications
        - Incorporate and apply management techniques and theories into leadership activities
    - Managing change
        - Promote and manage change

Chapter 10. Organizational Culture

Competencies:

- Communication and relationship management
    - Communication skills
        - Sensitivity to what is correct behavior when communicating with diverse cultures, internal and external
- Leadership
    - Organizational climate and culture
        - Create an organizational culture that values and supports diversity
        - Knowledge of own and others' cultural norms
        - Assess the organization, including corporate values and culture, business processes, and impact of systems on operations
- Professionalism
    - Personal and professional accountability
        - Cultural and spiritual diversity for patients and staff as they relate to healthcare needs
- Business skills and knowledge
    - Organizational dynamics and governance
        - How an organization's culture impacts its effectiveness

Chapter 11. Developing Employees Through Mentoring, Coaching, and Delegation

Competencies:

- Communication and relationship management
    - Relationship management
        - Practice and value shared decision making
- Leadership
    - Leadership skills and behavior
        - Support and mentor high-potential talent within the organization
- Professionalism
    - Contributions to the community and profession
        - Mentor, advise, and coach

Chapter 12. Performance Management

Competencies:

- Business skills and knowledge
  - General management
    - Collect and analyze data from internal and external sources relevant to each situation
    - Analyze the current way of doing business and clinical processes
    - Perform audits of systems and operations
    - Measure quantitative dimensions of systems and departmental effectiveness
  - Financial management
    - Outcomes measures and management
    - Fundamental productivity measures
    - Develop and use performance monitoring metrics
  - Human resource management
    - Performance management systems
    - Develop and manage employee performance management systems
  - Strategic planning and marketing
    - Develop and monitor departmental strategic and tactical objectives
    - Develop a benefits realization model that measures product or service performance to ensure that strategic goals are met

Chapter 13. Decision Making

Competencies:

- Leadership
  - Leadership skills and behavior
    - Potential impacts and consequences of decision making in situations, both internal and external
- Business skills and knowledge
  - General management
    - Ability to analyze and evaluate information to support a decision or recommendation
    - Ability to integrate information from various sources to make decisions or recommendations
    - Distinguish between important and unimportant aspects of business and clinical situations as a basis for sound decision making

- Human resource management
  - Decision making on operations, finances, healthcare, and quality of care

Chapter 14. Creativity and Innovation

Competencies:

- Leadership
  - Managing change
    - Promote and manage change
    - Explore opportunities for the growth and development of the organization on a continuous basis

Chapter 15. Group and Team Dynamics

Competencies:

- Communication and relationship management
  - Facilitation and negotiation
    - Team-building techniques
    - Build effective physician and administrator leadership teams
    - Create, participate in, and lead teams
    - Facilitate group dynamics, processes, meetings, and discussions
- Leadership
  - Organizational climate and culture
    - Create an organizational climate that encourages teamwork

Chapter 16. Communication

Competencies:

- Communication and relationship management
  - Communication skills
    - Principles of communication and their specific applications
    - Sensitivity to what is correct behavior when communicating with diverse cultures, internal and external
    - Identify and use human and technical resources to develop and deliver communications

Chapter 17. Managing Diversity

Competencies:

- Communication and relationship management
  - Communication skills

        - Sensitivity to what is correct behavior when communicating with diverse cultures, internal and external
- Professionalism
    - Personal and professional accountability
        - Cultural and spiritual diversity for patients and staff as they relate to healthcare needs

Chapter 18. Conflict Management and Negotiation

Competencies:

- Communication and relationship management
    - Facilitation and negotiation
        - Mediation, negotiation, and dispute resolution techniques
        - Facilitate conflict and alternative dispute resolution
- Business skills and knowledge
    - Human resource management
        - Conflict resolution and grievance procedures

Chapter 19. Organizational Design

Competencies:

- Communication and relationship management
    - Relationship management
        - Organizational structure and relationships
- Knowledge of the healthcare environment
    - Healthcare systems and organizations
        - The interdependency, integration, and competition among healthcare sectors
- Business skills and knowledge
    - General management
        - Organize and manage the human and physical resources of the organization to achieve input, buy-in, and optimal performance
    - Organizational dynamics and governance
        - Organization systems theories and structures
        - Governance structure
        - Construct and maintain governance systems

Chapter 20. Strategy and Change Management

Competencies:

- Communication and relationship management
    - Communication skills

        - Communicate organizational mission, vision, objectives, and priorities
- Leadership
  - Communicating vision
    - Establish a compelling organizational vision and goals
  - Managing change
    - Promote and manage change
    - Anticipate and plan strategies for overcoming obstacles
- Business skills and knowledge
  - Strategic planning and marketing
    - Strategic planning processes development and implementation
    - Develop and monitor developmental strategic and tactical objectives
    - Organizational mission, vision, objectives, and priorities

Acknowledgments

I would like to thank Britt Berrett, PhD, FACHE, and Ben Whisenant, JD, for their assistance in writing and editing chapters in this text and their contribution of materials for cases. Both have extraordinary experience in business and academics. I appreciate their influence and friendship.

—Stephen L. Walston

Instructor Resources

This book's instructor resources include PowerPoint slides, case study guidelines, answer guides to the chapter discussion questions, and a test bank.

For the most up-to-date information about this book and its instructor resources, go to ache.org/HAP and browse for the book by its title or author name.

This book's instructor resources are available to instructors who adopt this book for use in their course. For access information, please e-mail hapbooks@ache.org.

CHAPTER

1

ORGANIZATIONAL BEHAVIOR, ORGANIZATIONAL THEORY, AND THEIR IMPORTANCE IN HEALTHCARE

Learning Objectives

After studying this chapter, readers should be able to

- understand the history of organizational behavior study and organizational theory;
- comprehend that managing healthcare has become more challenging because of greater complexity and change, as organizations have moved from individual-based work to team-based work;
- discuss social, demographic, and technological changes that create greater needs for better management;
- explain that the differentiating factor for any organization is the engagement and value of its employees, which correlate strongly with enlightened management; and
- project how new payment structures and a focus on population health will require greater interaction and cooperation among healthcare workers and organizations.

Key Terms

- Henri Fayol
- Max Weber
- Organizational behavior
- Organizational theory
- Organizations
- Scientific management

We live in a world full of organizations, and nearly everyone is associated with multiple organizations at any one time—as an employee, a boss, a volunteer, or a recipient of service. No matter the role or roles we play in organizations, those affiliations are a constant presence in our lives.

Organizations are socially constructed entities created for specific purposes. They are goal directed; composed of people tied together in formal and informal relationships; and linked to their external environment through their customers, suppliers, competitors, and government regulatory bodies. The central aspect of an organization is the coordination of people and resources to produce a product or provide a service (Daft 2012).

This book explores organizational behavior and organizational theory in the context of healthcare organizations—doctors' offices, pharmaceutical companies, public health agencies, hospitals, nursing homes, home health agencies, outpatient surgery centers, medical device manufacturers, volunteer groups, insurance companies, and many others. Organizational behavior study and organizational theory are made up of numerous theories that seek to explain the factors that influence the behaviors of individuals and organizations—large corporations, small entrepreneurial ventures, governmental agencies, military groups, social groups, family and religious organizations, and so on—to succeed or fail.

Most organizations are similar in that they typically have rules and policies, decision-making lines of authority with formal and informal relationships, and divisions of labor, but their performance and effectiveness vary radically. Some organizations are highly organized, have nurturing cultures, and seem to accomplish astonishing results; others languish and appear to stumble from one crisis to another. As discussed in this chapter, organizational behavior study and organizational theory were developed to help academics and managers understand the way businesses work and the dynamics of organizations' internal and external environments.

Both fields evolved in the early to mid-1900s, when management theorists suggested a variety of ways to improve management practices and explain the human factor in organizational success and failure. Over time, the theoretic guidance for how and why people and organizations behave began to be considered separately.

Organizational Behavior

Organizational behavior study broadly explores the behavior and influence of individuals, groups, and structures in an organization and their impact on the function and effectiveness of that organization. These three levels of organizations are highly interactive, such that changes in one area affect the other areas (exhibit 1.1). Individuals' behavior is linked to the broader context of the organization, and, likewise, group behavior influences and is influenced by individual and organizational (structural) factors. Each individual brings unique characteristics, personal background, perspectives, and experiences

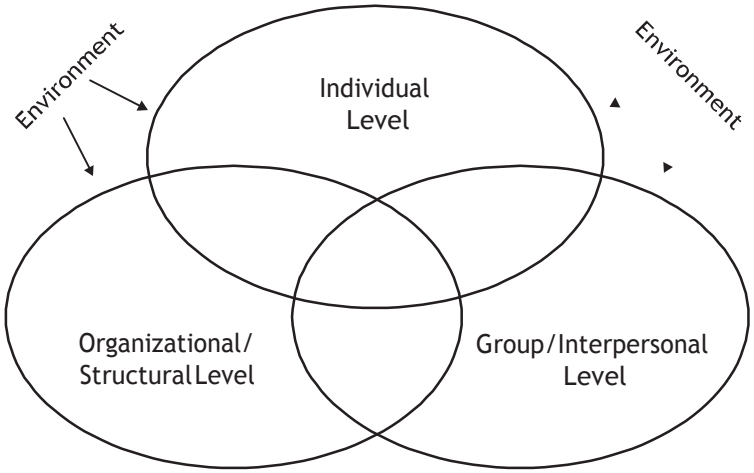


EXHIBIT 1.1
Interactive Nature of the Three Levels of Organizational Behavior

to the organization. Furthermore, each person acts and reacts uniquely to the organization's rules and processes and to the interactions with his or her teams and groups.

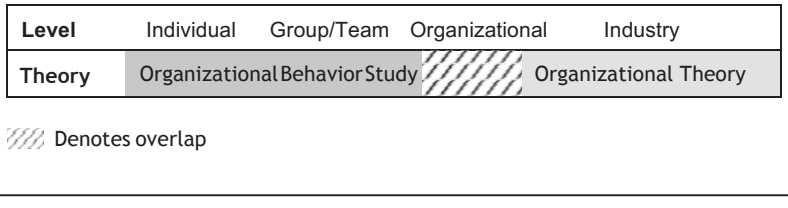
Understanding the dynamics of organizational behavior helps us gain insight into the organization's processes and activities and the consequences of behavior. It also provides the means to study and understand leadership, power, communication, teamwork, satisfaction, commitment, decision making, conflict, learning, and other important management issues. In short, organizational behavior study permits managers to appreciate why employees act as they do and to help them improve their behavior. Long-term, desired organizational performance results only when employees are engaged in their work, and employees become engaged only when their leaders provide a work context that promotes positive group and organizational interactions.

Organizational behavior study encapsulates many of the theories explored in this book, which come from disparate disciplines such as psychology, social psychology, sociology, political science, and anthropology (Sarfraz 2011). The book's chapters address topics, practical applications, and definitions commonly considered under the umbrella of the field of organizational behavior.

Organizational Theory

In some settings, organizational behavior study and organizational theory are taught jointly, as presented in this book. However, at many schools, each is considered a separate management specialization. Their differentiation can be seen in exhibit 1.2.

EXHIBIT 1.2
Relationship of Organizational Behavior Study to Organizational Theory



Organizational theory focuses on the organization as a whole or on populations of organizations. It seeks to explain the processes and factors influencing the structure and outcomes of organizations, including how organizations interact in and across industries and societies. Organizational theorist Jeffrey Pfeffer (1997) wrote that organizational theory focuses on the impact of social organizations and individuals' characteristics and actions on behavior, attitudes, and the performance, success, and survival of organizations, as well as on the organizations' resource and task, political, and cultural environments. Chapters 2 through 7 discuss in detail the concepts, applications, and subtheories of organizational theory.

History and Development

Both organizational behavior study and organizational theory are rooted in the Second Industrial Revolution, which began in the late 1800s. The new technology of the nineteenth century ushered in factories, which created novel organizational and management problems. This environment required the management of immense flows of material, people, and information across large distances and the creation of new methods for dealing with these management challenges.

One early theorist was sociologist **Max Weber**. Born in Germany in 1864, he lived in a rapidly changing Europe that had experienced centuries of feudal control, primarily from small principates. Promotions and authority had been most often tied to familial relationships. Weber postulated that the ideal organization was a formalized, somewhat rigid bureaucracy that had rules everyone in the company obeyed and in which people were given positions on the basis of competence; clear, formal hierarchies established chains of command for decision making; and division of labor was in place to allow employees to align their skills with work needs (Wilson 1989). His bureaucracy theory was widely perceived as an improvement over the nepotism, irrational behaviors, and lack of professionalism that existed in firms during that time.

Another early, influential contributor to management theory, a contemporary of Weber, was Frenchman **Henri Fayol**, who developed a general

theory of business and is recognized as one of the founders of modern management. As a mining engineer and director of mines, he observed a variety of management practices, which he distilled into 14 principles of management to frame a general management perspective—many of which continue to be used. His 14 principles of management are the following:

1. *Division of work*, also known as *division of labor:* Employees are assigned to different tasks or parts of a work process and become specialized in the tasks to which they are assigned.
2. *Authority and responsibility:* Management has the authority to give orders but also the responsibility to be accountable for the results.
3. *Discipline:* Management instills obedience and discipline among employees by means of penalties and sanctions.
4. *Unity of command:* Each employee receives orders from only one manager.
5. *Unity of direction:* Activities have common objectives, and the organization is moving toward a common goal.
6. *Subordination:* Individual interests do not take priority over the interests of the organization.
7. *Remuneration:* Cost-of-living factors are considered in pay for work to ensure that employees are paid a fair wage.
8. *Centralization:* Subordinates are involved in organizational decision making to a particular level determined by the needs of the organization.
9. *Scalar chain:* Employees communicate according to the line of authority, from top management to the lowest ranks.
10. *Order:* All resources—people and materials—are treated systematically and have a specific place in the organization.
11. *Equity:* Managers treat their subordinates fairly and without bias.
12. *Stability of tenure of personnel:* Managers seek to retain productive employees, as high turnover is wasteful. Orderly personnel planning is key to ensuring that replacements are available to fill any vacancies that arise.
13. *Initiative:* Managers encourage employees to practice self-direction.
14. *Esprit de corps:* Managers promote team spirit to build harmony and unity.

Fayol condensed these principles into five core management functions: (1) planning, (2) organizing, (3) coordinating, (4) commanding, and (5) controlling.

Fayol is credited with identifying strategic planning and employee recruitment and motivation as critical management functions. He was also

one of the first theorists to promote management as a separate discipline from psychology, sociology, and other fields (Pugh and Hickson 1993).

Weber's and Fayol's writings complemented the concurrent theories and work of American mechanical engineer Frederick W. Taylor. In an attempt to create greater efficiency and address the new management challenges, Taylor, in the late 1800s and early 1900s, was among the first theorists to systematically use time and motion studies to analyze human behavior at work. He developed the theory of **scientific management**, which conceives of human input as among the cheap, interchangeable components that can be "engineered" to maximize efficiency. In the scientific management approach, production processes are broken into small units, and employee and material movements are studied to find the most efficient way to perform each job.

At the time, Taylor's work was groundbreaking, and many businesses adopted his advice and processes; the human influence on work outcomes was largely ignored. Advances in fields such as psychology, threats of unionization, growing urbanization, and world events such as the Great Depression and the two world wars pointed to the discrepancy between scientific management theory and actual human behavior in organizations. Research conducted in the 1920s—the most famous of which was the Hawthorne experiment at Western Electric Company in Chicago (discussed in chapter 2)—began to suggest that human behaviors were significantly affected by social and other nonwork factors (Parsons 1974). As the twentieth century progressed, managers began to see their organizations not only as a formal arrangement of structures and functions but also as work embedded in and highly influenced by a social system. The Human Relations Movement evolved from these studies and efforts, which helped produce the theories that make up organizational behavior and are discussed in detail in this book.

Organizational theory owes its existence to the same social and technological changes that influenced organizational behavior study. The rapid increase of large, formalized, organized businesses made the study and theories of organizations relevant and meaningful to many more people.

Relevance of Organizational Behavior Study and Organizational Theory to the Healthcare Industry

Organizational behavior study and organizational theory can be exceptionally helpful in guiding managers in the healthcare industry. Healthcare organizations consist of complex, changing relationships and reporting structures. They involve multiple specialties with different professional cultures and a wide variety of services, making healthcare one of the most challenging industries to manage. As Marcus (1995, 3) stated, in healthcare

> work is accomplished via an intricately structured set of relationships. Formal and informal rules determine who speaks to whom, who makes what decisions, and who has what information. People are organized and decisions are aligned in a cautiously defined order.

Service providers are highly professionalized, with their own distinct ethics and cultures. Healthcare professionals (e.g., doctors, nurses, radiology technicians) are differentiated by their training, licensure, and skills and often interact under "pecking orders" of importance. The implications of this structure are heightened in acute care settings, where conflicts in priorities often arise because "doctors and nurses are trained differently" (Brown 2013).

That said, the delivery of patient care and services today is not an individual effort but instead involves cross-disciplinary teams that must coordinate their efforts and constantly adapt to rapid knowledge expansion (Nembhard and Edmondson 2006). The shift from individual, physician-based treatment to a team approach finds physicians, nurses, pharmacists, respiratory therapists, dietitians, and other providers with advanced degrees working side by side. The unprecedented reliance on each other to jointly make decisions and provide services complicates the human factor in healthcare and distinguishes hospitals and health systems from many other organizational types.

In addition, the critical nature of healthcare requires that actions be precise to ensure specific positive outcomes. Unlike manufacturing and many other industries, healthcare has limited room for error in the provision of its services to patients. Yet errors continue to plague the industry, with hundreds of thousands of avoidable injuries and deaths occurring in the United States alone (James 2013). Many of these events are caused by a failure to adequately communicate critical information and coordinate efforts. In fact, approximately 80 percent of serious medical errors may involve miscommunication among caregivers, a situation being addressed by the Joint Commission Center for Transforming Healthcare (2016) and participating health systems.

Organizational behavior study and organizational theory are similarly relevant to the healthcare industry's rapid reorganization and transformation. Economic forces, government regulations, and employers are driving change (Carr 2013), with governments and businesses across the globe altering their existing healthcare systems to improve quality, increase access, and control costs, as illustrated in the box on page 8. Many are changing strained relationships, reordering hierarchical power bases, upending long-standing incentives, and demanding greater leadership and direction from healthcare organizations than ever before.

Understanding organizational behavior can help inform and direct actions across these many changes, among them the move to a population health focus, which raises questions such as those posed by Marcus (1995, xiii):

The Changing Nature of and Relationships in Healthcare: Hepatitis C

Healthcare is changing. Innovations are disrupting the status quo. Emerging technology is allowing fundamental design shifts to bring knowledge transfer to less intensive care delivery settings.

Dr. Sanjeev Arora has been part of that change in practicing medicine. Since 1990, Arora has specialized in the treatment of chronic hepatitis C, a leading cause of cirrhosis and liver cancer affecting 3 million Americans and 170 million people across the globe. Cure rates vary according to patient access to care, with many rural patients and prisoners with the disease receiving no treatment. Arora noted that only the very sick access care, often when they have liver cancer or their livers are failing. If only they could be treated earlier, he lamented, and more people had his knowledge and skills to deliver care to them.

Project ECHO (Extension for Community Healthcare Outcomes) resulted from this idea. It combines videoconferencing technology to facilitate weekly case-based training with collaborative care and careful patient tracking. ECHO was demonstrated in 2011, and as published in the *New England Journal of Medicine,* Arora's primary care network physicians achieved better cure rates and fewer complications than did a major university hospital treating hepatitis C. By 2012, ECHO had been adopted to treat other diseases (e.g., rheumatology, HIV, addiction) throughout the United States and internationally. One ECHO user in a military health system stated, "It allowed us to grow and manage the transformation all across army medicine pain care."

The change in technology use forced specialists to rethink their fundamental roles to become mentors and collaborators, equal to primary caregivers. However, even with the proven benefits, reimbursement for care using the ECHO model still provides little incentive to adopt it, and most specialist time is paid for by grants. Will the healthcare system transform its payment system to encourage this collaborative form of care? How does the change in incentives alter the relationship between primary caregivers and specialists?

Source: Information from Bornstein (2014).

a. Who will get the responsibilities for integrated service delivery?
b. Will the new responsibilities change the jobs of the people involved so that their work is less meaningful and interesting?
c. Will staff still be reporting to their current managers?
d. Who among the business [leaders] will be perceived as a winner and who will be perceived a loser?

Furthermore, healthcare is a service industry, centered on the provision of services by employees, many of whom provide direct care to patients. Thus, employees are not only the key component in but also the main cost of healthcare. The manner in which they interact affects both patient and staff satisfaction, the degree to which the organization is in compliance with regulations, and the extent to which the patient achieves clinical benefit. Likewise, the level of positive interaction among employees, their managers, and others in the organization influences the organization's ability to achieve its mission and objectives. As a result, some observers have suggested that healthcare managers' most important asset remains their employees, and success is dictated by the presence of collegial relationships and employee engagement rather than by the implementation of patient- or customer-focused efforts (Spiegelman and Berrett 2013). Lasting strategic advantage and differentiation evolve from and are sustained by positive relationships, culture, and communication—all factors in organizational behavior

study and organizational theory—rather than purchased assets, documents, and directives (Walston 2014).

Moreover, the skills that result from organizational behavior study and organizational theory are needed now more than ever, as healthcare systems in many countries are seeing rapid transformation. In the United States, the Affordable Care Act (ACA) serves as both driver of and guide to the multifaceted changes affecting healthcare. The ACA was signed into law in 2010 and implemented over the subsequent years, significantly affecting healthcare coverage, costs, and access (US Department of Health and Human Services 2015). Likewise, many other nations are experimenting with different models that will alter employee incentives, worker behaviors, and organizational structures—and thus interactions and relationships—all of which make the understanding of organizational behavior study and organizational theory much more important in the future.

Exhibit 1.3 illustrates the concepts associated with the three levels of organizational behavior—individual, group, and organizational—and the chapters in which these concepts are discussed. Because these three levels are interactive, the concepts often apply to more than one level and are therefore

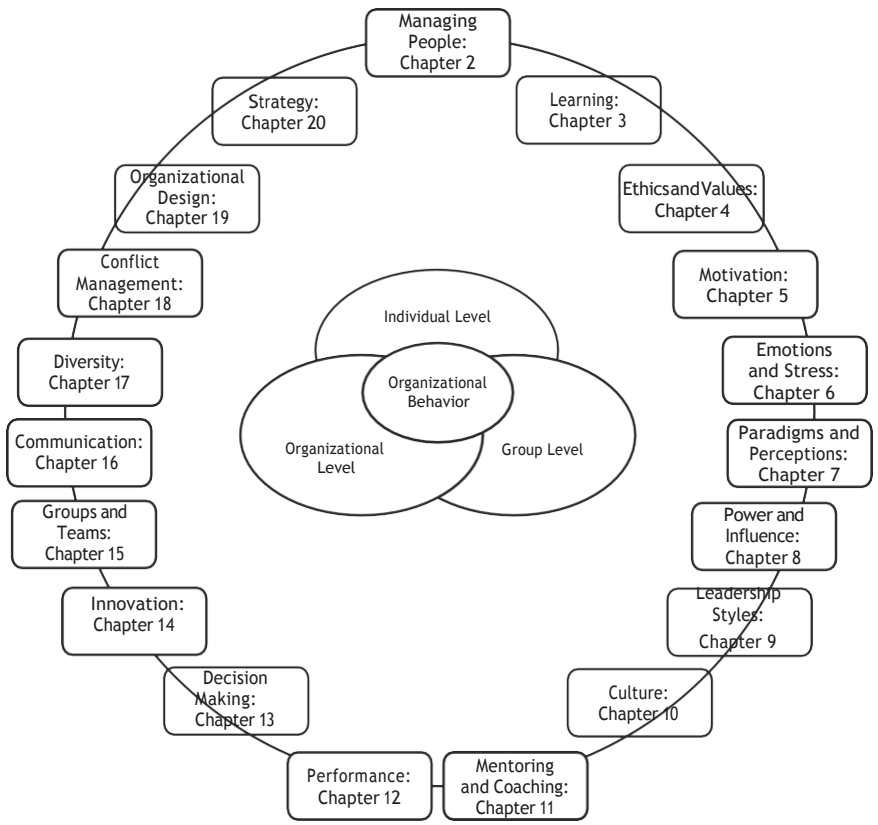


EXHIBIT 1.3 Chapter Topics as They Interact and Relate to Levels of Organizational Behavior

discussed in more than one chapter. For example, ethics and values appear at the individual level yet greatly affect and are relevant to the group and organizational levels as well. Thus, the concepts discussed in the chapters affect the individual, group, and organizational levels of organizational behavior study and organizational theory. Learning and understanding these concepts will prepare managers to work in an organization and to lead others, too.

Chapter Summary

This book provides the reader with a thorough overview of organizational behavior study and organizational theory that can be applied directly to the healthcare field. Organizational behavior study broadly explores the behaviors of individuals, groups, and structures in an organization and their effect on the organization's outcomes and functioning. Organizational theory examines how organizations interact in and across industries and societies. Both concepts originated in the late 1800s, triggered by the Second Industrial Revolution. Early theorists included Max Weber, Henri Fayol, and Frederick W. Taylor.

The concepts and application of organizational behavior study and organizational theory are extremely important in healthcare, given its heavy reliance on services provided by numerous personnel (who come from distinct cultures and professions) and the team-based nature of healthcare delivery (which involves complicated relationships that, if not managed correctly, can be prone to tragic errors). Successful healthcare executives master these concepts and know how to apply them in their organization.

Chapter Questions

1. What are some challenges in healthcare that make managing a hospital or health system more complex than managing a company in any other industry?
2. Why are organizations important in our lives?
3. What were the precursors to the development of organizational behavior study and organizational theory?
4. What factor or factors did Max Weber and Frederick W. Taylor mostly overlook in their theories?
5. What is the difference between organizational behavior study and organizational theory?
6. Why did the Industrial Revolution in the late 1800s affect work relationships so greatly?
7. What events encouraged managers to seek means to address the human influence on work?

Chapter Cases

The Frustrated New Employee

A new hospital employee arrived at orientation and was impressed with the time leaders took to speak with her about the company's values, especially teamwork. She had just graduated from college and was beginning work as a medical technician. She dreamed of working with the team of physicians, scientists, and other researchers to help in the discovery of new treatments.

After two days of invigorating orientation, she was ready to exemplify the values she had been taught. However, when she began her job, she quickly learned that "teamwork" often meant doing what she was told and not speaking up. She tried to engage with the physicians and listened in on their conversations, but they tended to ignore her, and, most of the time, she only understood about half of what they were talking about. She was frequently frustrated and found that the only people who listened to her were the new medical technicians during their breaks.

Case Questions

1. What should the new employee do?
2. How does the professionalization of healthcare personnel influence this situation?

The CEO's Salary Dilemma

Mark was the CEO of a midsized hospital in the Intermountain West region of the United States. He had worked at the facility for more than five years and had a close relationship with the medical staff and his employees. He had a habit of going into different departments and getting to know the employees personally. He was generally liked by most of the employees and "felt their pain" when he heard stories about their family problems and financial struggles.

On the other hand, Mark represented a for-profit company that set very high goals and financial standards. As the hospital was preparing its budget during one very trying year in which the hospital was barely meeting its financial targets, Mark proposed that a 3.5 percent cost-of-living increase be given to all of his employees. This request seemed reasonable, considering employment surveys had found that many of his employees were on the low side of market wages. It appeared that this increase had been approved, so Mark told his employees that they should expect the indicated raise. However, the following week, his regional vice president called to inform him that the

(continued)

(continued from previous page)

profitability of his facility was not high enough and demanded that he rescind the cost-of-living wage increase and allow the amount (about $1.5 million) to be posted as net profits for the organization. Mark explained that he had already announced the salary increase and said it would be damaging to employee morale and his credibility to not proceed with it. The regional vice president bluntly replied that if Mark didn't rescind the pay increase, she would find someone else to do it and he would be fired.

Case Questions

1. Given the circumstances, what would you do?
2. What are some consequences of following the regional vice president's directive? Of not following the directive?
3. What organizational behavior issues are involved in this case?

Integration of an Academic Medical Center and a Private Hospital

In 1995, the course of national politics suggested that healthcare in the United States was moving rapidly toward a new payment system that would be driven by capitation, whereby providers would be paid a fixed amount of money per time period for each insured person. To succeed, most hospitals felt the need to reorganize and create a large base of primary care physicians, who would manage and control costs under capitation payments.

Brigham and Women's Hospital (BWH), a large, tertiary care hospital in Boston, and Faulkner Hospital, a community facility located three miles away from BWH, anticipated the pressures of the forthcoming changes and began exploring close collaboration.

At that time, large, tertiary centers also faced increasing cost competition, as their costs were much higher than those of community hospitals because of their academic teaching activities and patient mix. In addition, in the early 1990s, BWH began to feel pressure from the local insurance companies and decided it could not continue to offer the insurance companies the high discounts from BWH charges to which they were accustomed. Finally, BWH was functioning almost at full capacity, with more than 90 percent of its inpatient beds filled and outpatient services jammed with patients.

Faulkner Hospital, for its part, experienced declining admissions and a small financial loss.

In 1997, after considering several offers from other institutions, BWH and Faulkner convened a meeting of their CEOs, medical staff

presidents, and other key administrative and board members to design a joint collaboration agreement. To preserve local identity while increasing total utilization, the agreement involved a complicated arrangement whereby a parent governing entity, Brigham and Women's/Faulkner Hospital (BW/F), would manage both hospitals and BW/F would become a subsidiary of Partners HealthCare, the largest integrated delivery network in Massachusetts. Each hospital would keep its own board of trustees, but all financial activities would be performed at BW/F. The affiliation would integrate their teaching programs, develop common clinical services, and open up new sites for physician referrals. BWH would seek to transfer about 3,000 secondary care admissions per year to Faulkner, which could generate $13 million to $15 million in additional revenue per year.

Clinical integration was more problematic, as common access to the information systems and other communication pathways was not available. Nonetheless, the decision was made to move surgical and cardiac patients from BWH to Faulkner almost immediately. Later, joint programs in pulmonary medicine, oncology, neurology, infusion, and dialysis were developed at Faulkner. In addition, BWH began moving primary physician practices to Faulkner. The determination of which programs would be relocated was accomplished at a monthly meeting of both hospitals and the involved departments. The range of issues included clinical roles, coverage personnel, and teaching responsibilities.

In early 2000, when BWH was approached by one of the powerful local insurance companies to renegotiate its relationship, it was able to accommodate the insurer by using its network to relocate patients with less complicated conditions to Faulkner and lower overall costs. The insurance company was impressed and agreed to fund some of the transition costs to move the care to Faulkner and establish an advanced medical management program. As can be seen in the following table, the first years following the new contract appeared successful, with high patient satisfaction and a steady increase in volumes:

Admissions and Ambulatory Procedures at Faulkner Hospital

	1999	2000	2001	2002
Number of referred patients	—	491	2,216	3,241
Ambulatory procedures	720	1,270	1,983	2,338

(continued)

(continued from previous page)

Despite the apparent success, the implementation of many of the joint programs caused problems and concern among existing providers. For example, the addition of a hospitalist program (a critical care physician based at the hospital) required reassuring local staff at Faulkner that the program would not affect their income but would improve the efficiency and coordination of patient care. Initially, the use of hospitalists was voluntary for admitting physicians.

The integration of services also required significantly greater coordinative structures than had been in place at either organization in the past. Joint planning and monitoring became a shared activity directed by a monthly BW/F steering committee. Quality assurance protocols demanded the exchange of patient records and cases between institutions, and staff had to be trained to adopt these measures.

Many challenges continued to surface, especially in regard to the different cultures at the hospitals. Trust also had to be built among the members of both medical staffs. Physicians at Faulkner were concerned they would lose autonomy and BWH doctors would try to control clinical practices. Their style of practice and different employment relationships created tension and required continued negotiation.

Although the agreement was deemed reasonably successful seven years into the affiliation, resolution of all problems was not likely to be accomplished and would require continuous monitoring and discussion by the joint leadership groups.

Sources: Adapted from Sussman et al. (2005). See also Altman (1998).

Case Questions

1. What cultural challenges were found in merging the two organizations?
2. What problems surrounding integration were discovered?
3. Why did issues with clinical practice arise?
4. What could be done to improve the likelihood of a successful merger?

CHAPTER 2

THEORIES OF MANAGING PEOPLE

Learning Objectives

After studying this chapter, readers should be able to

- explain the historical progression of prominent early management theories;
- compare and contrast the principal management theories; and
- summarize scientific management theory, administrative theory, human relations theory, theory X and theory Y, the contingency approach, and open systems theory.

Key Terms

- Administrative theory
- Contingency approach
- Human relations theory
- Maslow's hierarchy of needs
- Open systems theory
- Theory X and theory Y

As anyone who has held a managerial position knows, dealing with people is the biggest challenge in making a business work well. Although understanding money, strategy, economics, and statistics is important, the majority of most managers' time is spent handling employees. Being a boss can be very lonely. Managing often requires making unpopular decisions, allocating resources to one group over another, and balancing personal and business priorities.

In the box on page 16, a consultant reviews some of the most difficult management challenges he faced in his career. Healthcare managers confront these types of issues as well. While needing to be transparent about most activities, managers also must be able to withhold confidential information. They constantly face quality-versus-cost issues. Managers have to meet budgets and financial targets and still preserve a high quality of service delivery.

In addition, they must properly and consistently apply policies—a duty that can quickly become a headache. As mentioned throughout the book, policies

The Most Difficult Challenges Faced by One Consultant

1. *Knowing things you can't share with your employees*. Your business may be struggling. Decisions to lay off employees, discussions of confidential matters at board meetings, and secret negotiations about acquisitions and mergers may be ongoing. None of these activities may be shared prior to formal announcements.
2. *Balancing quality against finances*. Managers are held to budgets and financial expectations, whether in terms of profits or other financial standards. The challenge of extending resources while achieving excellence in products or services and meeting financial goals remains significant for most.
3. *Enforcing policies at the risk of losing a superstar*. Consistent application of policies can be difficult if a superstar salesperson, physician, or manager violates a policy. For example, medical staff bylaws usually call for suspension of admitting privileges if a physician does not complete charts in a certain number of days. If a top admitter has surgery scheduled and should be suspended, the manager must decide whether to enforce the bylaws and suspend her.
4. *Dealing with interpersonal conflict among employees*. Managers have to sort out interpersonal issues without seemingly taking sides. Employees almost always perceive situations differently than do those with whom they are in conflict, may stop speaking to each other, and may even seek to sabotage the work of others they see as their enemies. Managers must take the role of facilitator, arbitrator, and peacemaker.
5. *Lacking rewards to retain talented employees*. The need to continually motivate and reward highly talented employees is a huge challenge. The best employees usually have many more work opportunities than do those with lesser abilities. Managers must often be creative to develop opportunities and rewards that motivate and engage top talent.

Source: Adapted from Haden (2011).

are only a means to an end and can be appropriately ignored, but in critical situations, the challenge to apply them to an organizational superstar can be difficult. Likewise, dealing with conflicted employees, who often tell contradictory stories, requires an inordinate amount of time to ferret out what is really occurring and resolve the issues. Finally, managers must find the right rewards to continue to motivate top employees.

At issue is that many managers do not handle the challenges well and fail to arrive at positive resolutions. The fact that about 75 percent of American workers feel disengaged from their work and 35 percent quit in their first six months of employment bears out the poor management skills of many bosses. Gallup (2013) estimated that poor management and its resulting disengagement cost the US economy an estimated $450 billion to $550 billion annually. Specific to healthcare, research suggests that disengaged healthcare workers exhibit negative behaviors that can diminish quality of care and damage their organization (Christian and Ellis 2014).

Yet people around the world are often more involved in work relationships than in any other aspect of their lives. Most spend far more time with their coworkers than with family and friends, and the majority of employees' organizing and coordinating activities,

disagreements, and conflicts occur in work environments and involve coworker relationships (Sias 2008). Clearly, human relationships matter a great deal in management.

As mentioned in chapter 1 and discussed in the adjacent box, the Hawthorne studies demonstrated that relationships and social context, along with organizational design and structure, affect employee performance. This finding led to the creation of many "new" management theories that embodied the influence of interpersonal relationships and human dimensions. In this chapter, the more prominent of these management theories are explored.

The Hawthorne Studies

One of the early major advances in organizational behavior study resulted from research conducted by Elton Mayo and Fritz Roethlishberger in the 1920s, often referred to as the Hawthorne studies because they were conducted on workers at the Hawthorne factory of the Western Electric Company in Chicago. The Hawthorne findings were influential in refocusing management strategy from scientific management to include the social and psychological aspects of human behavior in organizations.

Mayo and Roethlishberger hypothesized that worker productivity would improve if employees chose their own coworkers, worked as a group, were treated distinctively, and had sympathetic supervisors. Following numerous experiments, they concluded that monetary incentives and working conditions were generally less important to productivity than employees' need and desire to be part of a group and their inclusion in decision making. Employees were motivated by more than money, and productivity was affected by factors other than just pay and optimizing work flow.

Source: Information from Boundless (2016).

Weber's Efficient Bureaucracy

As discussed in chapter 1, the early theorists founded administrative theories that postulated optimal structures and operations of businesses. Max Weber, a prominent scholar in the late nineteenth and early twentieth centuries, believed in the Protestant work ethic and that work structures and processes should be rationally organized to increase the economic efficiency of a company. Weber's writings, juxtaposed at that time with Marxism's class struggle, promoted modern capitalism as a means for rational efficiency through bureaucratic management. He became best known for his book *The Theory of Social and Economic Organization,* published after his death (Weber 1958). He proposed that as organizations mature, bureaucracy, with its structures, processes, and routines, is the best means by which to achieve efficiency and is even required by modern society's move to larger, more mature organizations driven by capitalism, rather than the management approaches based on lineage, patronage, and kinship of previous eras. As he stated, "Precision, speed, unambiguity, knowledge of files, continuity, discretion, unity, strict subordination, reduction of friction and of material and personal costs—these are raised to the optimum point in the strictly bureaucratic administration" (Weber 1958).

Weber's ideal bureaucracy was defined by the following six characteristics:

1. *Hierarchy of command:* Each office has a clearly defined chain of command, and each person has a specific leader to whom he reports. Planning and decision making are exercised along the hierarchy and chain of command.
2. *Impersonality:* Officeholders are selected on the basis of their technical qualifications, and rules are systematically applied. All employees are treated equally.
3. *Written rules of conduct:* Rules are clearly defined and understood by all employees, allowing higher-level decisions to be executed at lower levels.
4. *Advancement on the basis of achievement:* The best-qualified people, as determined by their work performance and skills, are promoted.
5. *Specialized division of labor:* Each job has clear duties that are broken down into component parts and performed by specialists. The organization is divided into units according to the specialties workers perform.
6. *Efficiency:* The overall goal of the organization is to structure itself to maximize its efficiency.

Although bureaucracies today have gained a reputation for being complex, inefficient, inflexible, and dehumanizing, in the late 1800s and early 1900s Weber's work found many adherents who were seeking ways to improve organization and management. His work did have significant benefit and became the foundation for many public administration and civil service systems (Hooghe 2001).

Administrative Management Theory

Building on Weber's propositions, in the early 1900s a number of individuals sought rational ways to design and structure an organization. Their theories aimed to describe best management practices for all firms. The best organizations were thought to have a formal administrative structure, a clear division of labor, and delegation of power and authority for managers over their specific areas of responsibility. The formal administrative structure has clear lines of authority from the top to the bottom of a company, forming the organization's hierarchical framework. The division of labor provides an obvious demarcation of each department's responsibilities and allows increased specialization.

As mentioned in chapter 1, Henri Fayol was one of the primary contributors to **administrative theory** and proposed 14 general management principles

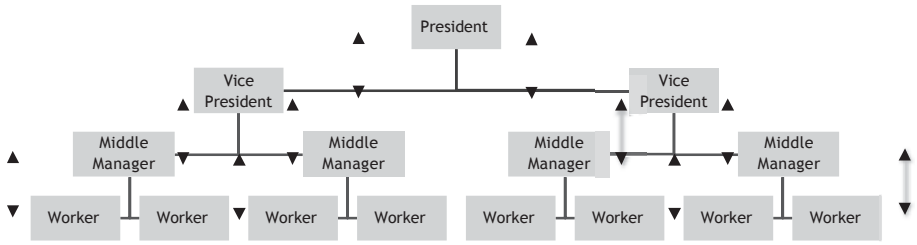


EXHIBIT 2.1
The Scalar Principle

(distilled into five managerial functions). Others, such as Luther Gulick, James Mooney, and Alan Reiley, using historical precedents, formulated systematic guidelines for organizations such as the scalar principle, functional principle, coordinative principle, and staff principle (Mooney and Reiley 1939; Ramos 1978).

Scalar Principle

According to the scalar principle, subordinates at each level communicate only through a chain of command to their immediate supervisor or subordinate (exhibit 2.1).

Functional Principle

Under the functional principle, the function of each job and activity is defined by objectives, implementation, and control to clearly denote the nature of the job. Job descriptions, such as the following nursing job description (reprinted from Saint Louis University 2016), follow the functional principle:

Staff Nurse
JOB DESCRIPTION

Job Summary: Under general direction, manages and directs nursing care activities and coordinates care planning with other disciplines.

CHARACTERISTIC JOB TASKS AND RESPONSIBILITIES

May include any and/or all of the following:

1. Ensures efficient and coordinated clinic flow by coordinating and planning clinic activities; communicates patient's needs; makes referrals; serves as a resource person of insurance information.
2. Delivers direct patient care; assesses patients' physical, psychosocial and/or emotional needs; provides patient and family teaching; triages patients and informs physician of patient status; responds to phone messages from patients and informs physicians as needed; orders supplies; stocks and maintains patient's rooms; sterilizes instruments.
3. Administers medications as assigned; serves as a resource person for knowledge of medication uses, side effects, and dosage; checks for proper medication order; documents medications; obtains required consent forms to administer

immunizations; notifies pharmacies of physician approved prescriptions; reviews drug samples to insure they have not exceeded the expiration date; labels sample drugs and educates patients of medication administration.

4. Performs other duties as assigned.

Coordinative Principle

The coordinative principle describes an orderly arrangement of a group's effort, creating unity of action to seek a common objective. This principle can be institutionalized by emphasizing the organizational mission and vision statements. Strong Memorial Hospital's (2014) mission and vision provide an example of the coordinative principle:

Our Mission

We improve the well-being of patients and communities by delivering innovative, compassionate, patient- and family-centered health care, enriched by education, science, and technology.

Our Vision

We will define and deliver "Medicine of the Highest Order" and set the standard for compassion and innovation, always placing patients and their families first.

Staff Principle

In the staff principle, sometimes called the *line-staff principle*, staff members provide advice and ideas while line management makes sure tasks are accomplished (Sahni and Vayunandan 2010). The following description of the duties of rehabilitation counselors demonstrates their line duties (US Bureau of Labor Statistics 2010):

Rehabilitation Counselor Duties

Counsel individuals to maximize the independence and employability of persons coping with personal, social, and vocational difficulties that result from birth defects, illness, disease, accidents, or the stress of daily life. Coordinate activities for residents of care and treatment facilities. Assess client needs and design and implement rehabilitation programs that may include personal and vocational counseling, training, and job placement.

Maslow's Hierarchy of Needs

By the 1940s, management theorists were attempting to understand what factors motivated humans to work. In 1943, Abraham Maslow published his first book, which sought to explain the stages of human motivation and needs.

What became known as **Maslow's hierarchy of needs** is often portrayed as a pyramid with five levels, representing categories of needs (exhibit 2.2). Maslow categorized these needs by complexity, with the least complex (most basic) need—physiological requirements for survival—at the base of the pyramid, and increasingly complex (less basic) needs cascading upward. Maslow postulated that each type of need has to be met before an individual can move up to the next level of need. For example, a person who is starving seeks to satisfy the need for food before addressing the needs for safety and social interaction.

Maslow saw the uppermost level of need as different from the rest. He believed the highest set of needs were "growth needs" that came from a person's desire to grow, whereas the lower needs were triggered by the absence of something and thus were "deficiency needs." From a work perspective, Maslow's hierarchy calls for managers to first help workers meet basic needs before helping them achieve their full individual potential. If workers lack basic physiological, security, social, or esteem needs, they cannot self-actualize.

Although the theory makes intuitive sense, most research has not supported Maslow's hierarchy of needs. However, despite this lack of empirical support, Maslow's theory helped make managers aware of categories of needs that should be addressed, and it still has application today. Many managers now understand that the greatest level of productivity generally occurs when employees are fully engaged and self-actualized (Villarica 2011). That said, as the box on page 22 illustrates, too often supervisors seek to motivate by threat and fear, which may change employees' immediate behaviors but impedes their growth and ultimate positive outputs.

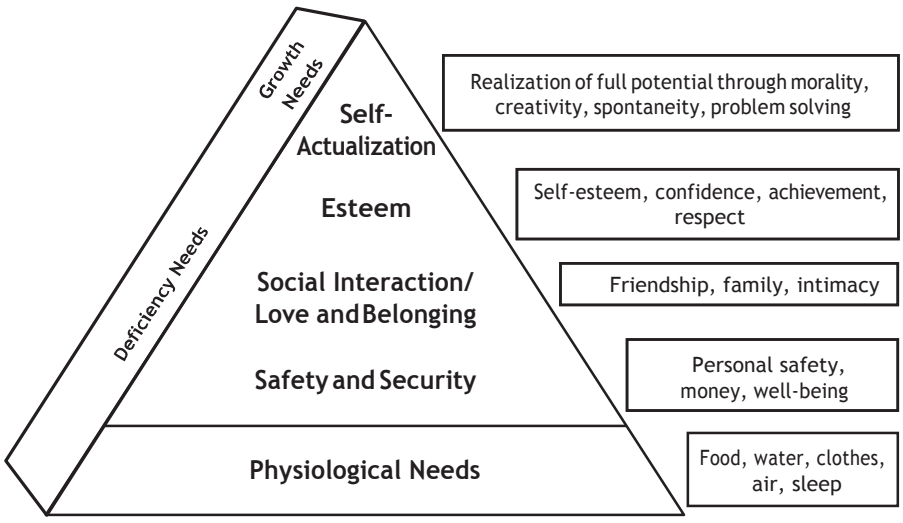


EXHIBIT 2.2 Maslow's Hierarchy of Needs

Jean's Irritation

A huge open house event was planned at the medical clinic where Jean worked, and she was not pleased with the response of her employee, Sue. Jean had been delayed in planning the open house until a couple of weeks prior to its date and had stressed to Sue that she would have to put all of her effort into the event's preparation. However, Sue's sister was getting married on the Saturday before the event, and Sue was not available to help for most of the weekend. Jean was irritated that Sue did not even answer her phone or return e-mails until late Sunday. By Monday morning, Jean was fuming, as she had worked all weekend and had wanted to motivate Sue to get going. She called Sue into her office and threatened to fire her if she ever failed to answer her phone and e-mails when they had a critical function to coordinate. After the meeting, Jean felt she had motivated Sue and was sure she would not fail to respond in the future.

According to Maslow's hierarchy of needs, would this behavior motivate a person to become self-actualized? How does Jean's behavior affect Sue's lower deficiency needs, as described by Maslow? If you were Jean, what would you do to motivate Sue?

Human Relations

As discussed earlier, the Hawthorne studies, conducted in the 1920s, were the first significant empirical examination of the effect of the human element on organizational outcomes. This and other early studies suggested that workers' needs for achievement, recognition, and social interaction could affect their productivity.

Theory X and Theory Y

One of the founders of modern **human relations theory** was Douglas McGregor, who became known for his theory X and theory Y paradigm (Overvold 1987). Developed in the 1960s, his seminal work at the Massachusetts Institute of Technology Sloan School of Management has been applied since that time to many management perspectives.

Theory X and theory Y describe how managers perceive their employees and how these perceptions affect motivation and behavior. McGregor suggested that individuals have differing opinions and expectations regarding human nature (Overvold 1987). As shown in exhibit 2.3, managers with a theory X perception supervise their workers closely and adopt strict control systems that involve incentives and threats. On the other hand, managers with a theory Y perspective allow their employees more freedom to make decisions, focus on developing workers' skills, and encourage participation.

McGregor's theory X and theory Y describe fundamental distinctions in management style and contrast the extremes of scientific management with the underlying assumptions of the Human Relations Movement. As such, it has become a foundation for much current management perspective (*Economist* 2008). McGregor claimed that both perspectives have value in different contexts. However, theory Y has been widely adopted as the preferred model in business and management literature. Nevertheless, as many workers can attest, theory X persists across many industries and work settings (Bobic and Davis 2003).

Theory X Manager Believes Employees	Theory Y Manager Believes Employees
Are inherently lazy	May be ambitious and self-motivated
Avoid and dislike work	Enjoy mental and physical work
Need incentive programs for motivation	Have abilities to problem solve
Require a narrow span of control	Seek out and accept responsibility
Avoid responsibility and work	Exercise self-control and self-direction
Respond to threats and coercion	Want to do well at work
Need to identify person at fault to solve problems	Find satisfaction of doing a good job—a strong motivation
Need managers to structure the work and provide motivation	Need to be challenged to discover and innovate
Need restrictive controls and constant pressure to perform well	Should be involved in decision making
Prefer security at work	
Resist change at work	
May be gullible and easy to manipulate	

EXHIBIT 2.3
A Comparison of Theory X and Theory Y Perceptions Regarding Employees

Contingency Approach

In the 1950s, several researchers and management writers explored the effects of the internal and external situational environment on management actions. Those proposing the **contingency approach** suggested that Weber's bureaucracy and Frederick Taylor's scientific management theories had failed, as they had implied one best way to organize and ignored the effects of the environment on management style and organizational structure. There is no one best way to lead and organize, they contended; instead, how an organization is led depends on which of a variety of management structures is in place (Mintzberg 1979). The critical issue is the fit of the organizational structure with the contingent environmental factors. Firms that fit into, or match up with, the environment are more likely to succeed than are firms that are not well matched to the environment.

Different management theories proposed different factors. Joan Woodward (1958) believed that key contingencies included the following:

- Technology
- Suppliers and distributors
- Consumer interest groups

- Customers and competitors
- Government
- Unions

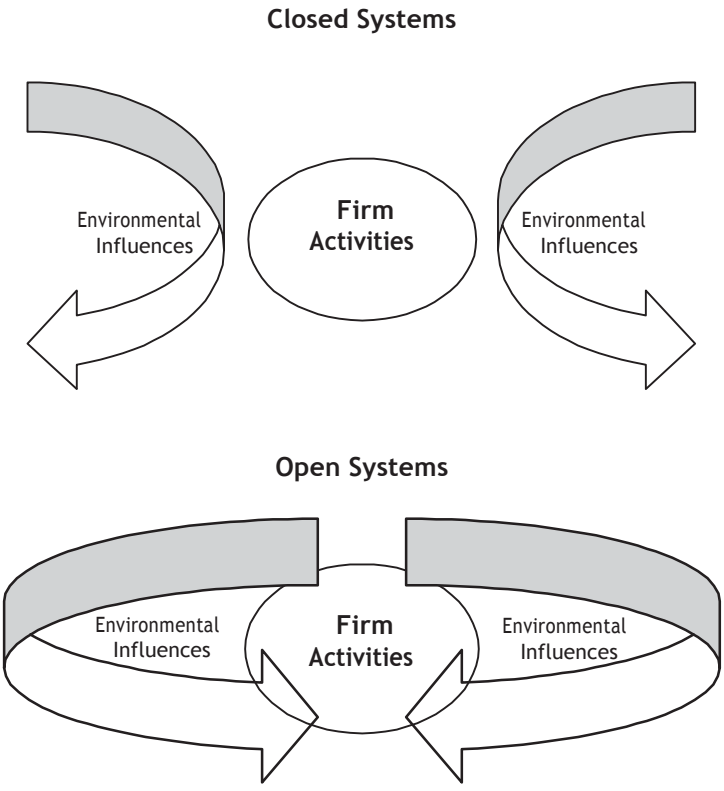
She suggested that the degree of span of control, centralization of authority, and formulation of rules and procedures should vary according to the existence, strength, and power of these factors.

Later management theorists named the theory the *structural contingency theory* (Pfeffer 1982) and expanded the methods and processes that organizations use to adapt to environmental influences.

Open Systems Theory

Concurrent with the contingency approach, other theorists developed the concept of open systems. Earlier management theories typically were based on the assumption that organizations are largely self-contained entities that can be relatively closed off from their environments. **Open systems theory** postulates that firms are highly influenced by their environments and that the environment plays a significant role in explaining what happens in a firm (exhibit 2.4). Today, most management theories presuppose the open systems concept (Scott 2002).

EXHIBIT 2.4
Open Systems vs. Closed Systems



Chapter Summary

Organizations frequently struggle with their employee relationships. Human relationships matter a great deal to organizations, as they are a key factor in productivity. Early management theorists often ignored the human relations aspect of business while seeking to explain how organizations could best be structured and operated. Weber crafted rules for an ideal bureaucracy, which became the foundation for most public administration and civil service systems. Others formulated principles of management to derive efficient and effective business practices.

In the 1940s, Maslow and others began to explore what motivates employees. Maslow's hierarchy of needs grouped workers' needs into five levels, with the highest—self-actualization—said to be unachievable until lower-level deficiency needs are met.

Other theories evolved to address the human relations aspect of work, including theory X and theory Y, which are contrasting manager perspectives of employees. The contingency approach informs managers that effective management style and organizational structure change depending on the firm's internal and external conditions. Companies with a greater fit with these conditions have a greater likelihood of success. Open systems theory suggests that organizations are subject to pressures and influences by their environments.

All of these theories have contributed greatly to the modern theories of organizational behavior and are the foundation of the leadership and management perspectives discussed in the remainder of this book.

Chapter Questions

1. How might the components and application of the principles of bureaucracy in a public health agency benefit the community?
2. What is a hierarchical structure?
3. How does the coordinative principle differ from the scalar principle? How could they conflict?
4. Maslow divided human needs into five categories and contended that lower-level needs have to be met prior to achieving the highest need of self-actualization. Describe a situation in which this hierarchy holds. Describe one in which it might not hold.
5. Would a manager with a theory X perception of workers give more or less responsibility to his employees? Why?
6. The contingency approach suggests that a firm will be more successful when what occurs?
7. Open systems theory suggests that the external environment affects a company's ability to function. Identify any similarities between the contingency approach and open systems theory.

Chapter Cases

Nepotism at Central Illinois Community Hospital

Central Illinois Community Hospital was a new, 67-bed, acute care hospital in semirural Redmond, Illinois. The hospital had been planned and financed by a community board as the first hospital in the county. The first executive the community board hired was Syd Baker, as CEO. Syd had been a successful pharmacist in town and was respected by many, but he was also related to a large portion of the population in the county.

Immediately he was swamped by requests for positions at the new hospital. One board member joked that he probably had enough relatives to staff the entire hospital. Others wanted to hold positions of responsibility in the new hospital because of their status and political connections in the county. Syd had concerns about showing favoritism to any group, especially his relatives. At one of the first board meetings, at which his second cousin presided as board chair, Syd proposed a set of policies that would govern hiring for the new hospital. He suggested creating job descriptions for each position, which would establish minimum degree and experience requirements. The hiring process for each department head would involve a panel, composed of the human resources director, one board member, and Syd. In addition, he proposed the following nepotism policy, which would apply to all new hires.

Nepotism Policy

It is the goal of this policy to avoid creating or maintaining circumstances in which the appearance or possibility of favoritism, conflicts or management disruptions exist. The hospital will not allow related persons to be hired by and/or work in the following relationships:

1. Individuals may not work under the supervision of the same manager;
2. They may not create a supervisor/subordinate relationship with a family member;
3. They may not supervise or evaluate a family member;
4. The relationship will not create an adverse impact on work productivity or performance;
5. The relationship may not create an actual or perceived conflict-of-interest;
6. They may not audit or review in any manner the individual's work.
7. They may not be employed if a related* member of the employee serves on the hospital's Board or any Committee or Council which

has authority to review or order personnel actions or wage and salary adjustments which could affect his/her job.

*For purposes of this policy "related" persons shall include relationships established by blood, marriage, or legal action. Examples include the employee's spouse, mother, father, son, daughter, sister, brother, mother-in-law, father-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepparent, stepchild, uncle, nephew, niece, grandparent, grandson, or cousin.

Upon receipt of the proposed nepotism policy, one board member expressed the view that the new hospital should be an innovative, adaptive organization and was concerned that this kind of policy would turn it into a "bureaucracy." He then launched into a story about how the hospital in the neighboring county had refused to take responsibility for billing errors and its "policies" had prohibited the hospital from helping his family members receive the care and respectful treatment they deserved.

The rest of the board seemed to agree with the member's comments, but no action was taken and Syd was left wondering what he should do.

Source: Nepotism policy excerpted from Northeast Institute for Quality Community Action (2016).

Case Questions

1. Would establishing a nepotism policy create a bureaucracy?
2. Is a bureaucracy necessarily bad?
3. How could Syd convince the board that a nepotism policy would protect the hospital and promote general goodwill and productivity?
4. If a nepotism policy were necessary, how could Syd make certain that it would not have negative effects on the organization?

Believing Theory Y but Living Theory X

When Elizabeth was hired as the manager of Stonybrook Medical Clinic, she was asked what management style she used. She had recently graduated with an MBA from Stonybrook College, and in her organizational behavior class she had learned about theory Y and theory X. Her response reflected her belief that people should be trusted and engaged and that she was a theory Y manager.

A month after she started, Elizabeth's boss, James, began to ask for improved productivity from her staff. He said times were tough and, if she were to receive a good year-end review, she would have to quickly

(continued)

(continued from previous page)

increase productivity by 20 percent. They discussed the reasons for the staff's low productivity and concluded that many of the workers were just lazy. They seemed to call in sick more often on Fridays and Mondays than on the other days of the workweek. They also seemed to be surfing the Internet and using social media on their smartphones rather than doing their work. Elizabeth and James concluded that the best way to get productivity up was to institute a series of controls: Each employee would begin documenting his activities and asking permission to go anywhere outside his work area.

Case Questions

1. How were Elizabeth and James living theory X?
2. What could they have done from a theory Y perspective?
3. Why do managers often implement controls that are based on a theory X perspective?

CHAPTER 3

INDIVIDUAL AND ORGANIZATIONAL LEARNING

Learning Objectives

After studying this chapter, readers should be able to

- appraise the mechanisms and processes that allow individuals and organizations to learn,
- compare and contrast models of learning,
- evaluate the definition and purpose of organizational learning,
- discover the components and processes of organizational learning,
- realize that learning is a cycle that repeats,
- explain the barriers to individual and organizational learning, and
- explain the differences and similarities between organizational learning and a learning organization.

Key Terms

- Double-loop learning
- Learning communities
- Learning management systems
- Learning organization
- Organizational learning
- Single-loop learning

Learning has been defined as a change in knowledge that occurs as the result of experiences (Fiol and Lyles 1985). **Organizational learning**, then, is "an organizationally regulated collective learning process in which individual and group-based learning experiences concerning the improvement of organizational performance and/or goals are transferred into organizational routines, processes and structures" (Schilling and Kluge 2009, 338).

Learning can be achieved by gaining new facts and information; acquiring new procedures, processes, or skills; or establishing new routines and knowledge of action–outcome relationships (Argote 2013; Duncan and Weiss 1978). Learning is critical in healthcare, which is constantly evolving and continues to be challenged with patient safety issues. Change drives the need for learning, and learning allows the implementation of new knowledge and practices

to initiate change. Learning in healthcare must be a continuing function that occurs by both formal and informal means to produce the best possible outcomes for the organization and those it serves (Ratnapalan and Uleryk 2014).

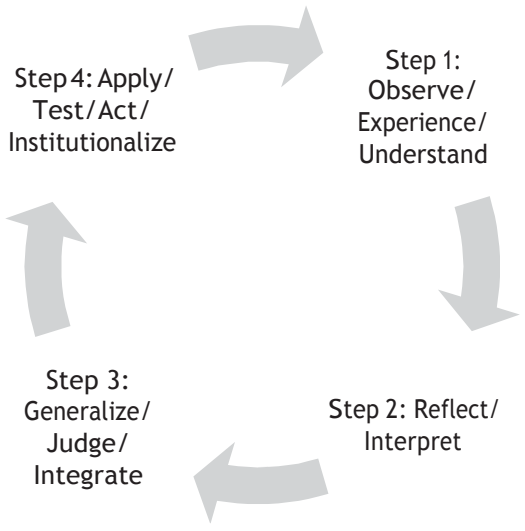
The following four processes constitute the act of learning in an organization (Schilling and Kluge 2009):

1. *Understanding*—gaining new insights and ideas based on personal experience
2. *Interpreting*—deducing relationships among insights, including the ability to explain the relationship to self and others
3. *Integrating*—assimilating new insights into groups to allow for collective action
4. *Institutionalizing*—implementing the shared understanding through organizational rules, procedures, and strategies

As this list implies, organizational learning also occurs at different levels in an organization: individual, group, and institutional (Crossan, Lane, and White 1999).

Because organizational learning processes are ongoing, learning can be seen as a cycle, as shown in exhibit 3.1. In step 1, people or organizations observe or experience an activity and gain understanding. The new understanding can be vicarious or personal, depending on whether it comes from training, news, interactions, or other means. The information is processed, interpreted,

EXHIBIT 3.1
The Cycle of Learning



Source: Adapted from Beard and Wilson (2006).

and reflected on in step 2, leading to generalizations and judgments in step 3 that allow integration of new insights. In step 4, actions occur that apply and test the generalizations and judgments made in the previous step to institutionalize the learning, which leads back to step 1, where the individual or organization again makes observations and gains experiences from its actions.

Argyris and Schon (1978) proposed that organizational learning can be either single- or double-loop learning. **Single-loop learning** occurs when employees search for solutions within the confines of given goals, values, plans, and rules. **Double-loop learning** takes place when the "governing variable" is questioned, causing shifts in strategies, values, or mission. Argyris and Schon (1978, 2–3) explained the difference as follows:

> When the error detected and corrected permits the organization to carry on its present policies or achieve its present objectives, then that error and correction process is a single-loop learning. Double-loop learning occurs when error is detected and corrected in ways that involve the modifications of an organization's underlying norms, policies, and objectives.

Of course, organizations are only a composite of individuals, and the type and degree of learning that transpire in an organization are only a reflection of the aggregation of all its employees and stakeholders. As a result, the term **learning organization**, having gained popularity in recent decades, is viewed differently from organizational learning. Organizational learning is a process, whereas a learning organization is a place in which ingrained structures and culture constantly facilitate and encourage learning (Malhotra 1996).

A learning organization purposely creates appropriate strategies and structures to enhance education and training. As a reflection of this concept's level of popularity, some firms now employ a chief learning officer, who typically reports directly to the CEO and is responsible for corporate training, development, and knowledge management. (The trend has even resulted in the creation of *Chief Learning Officer* magazine [www.clomedia.com].) Efforts to transform into learning organizations help companies transcend single-loop learning and produce creative solutions to position themselves for success today and in the future.

One of the early proponents of the learning organization concept, Peter Senge (2006), noted the presence of five main characteristics of learning organizations:

1. *System thinking*—understanding and analyzing how all the components of an organization influence each other within the whole to find and eliminate obstacles to learning
2. *Personal mastery*—individual commitment to self-improvement and the process of learning

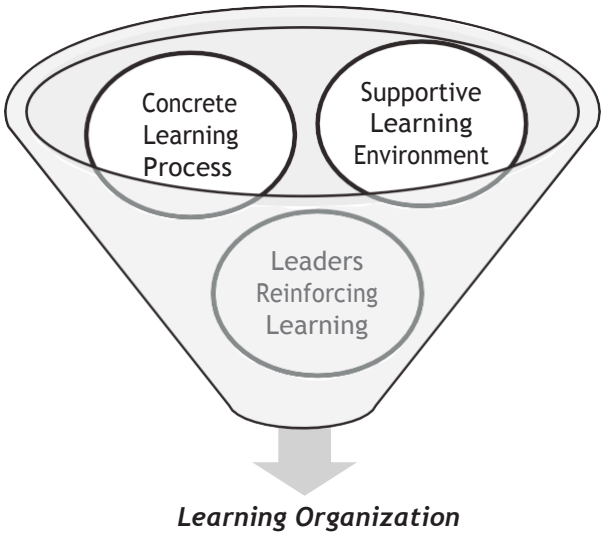
3. *Mental models*—assumptions held by individuals and the organization that promote learning through their culture and mind-sets
4. *Shared vision*—a common vision that stimulates learning
5. *Team learning*—group cohesiveness and dialogue that motivate common team learning

Garvin (1993, 80) further defined a learning organization as one "skilled at creating, acquiring, and transferring knowledge, and at modifying its behavior to reflect new knowledge and insights."

For learning to be sustained, an organization needs a supportive environment that allows employees to disagree, ask questions, and take risks by providing a sense of psychological safety that eliminates fear of disagreement and failure, an appreciation of the differences among employees, openness to new ideas, and adequate time for thought and reflection (exhibit 3.2). Learning organizations also structure learning in a concrete way that identifies, collects, interprets, and allocates data for decision making and problem solving. Finally, such organizations hire and retain leaders who reinforce learning: Bosses encourage questioning and the voicing of alternative viewpoints, and they listen (Anderson and Escher 2010; Garvin, Edmondson, and Gino 2008).

Although these concepts may seem simple and logical, many organizations struggle to learn and often fail as a result. Many factors—personal, group, or organizational—can impede learning in organizations and include the following:

EXHIBIT 3.2
Components of a Learning Organization



Source: Adapted from Garvin, Edmondson, and Gino (2008).

Personal barriers:

- Personal biases
- Lack of motivation
- High degree of stress
- Lack of skills
- Deficit of trust
- Fear of punishment

Group and organizational barriers:

- Lack of clear goals
- Minimal feedback
- Strict work rules
- Excessive competition
- Blaming culture

The US Joint Chiefs of Staff Learn Not to Learn

In 1965, the Vietnam War was not going well for the United States. Assumptions regarding the way the war was being conducted were known to be faulty by many of the top generals, but many feared voicing their concerns. Finally, in November of that year, the members of the Joint Chiefs of Staff, the senior body of military officers who advise the president, gathered up the courage to meet with President Lyndon Johnson to call for a completely different strategy informed by their concerns.

President Johnson was not pleased to hear from them and did not offer them seats at the meeting. He sat while they stood in a semicircle and gave him their presentation. When they finished, the president turned his back on them for about a minute. Then he whirled back around and in an angry tirade screamed obscenities at the generals, both as a group and individually. He ridiculed them and told them to "get the h— out of here right now" (Ricks 2013).

The war continued on its blundering, bloody path and concluded only when the United States pulled out ten years later, after more than 58,000 US lives were lost and almost $700 billion was spent (Barnes 2009).

Barriers to learning can have a profound impact on an organization's outcomes. As shown in the adjacent box, the behavior of the leader can dramatically influence the actions and learning behaviors of even very senior, highly trained individuals. One of the most destructive impediments to individuals' learning is being publicly embarrassed and shamed for mistakes. The old adage to praise publicly and punish privately remains an essential management strategy to allow organizational learning to take place.

Role of Motivation in Learning

People can be motivated to learn. Furthermore, certain motivation techniques have been shown to affect the amount of time individuals devote to learning (Bransford, Brown, and Cocking 2000).

Motivation can originate from both extrinsic and intrinsic sources. Extrinsic rewards are external incentives offered to encourage a certain behavior. As discussed in chapter 5, extrinsic rewards can be monetary, social, or organizational. Most changes in work activities and behavior require some amount of extrinsic motivation, as the work itself may not be inherently interesting. Companies often seek to motivate learning by giving external monetary and nonmonetary rewards to their employees. However, the primary reason people perform a behavior or an activity is that they feel valued by their social and work group (Ryan and Deci 2000), which constitutes intrinsic motivation.

Because much of the learning in organizations occurs in and through groups and not in a classroom setting, effective organizations structure learning opportunities in social contexts to take advantage of intrinsic motivational factors. They create a sense of community by developing norms for behavior and creating an emotionally safe environment to allow employees and supervisors to teach one another (Hammond et al. 2001).

Challenges of Learning in Healthcare

Organizational learning in healthcare is tremendously important today. Healthcare technology and complexity have grown and continue to rapidly evolve, as the rate of new scientific knowledge has exploded in the areas of genetics, proteomics, telemedicine, robotic medicine, and molecular biology. All medical professionals are struggling to keep up with knowledge that is often "fragmented, uncoordinated, and diffusely organized" (Institute of Medicine 2013). At the same time, they must be focused on those they serve.

Creating a learning healthcare organization can be a complex endeavor in that it demands instantaneous access to rapidly evolving knowledge (exhibit 3.3). Healthcare systems must also be able to digitally capture experiences of patient care, engage their patients in the learning opportunity, provide proper incentives to staff, allow full transparency, develop a culture directed by enlightened leaders, and offer training and system analysis that allow competency development.

Healthcare demands high quality and no failures to ensure the safety and well-being of patients on a daily basis. However, process failures in healthcare occur and recur far too frequently when learning does not take place. Nurses have been found to effect short-term fixes to processes that solve the immediate issue but fail to resolve the problem, which then recurs. For example, a lack

EXHIBIT 3.3
Characteristics of a Continuously Learning Healthcare System

- Real-time access to knowledge
- Digital capture of the care experience for care improvement
- Engaged, empowered patients
- Incentives aligned to reward high-value care
- Full transparency
- Leadership-instilled culture of learning
- Supportive system competencies through training, system analysis, and feedback loops

Source: Adapted from Institute of Medicine (2013).

of clean linen may motivate a nurse to walk to another unit to borrow linen. This action may provide the needed linen but not solve the lack of adequate linen in the original location and may create secondary problems for other departments (Tucker and Edmondson 2003).

In some respects, learning in healthcare is more complicated than in other industries. The professionalism, functional organizational structures, and tight interdependencies that exist in healthcare create situations ripe for disaster unless diligence is practiced and learning takes place. For example, doctors and nurses are taught to make independent decisions and address individual patient problems. Their time is also very costly, so their organizations design their jobs to provide limited nonstructured time. Moreover, the work design often does not provide for an on-site manager to facilitate communication and activity across departmental boundaries, hindering problem resolution (Tucker and Edmondson 2003).

In addition, medical professional training programs have been designed to focus almost exclusively on clinical knowledge and minimize nonclinical learning, which occurs in training settings that often lack "self-reflection, dialogue, inquiry, and reciprocal communication" and result in healthcare providers who frequently find new learning difficult (Hoff, Pohl, and Bartfield 2006).

Some healthcare systems have developed **learning management systems** to formalize their learning processes. Southwestern Vermont Health Care, a small, not-for-profit health system located in Bennington, Vermont, uses a learning management system to "provide on-the-job support and resources . . . which reinforce the patient-centric culture." (Healthcare Source 2014). The system is online, which allows ready access to employees and permits managers to rapidly communicate changes in policy and archive meeting results in a consistent manner.

Others, such as Bon Secours Health System, in Marriottsville, Maryland (see the adjacent box), have crafted **learning communities** to redesign and improve their patient care. Learning communities have been defined as "as a select group of potential adopters and stakeholders who engage in a

Learning Communities Spread Best Practices Across a System

Bon Secours Health System's implementation of learning communities has helped the organization decrease infection rates by half and decrease the aggressive use of open-heart surgery by 45 percent. In 2007, Bon Secours, comprising 19 acute care hospitals in six Eastern states, began creating learning communities, each focused on a specific topic, to redesign its patient care.

The learning communities establish best practices that then become part of Bon Secours leadership's performance expectations. Staying focused on what is important to patients, achieving measurable outcomes, persisting across several years, spreading what is learned, and institutionalizing accountability from the C-suite to the bedside have been key factors in the success of Bon Secours.

Source: Information from Butcher (2012).

shared learning process to facilitate adaptation and implementation of innovations..... Learning Community participants work together in an interactive group setting and leverage ..... resources to address a defined problem" (Agency for Healthcare Research and Quality 2016).

An organization can more easily embed learning if it adheres to the following tenets:

- Reinforce key concepts (e.g., key ideas introduced at meetings) through complementary online learning modules.
- Tailor education to specific needs, such as by addressing a unit's particular learning needs through customized training.
- Give employees first-hand experience by using tools that allow hands-on training.
- Develop a safe environment in which learners may ask challenging, difficult questions.

A defining component of many organizational improvement movements is embedding learning as a primary work function. To be successful, Lean and other quality improvement approaches now extensively used in healthcare require an organizational culture that promotes learning. For example, Lean, which originated from the Toyota Production System, seeks to drive out waste and make all work add value. The approach is focused on a strategy of improving organizational processes by identifying the value desired by the user, examining each step in a process, and eliminating steps that do not add value. Lean and most other quality improvement programs require that difficult changes be made throughout an organization, as well as strong leadership and a culture that motivates learning and adaptation (Institute for Healthcare Improvement 2005).

Chapter Summary

Organizational learning has emerged as a critical operational element for businesses across the globe, especially for healthcare firms. It involves the collective application of individual and group experiences to improve company routines, processes, and structures. Such learning is critical in healthcare, with its rapidly growing knowledge base and existing concerns for patient safety. The learning process has four separate, cyclical processes that include (1) understanding, (2) interpreting, (3) integrating, and (4) institutionalizing. Learning can be either single-loop (where employees search for solutions within given goals, values, plans, and rules) or double-loop (where shifts in strategies, values, and mission may occur).

The concept of learning organizations has become popular, with some firms now employing chief learning officers. Learning organizations are characterized by their systems thinking, personal mastery, positive mental models, a shared vision, and team learning. Learning can be sustained only if a supportive environment exists, including a safe space in which workers are free to ask difficult questions, take risks, and disagree; leaders who reinforce learning are in place; concrete/structured processes are available for exploring new ideas; and adequate time is provided for thought and reflection.

Learning can be impeded by personal, group, or organizational barriers. If left unaddressed, barriers can greatly damage an organization's ability to adapt and learn. However, leaders can identify and reduce barriers and can motivate learning, in particular through social and group motivators.

Healthcare organizations must invest heavily in learning today, as clinical and managerial knowledge continues to rapidly expand. Successful healthcare firms are those that have processes and systems for knowledge dissemination and training while, at the same time, engaging their employees and patients in an atmosphere of transparency. This balance can be difficult to achieve in healthcare, which is more complicated in many ways than other industries because it involves professional training, interdependencies, and structures that make novel learning challenging. Some healthcare systems have developed learning management systems to formalize their learning processes.

Organizational learning is also a key component of most quality improvement programs that have proliferated in healthcare in recent decades. Lean is an example of an improvement approach that heavily uses learning concepts.

Chapter Questions

1. What is the difference between individual and organizational learning?
2. How does the learning process of integrating differ from institutionalizing?
3. How does the apply/test/act/institutionalize cycle lead to the observe/experience/understand cycle?
4. How could double-loop learning be disruptive to an organization?
5. Why are leaders' behaviors so important to organizational learning?
6. Of the three components of a learning organization, which do you think is the most important?
7. How do barriers to learning come to exist in organizations?
8. How does public punishment damage organizational learning?
9. Why is learning more difficult in healthcare than in other industries?
10. How is Lean quality improvement related to organizational learning?

Chapter Case

The Role of Information Technology in Healthcare Learning

St. James Medical System's CEO, Stephanie, knew her organization faced many current and future challenges. Diminishing reimbursement, potential restructuring as an accountable care organization, increased regional competition, and greater difficulty in recruiting and retaining skilled professional staff, among other factors, would make the next decade a transitionary period requiring many innovative changes. Yet she questioned whether her organization was prepared to learn new ways to meet these challenges.

Stephanie recently read the Institute of Medicine's (2013) nearly 400-page report *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,* which indicated that the US healthcare system has squandered about $750 billion per year—almost 30 percent of all expenditures—on unnecessary care, unnecessary administrative costs, and preventable health conditions while failing to deliver high-quality care. She was impressed by the Institute of Medicine's ten recommendations and thought about their ramifications for her organization. The recommendations were as follows (adapted from Institute of Medicine 2013):

1. *Digital infrastructure.* Increase the capability to capture clinical, care delivery process, and financial data to improve care and performance, and generate new knowledge.
2. *Data utility*. Simplify and revise research regulations to improve care, promote the capture of clinical data, and generate knowledge.
3. *Clinical decision support*. Accelerate integration of the best clinical knowledge into care decisions.
4. *Patient-centered care*. Involve patients and families in decisions regarding health and healthcare, tailored to fit their preferences.
5. *Community links*. Promote community–clinical partnerships and services aimed at managing and improving health at the community level.
6. *Care continuity*. Improve coordination and communication within and across organizations.
7. *Optimized operations*. Continuously improve healthcare operations to reduce waste, streamline care delivery, and focus on activities that improve patient health.

8. *Financial incentives*. Structure payment to reward continuous learning and improvement in the provision of higher-quality care at lower cost.
9. *Performance transparency*. Increase transparency on healthcare system performance.
10. *Broad leadership*. Expand commitment to the goals of a continuously learning healthcare system.

St. James had been working on many of these steps for years. It was constantly upgrading its information technology (IT) system, had developed clinical support decision systems, had spent the past five years trying to become patient centered, and at the same time had worked hard to lower its costs. Moving to a patient-centered care focus required a great deal of information gathering and learning, as encapsulated in St. James's four core concepts (adapted from MHA Keystone Center 2015):

1. *Respect and dignity*. Healthcare practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
2. *Information sharing*. Healthcare practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision making.
3. *Participation*. Patients and families are encouraged and supported in participating in care and decision making at the level they choose.
4. *Collaboration*. Patients and families are also included on an institutionwide basis. Healthcare leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in healthcare facility design; and in professional education, as well as in the delivery of care.

Trying to operate under these core concepts had been challenging, and Stephanie worried about the organization's ability to truly become patient centered without adopting many major changes. Just improving the speed and data capacity of the health system's IT infrastructure and electronic health record had been difficult; linking providers to streamline care continuity and providing financial incentives to reward continuous

(continued)

(continued from previous page)

learning while running a transparent performance system seemed especially challenging. She decided to make a few notes and discuss the difficulties with St. James's executive team.

Case Questions

1. If St. James truly wants to become a learning organization and be prepared for the future, what does it need to do?
2. How can the organization increase transparency and implement an IT system that facilitates and improves decision making?

Chapter Activity

Either review the website of IDEO (www.ideo.com), a design and innovation consulting company focused on improving its own innovation and growth, or read the article on design thinking by IDEO's CEO, Tim Brown, published in *Harvard Business Review* (www.ideo.com/images/uploads/thoughts/IDEO_HBR_Design_Thinking.pdf). Identify three different learning processes and practices that the company uses. Next, view IDEO's video on the future of automobility (http://automobility.ideo.com/) and determine how a company could use these scenarios to improve its innovation and creativity.

CHAPTER 4

INDIVIDUAL AND ORGANIZATIONAL ETHICS AND VALUES

By Stephen L. Walston and Benjamin Whisenant

Learning Objectives

After studying this chapter, readers should be able to

- appraise the means for creating environments that foster both ethical and unethical behavior,
- describe the relationship of ethics to individual and organizational values and culture,
- demonstrate the influence of professionalization on ethics in healthcare,
- realize the conflicts between ethics and values,
- identify their own values,
- differentiate among the ethical models,
- illustrate cultural and personal factors that create variations in ethics, and
- discuss factors that promote organizational justice and ethics.

Key Terms

- Autonomy
- Beneficence
- Corporate social responsibility
- Distributive justice
- Egoist model
- Ethical relativism
- Ethics
- Fairness, or justice, model
- Interactional justice
- Justice
- Nonmaleficence
- Procedural justice
- Rights model
- Utilitarianism

The expectation of ethical behavior exists in every nation, culture, company, and organizational position. **Ethics** are the often unwritten codes that constrain and guide actions. As discussed in this chapter, ethics are

not homogeneous around the world; context, facts, cultures, beliefs, values, and attitudes influence ethics and how they are practiced. Too frequently, individuals violate ethics and pursue self-interest, which can lead to embarrassing or tragic consequences.

Business Ethics and Corporate Social Responsibility

Businesses across all industries recognize the importance of ethics and proper ethical behavior for sustained success. To codify this understanding, an organization should integrate ethical principles with its stated **corporate social responsibility** statement (Business Roundtable Institute for Corporate Ethics 2007). Corporate social responsibility, sometimes referred to as corporate citizenship, is the self-regulated ethical behavior of doing more than what is legally required to make and promote social and environmental improvements. Many large companies have established ethics-based programs to improve the environment, promote clean energy, and sponsor social welfare initiatives to benefit their stakeholders.

Good, clear ethics guidelines are critical for healthcare organizations. Decisions are made daily in healthcare that present difficult moral choices. The healthcare industry, in both clinical and organizational situations, encounters many opportunities to make moral judgments that can challenge our ethics. These include issues of life and death and patient and employee rights. An understanding of ethics and their application is essential for any healthcare manager.

Ethics in Healthcare

An organization's core values should lay the foundation for its mission, vision, and ethics code (exhibit 4.1). The mission describes what an organization is, and the vision describes what it wants to become. Ethics set the parameters for acceptable actions and behaviors in accomplishing the mission and vision.

EXHIBIT 4.1
The Interaction Among Core Values, Ethics, and Mission and Vision

In essence, ethics describe how a firm should act in living its mission and achieving its vision.

Ethical Models

Numerous ethical models have been developed to explain human actions in the face of behavioral dilemmas. Each model makes different assumptions and focuses on different outcomes. Four are discussed here: (1) utilitarian model, or utilitarianism; (2) rights model; (3) fairness, or justice, model; and (4) ethical egoism, or egoist model.

Utilitarianism defines the moral value of actions on a valuation of their consequences. Actions are right when they produce positive consequences or the "greatest happiness" for the greatest number of people. For example, during times of disaster, patients are triaged on the principle of utilitarianism: The care and resources available are provided to those most likely to survive, rather than to a single critically ill person unlikely to live. This approach is deemed ethical under a utilitarian view of ethics.

The **rights model** distinguishes right from wrong on the basis of the underlying intentions. Individual moral or legal rights are paramount. Respect for others is woven throughout this model, highlighted by the importance of autonomous decision making.

Many rights are either explicitly or implicitly understood in the world today. Some of these include civil rights, women's rights, religious rights, consumer rights, nonsmoker rights, fetal rights, and animal rights. An example of this model is informed consent, whereby patients have the right to a full understanding of the risks and potential outcomes of treatments, allowing them to choose whether to accept or reject medical alternatives.

Deciding whether something is a right can be difficult and controversial. For example, the debate over whether access to healthcare is a right or a privilege continues in the United States. Is it "a contract between the nation and its inhabitants at birth" or an entitlement "that must be earned as opposed to universally provided" (Maruthappu, Ologunde, and Gunarajasingam 2013, 15)? Opinions vary widely, even from state to state (Orentlicher 2012).

The **fairness, or justice, model** is concerned with the perceived fairness of actions. Just actions involve consistent, fair treatment on the basis of ethical, religious, or legal standards. Everyone, and every group, is treated equally; no group is favored over another.

The justice model is made up of three subcategories of justice (described in terms of organizational ethics):

1. **Distributive justice**—the perceived fair distribution of resources, evaluated by the benefits derived and equity in awards

2. **Procedural justice**—the perceived fairness of the process by which a decision is made, evaluated by compliance with decision-making processes, level of access, openness, and participation by employees
3. **Interactional justice**—the perceived fairness of actions, decisions, and treatment of individuals, evaluated by the accuracy of information and the respect and courtesy shown throughout the decision-making process

Research suggests that employees perceive greater justice when they have the ability to provide input and participate in decision making and other organizational processes, even when outcomes are not favorable to the employees (Bies and Shapiro 1988). Likewise, employees experience greater job satisfaction when they perceive greater organizational justice (Kumar, Bakhshi, and Rani 2009).

The **egoist model** defines the moral value of action on the basis of whether the foreseeable impacts of the action are favorable for the actor. Simply stated, self-interested behavior is ethical. Like utilitarianism, ethical egoism is a consequential theory—that is, the ethical value of a decision depends not on the action taken but on the resulting outcome.

In one particular view of egoism, an individual or organization is justified in any action taken to advance its own long-term interests. While this self-interested approach to ethics remains unsettling in individual behavior, some might argue that such an approach to ethics is an organization's fiduciary obligation.

Perhaps the most objectionable part of the egoist model is the intent that accompanies it. Although actions and outcomes may mirror those of other ethical approaches, the purpose behind the behavior seems fundamentally Machiavellian.

Four General Ethical Principles

Four general principles are commonly accepted across most ethical models and are particularly applicable in healthcare: autonomy, beneficence, nonmaleficence, and justice (Beauchamp and Childress 2001).

Autonomy—the ability of a person to make meaningful choices free of interference from others—is a fundamental principle in medical ethics. Medical professionals should create conditions that allow patients to make meaningful, informed choices and should not inappropriately interfere with those patient choices. Autonomy necessitates that providers present treatment options, explain risks in understandable terms, and ensure patients understand and consent to selected treatments.

This principle of medical ethics is also directly applicable to any healthcare leader or manager who supervises the work of subordinates. To ensure the autonomy of a patient or subordinate, providers and leaders must

- teach people to make their own decisions,
- support people in the choices they make, and
- not force or coerce people to do things.

Beneficence means taking action that benefits others. Beneficence includes the acts of mercy, charity, and kindness and requires active effort to improve the well-being and status of another.

Nonmaleficence is defined as "doing no harm." Especially for health-care practitioners, this principle can be challenging, as almost every treatment carries potential risks. Therefore, the risks and burdens must be weighed against the benefits.

Justice, as with the justice ethical model, requires the fair distribution of benefits, risks, and costs and the equal treatment of all people.

Teaching Ethics

Rather than treating the concept as a mystical and nontangible ideal, ethics should be taught through behavior. Ethics can be boiled down to behaviors that promote honesty and trustworthiness: keeping promises; being loyal, fair, accountable, and committed to excellence; obeying laws; and showing concern and respect for others (Carroll and Buchholtz 2003).

Leaders must display their ethics in their words and deeds. Even the smallest actions of leaders are scrutinized by their employees, who then often replicate the leaders' behaviors and attitudes. Leaders who try to cut corners or take advantage of a situation for personal benefit foster an unethical culture and encourage similar bad conduct. On the other hand, leaders whose actions emphasize ethical behavior engender similar employee comportment.

Leaders, and indeed all employees, must do more than just comply with legal obligations and choose values-based, ethical directions to embed an ethical code of conduct in their organization. The code of conduct needs to be demonstrated by everyone in the organization. As suggested by Deloitte (2009, 4):

> Companies should position ethics and compliance programs as a responsibility of each employee and a respected part of the company culture, not just a "thou shall not" obligation. Companies' senior executives and board members must adhere to the code of ethics and compliance policies in the same way that all other employees must.

Cultural Effects

Ethics and ethical behavior are derived from and take place in the context of the society's culture or cultures. What constitutes ethics is determined by the values and culture of a people. The moral and ethical behavior of one culture may be considered immoral and unethical behavior in another. The bases of

ethical decisions are made up of content-rich, concrete norms, ideals, and attitudes that emanate from culture. Some cultures find infanticide, genocide, racism, and torture morally acceptable, while others condemn such behaviors. Differences in ethics across cultures are referred to as **ethical relativism**, which is the concept that an action is considered right or wrong depending on the context and environment in which the action takes place.

Many observers argue that not all values are relative but that a core, universally moral standard exists across most cultures (Gowans 2012). Values such as honesty, loyalty, trust, and compassion tend to transcend cultures and nationalities. Even though groups and individuals may frequently violate them, the values translate to common ethical standards for most people around the world (Sanderson and Pugliese 2012).

Ethical Challenges in Business and Healthcare

Adhering to ethical values can be a significant challenge to all businesses, including those in healthcare. Research has shown that although most large companies have written codes of ethics, rampant unethical behavior may exist in their business culture and the actual behaviors often do not support the desired behaviors espoused by their ethical code (Webley and Werner 2008). Following are some of the more egregious ethical violations in recent memory:

- *Enron*. Ethics violations at this energy company were discovered in 2001, which led to its bankruptcy and the dissolution of Arthur Anderson, at that time one of the largest audit and accountancy firms in the United States. Enron lost more than $60 billion in market value, and its pension plan lost $2 billion. Employees were left without retirement plans. Many executives received jail sentences for unethical accounting practices.
- *WorldCom*. Once the second largest US telecommunication company, WorldCom was led by CEO Bernard Ebbers, who used fraudulent accounting methods to maintain WorldCom stock value despite actual losses. Meanwhile, Ebbers had more than $400 million in margin calls on his WorldCom stock and was granted substantial loans and guarantees by the board's compensation committee to avoid a sell-off of his shares. WorldCom filed for bankruptcy in 2002, and Ebbers began a 25-year prison sentence in 2006 for his crimes (Beresford, Katzenbach, and Rogers 2003).
- *Tenet Healthcare*. Tenet was accused of not just healthcare fraud but also "rank patient abuse." The for-profit health system agreed in 2003 to pay $54 million to the government to resolve accusations that heart physicians at its Redding, California, hospital conducted unnecessary heart procedures and operations on hundreds of patients (Eichenwald 2003).

- *Hollinger International*. Hollinger grew into one of the largest media groups in the world until 2003, when its board discovered that the CEO, Conrad Black, had paid himself and four other directors more than $200 million in extra compensation. Black was convicted and served 42 months in prison (Investopedia 2013).
- *Columbia/HCA*. In 2000, the US Department of Justice settled the second of two complaints against for-profit health system Columbia/HCA. The company was fined $1.7 billion for improperly billing Medicare and Medicaid, falsifying diagnostic codes, illegally claiming nonreimburseable expenses, and billing for services for patients who did not qualify to receive them (Sherman 2014).
- *Bernard Madoff*. In 2008, Madoff was arrested for conducting the largest Ponzi scheme on record. His clients lost more than $17 billion through his lavish spending and poor investments. At the time of his arrest, his company claimed to have control of approximately $68 billion under management, but its accounts actually held only a few hundred million dollars. Madoff was sentenced to a 150-year prison term (Calder 2014).
- *HealthSouth*. One of the largest companies in the United States at one time, HealthSouth's problems surfaced soon after its CEO, Richard Scrushy, sold $100 million of stock a few days prior to the company reporting a loss. Investigation by authorities revealed that the firm had falsely inflated its earnings by $1.4 billion. Many of the company's officers served jail time. (For more details on the HealthSouth case, refer to the in-depth case study by Hamilton [2016].)

As a result of these and other ethics violations, the federal government passed a number of laws to regulate ethical behavior and encourage compliance, including the Sarbanes-Oxley Act of 2002. The Office of Inspector General (OIG) of the US Department of Health and Human Services, which has enforcement responsibility for Sarbanes-Oxley, operates a website to "help health care providers, practitioners, and suppliers understand the health care fraud and abuse laws and the consequences of violating them" (OIG 2016). It provides guidance in establishing a compliance program (along with materials for boards and physicians) to encourage ethical behavior and to help them follow applicable laws.

Clinical Ethics Issues

Even though most healthcare managers and professionals never violate the law, ethical clinical challenges are common in the healthcare industry. Exhibit 4.2 shows the top ethical dilemmas for doctors according to a physician survey conducted by Medscape in 2010. These challenges include balancing patients' rights, societal benefit, and personal values.

EXHIBIT 4.2
Physicians' Top Ethical Dilemmas

1. Providing life-sustaining therapy when it was judged futile
2. Halting life-sustaining therapy because of family demands, even though doing so felt premature
3. Prescribing a placebo treatment, simply because the patient wanted treatment
4. Hiding information from a patient about a terminal or preterminal diagnosis to bolster the patient's spirit or attitude
5. Covering up or declining to reveal a mistake if the mistake would not cause harm to the patient
6. Performing a procedure that isn't medically warranted, for reasons of defensive medicine
7. Participating in physician-assisted suicide
8. Reporting a friend or colleague who was impaired (drugs, alcohol, illness) or incompetent to a superior or state medical board
9. Dropping insurers that don't pay well, even though longtime patients would not be able to continue in the practice
10. Overstating or falsifying a patient's condition when submitting claims or seeking prior authorization for treatment
11. Breaking patient confidentiality if a patient's health status is known to be harming others
12. Refusing gifts or perks from pharmaceutical companies because they may influence medical judgment
13. Performing an abortion in certain situations, even if doing so is against personal beliefs

Source: Adapted from Kane (2010).

Moreover, nearly every day, ethical healthcare challenges arise for all clinicians and other staff who interact with patients. Providers represent multiple stakeholders and must balance the needs and demands of each. The box at the top of page 49 illustrates how the healthcare worker must occasionally weigh the costs to his organization against the risks and benefits to the patient. Most situations do not have black-and-white resolutions and can be stressful on the provider or staff member.

Healthcare organizations have reacted to ethical violations and challenges by creating their own ethical codes of conduct. Most large healthcare companies now have firm, specific regulations governing ethics. Hospital Corporation of America (HCA), which had experienced ethical violations in the early 1990s, instituted a strict ethics and compliance program in 1997. Its program includes the following tenets (reprinted from HCA 2014):

- Articulating standards of compliance and ethical conduct through a Code of Conduct and a series of company Policies and Procedures.
- Creating awareness of these standards among everyone in the company through high quality ethics training, compliance training, and other ongoing communication efforts.

- Providing a means to report exceptions (i.e., possible misconduct). We maintain an Ethics Line (1-800-455-1996) to receive reports from anyone who is aware of a violation of our Code of Conduct or Policies and Procedures. This line is answered at all times.
- Monitoring and auditing performance in areas of compliance risk to ensure that established policies and procedures are being followed and are effective.
- Establishing organizational supports, including necessary committees, responsible executives and facility ethics and compliance officers, for this entire effort.
- And undertaking other efforts, such as clinical ethics and pastoral care services.

Ethical Challenge at Redmond District Hospital

It is 10:00 a.m., and Gary, a lead nurse at Redmond District Hospital, has received a discharge order for a homeless patient with pneumonia who has been in the hospital for more than a month. Gary knows that the patient requires further treatment that is normally received at home. The hospital has already spent a huge sum treating this man, and the Medicaid reimbursement covered only the first week of his care.

Gary is struggling with the thought of discharging the homeless man, knowing that he will probably not recover, but he feels that admission and discharge authority lies only with the physician. If he wants to change the discharge order, he will have to call the patient's doctor, Dr. Grump, who can be rather unpleasant. Gary had called Dr. Grump earlier that morning about an IV antibiotic. He was told that the prescription was correct and not to bother the physician unless it was a life-or-death issue. Gary needs to decide what to do before noon.

What should Gary do? What ethical principles are present in this case?

The box below illustrates an additional example, in which Ascension Health, the largest Catholic and not-for-profit health system in the United States, describes its two primary ethics goals.

Professional Ethics

Many professional organizations have developed and published codes of ethics for their members. With these codes, they seek to reinforce desirable behaviors and ethical conduct, which signal their commitment to specific values and moral standards. For example, the American College of Healthcare Executives (ACHE 2011), the largest professional association for healthcare managers in the world, has established a code of ethics for its members, which reads in part:

The Purpose of Ascension Health Ethics

First, this resource page is intended to allow members of Ascension Health and Ascension Health ethics committees to access tools that will aid them in fulfilling their professional duties.

Second, this resource page is intended to provide users with a comprehensive understanding of both general healthcare ethics and specific Catholic moral teaching as it relates to ethical issues in healthcare.

Source: Excerpted from Ascension (2016).

> [The *Code of Ethics*] contains standards of ethical behavior for healthcare executives in their professional relationships. These relationships include colleagues, patients or others served; members of the healthcare executive's organization and other organizations; the community; and society as whole. Healthcare executives have an obligation to act in ways that will merit the trust, confidence, and respect of healthcare professionals and the general public [and] function as moral advocates and models. Being a model means that decisions and actions will reflect personal integrity and ethical leadership that others will seek to emulate.

Similarly, the American Physical Therapy Association (APTA), with a membership of more than 88,000 practitioners, provides ethical guidance for its affiliates through its code of ethics, which is based on the APTA's established core values. The preamble to the code outlines the ethical values and expected behaviors for physical therapists (reprinted from APTA 2014):

> The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists The purposes of this Code of Ethics are to:
>
> 1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
> 2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
> 3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
> 4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
> 5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

The code then lists eight principles for ethical conduct and their related core values (reprinted from APTA 2014):

> Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals. (Core Values: Compassion, Integrity)
>
> Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients. (Core Values: Altruism, Compassion, Professional Duty)
>
> Principle #3: Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)
>
> Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research

participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)

Principle #5: Physical therapists shall fulfill their legal and professional obligations. (Core Values: Professional Duty, Accountability)

Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. (Core Value: Excellence)

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society. (Core Values: Integrity, Accountability)

Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. (Core Value: Social Responsibility)

Links to other professional healthcare associations' ethical codes can be found in exhibit 4.3. Each code delineates its expected professional behaviors and defines actions viewed as unethical.

EXHIBIT 4.3
Codes of Ethics and Behavior for Select Healthcare Associations

Academy of Nutrition and Dietetics
www.eatright.org/codeofethics/

American Academy of Ophthalmology
www.aao.org/ethics-detail/code-of-ethics

American Cancer Society
www.cancer.org/aboutus/acspolicies/code-of-ethics-and-conflict-of-interest-policy

American College of Nurse-Midwives
www.midwife.org/index.asp?bid=59&CAT=2&BUTTON=Search

American Dental Association
www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct/

American Occupational Therapy Association
www.aota.org/about-occupational-therapy/ethics.aspx

American Public Health Association
www.apha.org/~/media/files/pdf/about/ethics_brochure.ashx

American Veterinary Medical Association
www.avma.org/kb/policies/pages/principles-of-veterinary-medical-ethics-of-the-avma.aspx

Medical Group Management Association
www.mgma.com/LibrARIES/ASSETS/ABOUT/ABOUT%20MGMA/ArTICLES%20OF%20INCORPORATION%20AND%20BYLAWS/MGMA-Code-of-Ethics.pdf

The Newspaper Test for Ethical Behavior

Imagine your decision or action has been described in detail on the front page of a major newspaper such as the *Washington Post*. Would you be proud to have your family and community know what you are doing? If publishing it on the front page of a newspaper would embarrass you or your family, you might want to reconsider the decision.

Other Methods to Determine if Decisions Are Ethical

Every day, individuals confront situations and decisions requiring ethical judgments that may not necessarily be resolved by consulting a formal code of ethics. Several methods are available to test whether a decision is ethical or unethical. Velasquez and colleagues (2015), for example, suggested posing the following questions:

- What benefit and harm will each action produce, and which alternative will lead to the best overall consequences?
- What moral rights do the affected parties have, and which course of action best respects those rights?
- Which course of action treats everyone the same, except where there is a morally justifiable reason not to, and does not show favoritism or discrimination?
- Which course of action advances the common good?
- Which course of action develops moral virtues?

In addition, as described in the box above, a more personal and simplistic test can be used to determine a decision's ethicality—the newspaper test. Transparency is the key here: If you are comfortable that others have general knowledge of your behavior, you may be confident that you are proceeding ethically. However, if you do not want your actions to be front-page news, you should reconsider your decision because unethical behavior may be taking place.

Chapter Summary

Ethics delineate the proper actions and behaviors that individuals and organizations should take. They may be written as codes of conduct, or they may be unwritten societal norms. Ideally, a set of ethics is a tool used in determining whether behaviors are acceptable in accomplishing an organization's mission and vision. Healthcare managers and workers must demonstrate high ethical conduct that reflects their core values.

The utilitarian, rights, justice, and egoist ethical models make different assumptions as the basis of ethical decisions. Utilitarianism defines ethical

behavior as an action that produces the greatest value to the greatest number of people; the rights model focuses on a party's underlying moral or legal rights; the justice model relates to the perceived fairness of actions; and the egoist model values the outcomes that are most favorable to the actor. Along with these models, four general ethical principles are considered: autonomy, beneficence, nonmaleficence, and justice.

Leaders' behaviors dictate the ethical or unethical practices in an organization, as their actions are typically emulated for good and bad. In addition, whether an action is considered ethical depends on the values and culture of the society in which the conduct takes place. Although some behaviors may fall under the concept of ethical relativism, core values and ethics of honesty, loyalty, trust, and compassion are in place across most of the world.

Unethical conduct persists, although most firms have put in place written codes of ethics for their staff or members to comply with. To contain these ethical violations, governments have passed laws such as the 2002 Sarbanes-Oxley Act, and healthcare companies and professional organizations have adopted ethical codes of conduct. Individuals may also perform certain tests to determine whether a particular decision is ethical. One simple approach is the newspaper test, which helps someone judge his comfort level if his actions were to be reported on the front page of a major newspaper. Ethical behavior allows for full transparency of actions, whereas unethical behavior is left hidden.

Chapter Questions

1. How are ethics and values related?
2. How do ethics and organizational mission and vision interrelate?
3. What is the difference between the rights model and the justice model?
4. What are some challenges to using utilitarianism when considering ethical issues?
5. How do laws relate to the rights model?
6. Explain how more than one of the subcategories of the justice model could occur at the same time. Provide an example.
7. What role does autonomy have in patient care?
8. When does ethical relativism not apply?
9. Why do businesses consistently violate their written code of ethics?
10. What role do professional organizations have in establishing guidelines for ethical conduct?
11. How does transparency promote ethical behavior?

Chapter Cases

HealthT Seeks Healthier Employees

HealthT, a moderate-sized for-profit hospital company, was seeking ways to improve its bottom line. Charlie, its chief operating officer, noted the huge company expense for employee healthcare insurance costs. The amount had risen from about $140 million three years ago to $195 million in the current year. HealthT, like most large companies, was self-insured, which meant its expenditures for healthcare were reported as operating expenses and came directly out of its profits. The huge increase in overall healthcare costs infuriated Charlie, and he immediately called the human resources (HR) department demanding that its director meet with him in two hours to justify the large increase.

Glen, the HR director, arrived at Charlie's office on time, knowing that Charlie was a demanding boss. Glen had the following spreadsheet to share with Charlie.

HealthT's Employee Healthcare Expenditures 2013–2016

Expense Category	Total Employee Healthcare Costs	Third-Party Adminstration Costs	Hospital Costs	Physician Costs	Other	High-Cost Procedures	Chronic Illness Costs
2013 Expense*	$139.40	$9.76	$62.73	$34.85	$32.06	$42.10	$82.60
2016 Expense*	$195.30	$13.67	$78.12	$39.06	$65.45	$49.70	$121.80
Percent Increase 2013 to 2016	40.1%	40.1%	24.5%	12.1%	101.0%	18.1%	47.5%
2013 Number of Employees	28,000	28,000	28,000	28,000	28,000	28,000	28,000
2016 Number of Employees	35,000	35,000	35,000	35,000	35,000	35,000	35,000
2013 Cost Per Employee	$4,078.57	$348.50	$2,240.36	$1,244.64	$1,145.07	$1,503.57	$2,950.00
2016 Cost per Employee	$5,580.00	$390.60	$2,232.00	$1,116.00	$1,841.40	$1,420.00	$3,480.00
Percent Increase 2013 to 2016	12.1%	12.1%	–0.4%	–10.3%	60.8%	–5.6%	18.0%

* In millions

Glen was pleased to report that over the past three years, HealthT's healthcare cost per employee had risen only 12.1 percent, or about 4 percent per year. He also pointed out that, with the new network of physicians and hospitals, the per-employee physician expense had dropped from 2013 to 2016.

Charlie was still upset. He almost yelled at Glen. "Look at the total figures! We are spending almost $200 million on employee healthcare expenses, and the costs of chronic illness care have jumped 47.5 percent in just three years. That's 18 percent per employee! You have to come up with something to control these runaway costs. You have one week to present your recommendations."

Glen and his staff brainstormed ways to control chronic illness. Although they recognized that most efforts to control chronic disease were long term, they designed the following changes to their employee insurance plan:

1. *Higher deductibles for risky activities*: Any employee who required healthcare services as a result of a risky activity—defined as skydiving, scuba diving, motorcycle riding, rock climbing, and other similar activities—would have a hospital deductible of $3,000 instead of the normal $500.
2. *Smoking*: All smokers would be charged an additional $100 per month for their healthcare insurance.
3. *Overweight*: All employees with a body mass index (BMI) above 25 but less than 30 would be charged an additional $75 per month for healthcare insurance, and those with a BMI over 30 would be charged an additional $150 per month.

Glen presented the recommendations to Charlie, who thought they were great and asked that they be implemented immediately. Glen thought the changes would be received positively by employees, but he almost instantly began to receive complaints that the changes were not fair.

Case Questions

1. From an ethical perspective, how could you defend these changes? How would you reply to employees who claimed they were being unjustly penalized?
2. Would your arguments change if you considered the issue in terms of the utilitarian model? The justice model?

(continued)

(continued from previous page)

3. What would you do to address the potential ethical issues in this case if you were Glen? Charlie?

CEO Misuse of Company Funds?

A large health insurance company whose headquarters were located just north of Indianapolis had in place a written code of ethics that promoted the value of teamwork and equal treatment. The CEO, who started the company, felt strongly that his employees should treat each other equally.

However, it was apparent that he did not feel the code applied to him. He lived only three miles from the corporate headquarters in his $12 million mansion and yet began flying via helicopter to work. This choice disturbed many employees, as everyone was certain the company was paying for the CEO's excesses.

Staff also found it difficult to get an appointment with him. Many reasoned that this lack of access was caused by the distractions of his recent divorce and quick remarriage. As a result of his unavailability, most employees got their news about the company and their CEO primarily from the press or from social media.

Employee morale was already suffering, and the turnover rate had begun to accelerate when fraud charges were filed against members of the company's top management team.

Case Questions

1. What ethical issues does this case raise?
2. How would you handle these ethical issues differently under different ethical models?
3. If you were to replace this CEO, what actions would you take?

Compare and Contrast Ethical Statements

Compare and contrast the Nursing Code of Ethics provisions of the American Nurses Association (ANA 2015) with the Principles of Medical Ethics preamble of the American Medical Association (AMA 2001):

ANA's Nursing Code of Ethics Provisions

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

Provision 2: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and provide optimal care.

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Provision 7: The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

Provision 9: The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

AMA's Principles of Medical Ethics Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Case Questions

1. What differences do you see between the two ethical statements? What similarities, if any?
2. Do you think the differences influence the behavior of the respective association's members, or does the behavior of its members influence the written code of ethics?

CHAPTER

5

INDIVIDUAL AND ORGANIZATIONAL MOTIVATION

Learning Objectives

After studying this chapter, readers should be able to

- compare and contrast the theories presented, including Maslow's hierarchy of needs, Herzberg's two-factor theory, equity theory, reinforcement theory, and expectancy theory;
- discuss the methods and effects of goals on motivation;
- describe the benefits and challenges of job enrichment and job expansion; and
- distinguish between the advantages of intrinsic stimuli and those of external stimuli.

Key Terms

- Dissatisfiers
- Equity theory
- ERG theory of motivation
- Expectancy
- Expectancy theory
- External stimuli
- Frustration–regression
- Goal-setting theory
- Instrumentality
- Intrinsic stimuli
- Job characteristics model
- Satisfiers
- Two-factor theory
- Valence

One of the critical challenges for any leader is to motivate his employees. Motivation is defined as "the willingness to work at a certain level of effort," and motivation theories "explain the causes of workplace effort and direction of effort" (Sullivan 1989).

Motivation takes a central position in any performance theory and has been cited as essential to the success of healthcare systems (Cerasoli, Nicklin, and Ford 2014). Scholars and managers have sought for many decades to identify methods to motivate and inspire employees. As mentioned in chapters 1 and 2,

some of the first scholars to explore motivation included Frederick W. Taylor, through scientific management; Abraham Maslow, through his hierarchy of needs; and Douglas McGregor, who developed theory X and theory Y. This chapter continues the examination of theories and practices of motivation.

Evidence suggests that many managers struggle to motivate their employees. Most agree that strategies promoting positive employee commitment and motivation strengthen a firm's competitive position (Battistelli et al. 2013). Yet surveys reveal that almost two-thirds of US employees are not actually engaged in and motivated by their work; as a result, perhaps 20 percent act out negatively to damage their organization (Kim and Mauborgne 2014; Seidman 2012). Motivating and engaging employees remain important skills needed by managers.

The failure of many organizations to motivate their employees has been attributed to an overreliance on external motivators (Herzberg 2003). Most theories explaining motivation divide motivational efforts into external and internal stimuli (Cerasoli, Nicklin, and Ford 2014). Motivation by external stimuli was promoted in the 1930s by behavioralists such as B. F. Skinner, who systematically changed animal behaviors by providing rewards and punishments. The concept of external stimuli (also called *operant conditioning*) as sources of motivation became deeply rooted in business practices. Managers continue the behaviorist strategy of seeking to motivate employees with rewards and punishments to do more of what management desires, and better. However, most studies show that external stimuli from rewards and punishments deliver only short-term results, and long-term, heavy reliance on this type of stimuli may damage work relationships (Strickler 2006). Kohn (1993) characterized it this way:

> Research suggests that, by and large, rewards succeed at securing one thing only: temporary compliance. When it comes to producing lasting change in attitudes and behavior, however, rewards, like punishment, are strikingly ineffective. Once the rewards run out, people revert to their old behaviors.

Yet managers continue to use external factors, such as threats and adjustments to salary and benefits, to enforce work performance standards.

External Stimuli

External stimuli—means of instigation that originate from outside of a person—are used frequently, as they are the quickest way to obtain the desired results. Herzberg (2003) suggested that although the most rapid way to move and stimulate a person is to kick him, kicking does not create lasting

motivation and may even inspire negative behaviors, because the person might kick back or sabotage the work being done. Furthermore, to sustain the person's momentum and performance, the kicking or threat of kicking must continue.

Certainly, kicking is not the primary external stimulus used for motivation in businesses today. However, other types of threats and punishments—such as forced performance rankings, letters of reprimand, and verbal chastisement—are often used. Negative forms of external stimuli are, in fact, used regularly by managers because movement of some sort does occur as a result; the problem is that these managers often confuse movement with desired outcomes (Gardner 2012).

Other less intrusive types of external incentives include promotions, performance-based bonuses, grades, awards, and employee recognition programs. External incentives have been shown to increase output. However, motivation is multifaceted, and organizations often use multiple means—both external and intrinsic (described in detail in the next section)—to encourage desired outcomes. Good leaders must learn to merge external methods appropriately with intrinsic methods to achieve sustainable motivation. The type and mix should be carefully selected to achieve the behaviors sought (Cerasoli, Nicklin, and Ford 2014).

Intrinsic Stimuli

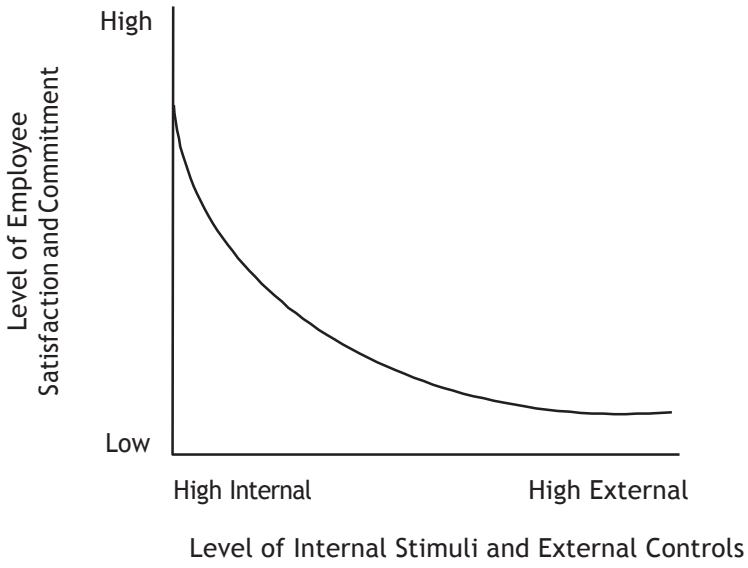
Internal or **intrinsic stimuli** originate from within the individual. Workers find meaning in their labor rather than performance for some external gain. Herzberg (2003, 88) stated that internal stimuli are the only mechanisms that induce motivation, as "only when one has a generator of one's own [can we] talk about motivation." The degree to which an individual or a group experiences internal motivation determines their level of satisfaction and commitment (Battistelli et al. 2013).

Work that is found more intrinsically satisfying motivates greater effort. For example, nurses who enjoyed learning activities were found to spend more time and effort in these activities (Simons, Dewitte, and Lens 2004). As illustrated in exhibit 5.1, the more internal stimuli are present, the greater are the resulting employee satisfaction and commitment to the work. Conversely, greater use of external controls and external stimuli decreases employee satisfaction and commitment. The level of satisfaction and commitment drops rapidly as external controls are introduced and can quickly overshadow internal stimuli.

Alderfer's ERG Theory

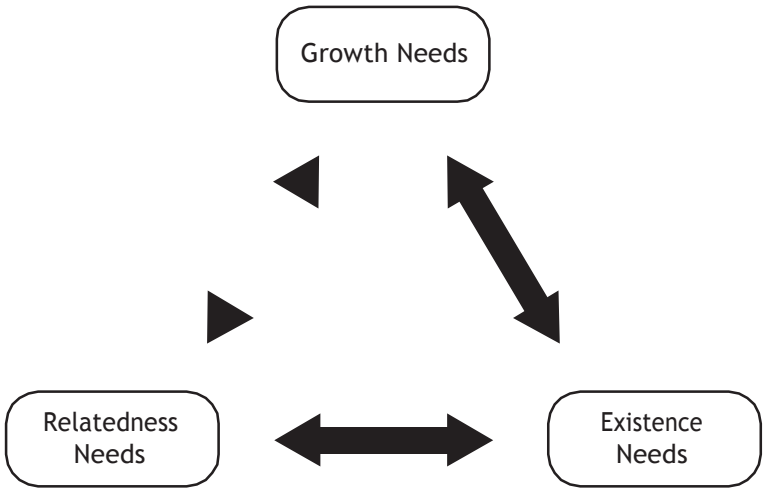
As a refinement of Maslow's hierarchy of needs, Clayton Alderfer proposed the **ERG theory of motivation**, which posits that motivation results from three

EXHIBIT 5.1
Effect of Internal and External Controls on Employee Satisfaction and Commitment



factors: existence, relatedness, and growth. This theory collapses Maslow's five categories into three simpler and broader classes: (1) existence needs, ensuring physiological and physical safety; (2) relatedness needs, addressing interpersonal relationships with family, peers, or superiors and public recognition; and (3) growth needs, covering self-actualization, personal growth, and advancement (exhibit 5.2).

EXHIBIT 5.2
Alderfer's ERG Theory of Motivation



Alderfer's theory suggests that at any time, more than one need may be active. Therefore, lower needs do not have to be met before higher needs are attained, as Maslow proposed. Alderfer also suggested that individuals' needs may change over time, as circumstances and situations change. The stage of life and career may dictate which need predominates. Early-career workers may focus more on existence or relatedness needs, while mid-career employees may find growth needs much more important.

Alderfer also proposed a **frustration–regression** element, which suggests that people who unsuccessfully seek a higher need become frustrated and regress to pursue a lower need. For example, an employee who desires personal growth and advancement but feels blocked and unable to attain it may revert to relatedness or existence needs either by further developing her friendships with family or fellow workers or by becoming more financially independent.

Herzberg's Two-Factor Theory

A further extension of Maslow's hierarchy of needs is the **two-factor theory**, developed by Frederick Herzberg, who postulated that job satisfaction and dissatisfaction are not opposites but simply reflect different employee needs (see exhibit 5.3). Herzberg categorized work factors into dissatisfiers, which match Maslow's lower needs, and satisfiers, which relate to Maslow's higher needs. **Dissatisfiers**, also called *maintenance* or *hygiene factors*, do not motivate because they do not produce satisfaction. However, their lack may create dissatisfaction. Dissatisfiers may include working conditions, interpersonal relations, job security, and salary. A fundamental suggestion from Herzberg's work is that the presence of these factors does not motivate personnel, but

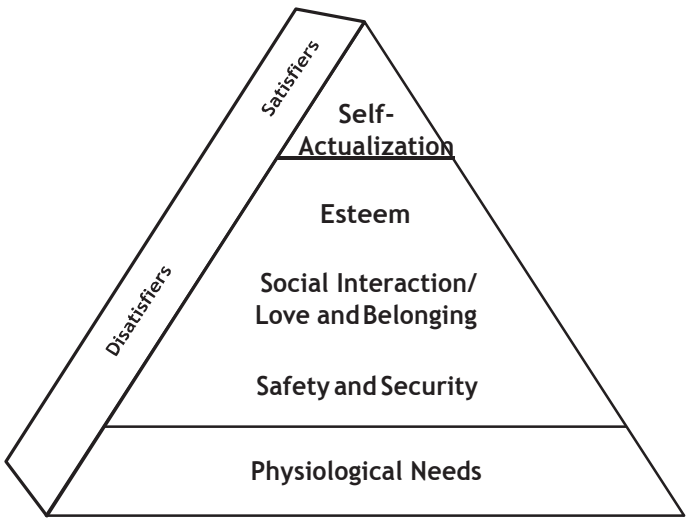


EXHIBIT 5.3
Herzberg's Two-Factor Theory as Extension of Maslow's Hierarchy of Needs

their absence can create negative consequences and diminish employee satisfaction. For example, organizations without clear policies by which to operate may produce unhappiness and frustration in employees. On the other hand, the presence of clear policies may not motivate employees but will eliminate their frustration and dissatisfaction.

Satisfiers, on the other hand, relate to job content and have longer-lasting effects than dissatisfiers have. These factors motivate employees and may include achievement, recognition, advancement, and growth. They help employees achieve psychological growth and self-realization, which lead to satisfaction. However, the absence of satisfiers does not lead to dissatifaction, only a lack of positive satisfaction (Sapru 2010).

Evidence to support the two-factor theory proposes that employers should not expect significant motivation from the addition of work policies, enhancements to the work environment, or salary increases and bonuses. However, the lack of changes can cause workers to become dissatisfied, which can lead to higher absenteeism and turnover. In healthcare, the work satisfaction of employees, who constantly deal directly with patients, affects every aspect of care. Recognition and achievement have been shown to motivate employees to be more productive, creative, and committed (Syptak, Marsland, and Ulmer 1999).

Herzberg (2003) suggested that the most positive attempts to instill motivation involve removing controls while retaining accountability. Such actions should include the following:

- Increasing employees' accountability for their own work
- Giving employees a complete, natural unit of work they can accomplish
- Granting additional authority to employees in their activity
- Making periodic reports directly available to the workers rather than just to supervisors
- Introducing new and more difficult tasks not previously attempted by workers
- Assigning employees specific or specialized tasks to enable them to become experts in those tasks

Job Design

Job design is the outgrowth of intrinsic motivation theories that point to self-actualization and job content as the main methods of motivating workers. Considerable research has demonstrated that the structure and content of job design can have significant consequences for employees' attitudes, satisfaction, work motivation, learning, and sense of well-being (Humphrey, Nahrgang, and Morgeson 2007; Parker 2014). Creating meaningful, fulfilling jobs has become a priority for many on an international scale, as shown in the box on page 65.

A central theme of job design has long been the **job characteristics model** developed by Hackman and Oldham (1976). According to their perspective, work should be designed to have five core characteristics:

1. *Work variety*—use of varied activities and different skills
2. *Work autonomy*—amount of discretion over daily work decisions
3. *Work feedback*—clarity of information regarding the worker's effectiveness in the job performance
4. *Work significance*—degree of impact the work has on the lives or work of others
5. *Work identity*—degree of responsibility for completing an identifiable segment of work from beginning to end

Decent Work

The content and function of jobs have become a topic of importance across the globe. The concept of decent work—which according to the International Labour Organization (ILO 2016) "involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social development and social integration"—suggests that the job design model is ideal. The ILO has created an index to compare countries against its decent-work measurement.

Job Enrichment

Enriching work by increasing the degree of these characteristics contrasts with Taylor's scientific management theory (discussed in chapter 1), which includes dividing jobs into small, repetitive components. Job enrichment expands the scope of jobs to decrease repetitive work, making them more challenging to employees. Expanding workers' jobs serves to "enrich" employment and may result in high internal work motivation, higher-quality work outcomes, higher work satisfaction, and lower absenteeism and turnover (Hackman and Oldham 1980).

The optimal job enrichment may vary by the individual characteristics of the employee. Skill level, desire for growth, and satisfaction for contextual job factors affect the effectiveness and appropriate level of job enrichment. Employees with limited skills, little need or desire for growth, or unhappiness about aspects of their work may not be prepared for job enrichment.

However, for employees prepared to expand their work, companies often approach job enhancement in the following three ways:

1. *Job rotation*—moving employees from one job to another periodically, which decreases boredom, improves work variety, and permits learning new skills
2. *Job enlargement*—increasing the number of tasks assigned to employees to strengthen work identity

3. *Job enrichment*—broadening responsibilities, giving more decision-making autonomy, and increasing feedback

Enrichment of workers' jobs is contrary to the high degree of micromanaging that occurs at many firms. Many managers believe that leading requires a detailed knowledge of a company's operations, so they respond by delving too deeply into minutiae and seeking to correct and direct insignificant decisions. Prominent leaders, such as former US president Jimmy Carter and Walt Disney CEO Michael Eisner, demonstrated micromanaging. President Carter personally reviewed requests to schedule the White House tennis courts, while Eisner chose the types of light bulbs to be used in Disney hotels (Tuna 2008).

Employees generally hate being micromanaged, whereas bosses frequently find micromanagement validating and engaging. As one nurse wrote, in part ("madwife2002" 2011):

> Recently it has come to my attention that I am being micromanaged, so what does micromanagement mean to the everyday worker? I can tell you that I don't enjoy being micromanaged and it feels very negative.

Equity Theory

The equity that workers perceive in their jobs also can influence motivation. People want to feel that they are treated fairly, and the perception of being treated fairly or unfairly can influence motivation. **Equity theory**, first proposed by J. Stacy Adams in 1965, sought to explain how perceptions of equity affect work performance. The theory suggests that employees seek to balance their work inputs and the outcomes or benefits they receive as compared with those of others. Inputs may include a wide variety of activities and efforts, such as time, loyalty, commitment, dedication, enthusiasm, personal sacrifice, and skill development. Outputs, although often focused on salary and compensation, also include job security, benefits, recognition, and reputation. Individuals look at the ratio of what they receive from a job to what they contribute and then compare it with others' or with their past experiences (Adams 1965).

Equity equilibrium exists when inputs equal outputs (exhibit 5.4). However, when

Equity in Athletics

In 2015, Jim Harbaugh, former head coach of the National Football League's San Francisco 49ers, was hired by the University of Michigan at a base salary of $5 million (Feinstein 2015). At the time, the average base salary of an NCAA Football Bowl Subdivision head coach was $1.75 million—an average that was 75 percent higher than seven years previously (Baumbach 2014). On top of this, under new NCAA rules, student athletes in selected Power Five conferences will now receive greater compensation, perhaps up to $10,000 each (Trahan 2014). This seems to have led to a diminished focus on gaining an education; as one former quarterback tweeted shortly after arriving at Ohio State, "Why should we go to class if we came here to play FOOTBALL, we ain't come to play SCHOOL, classes are POINTLESS." How might equity theory explain the relentless increases in compensation and diminished focus on education?

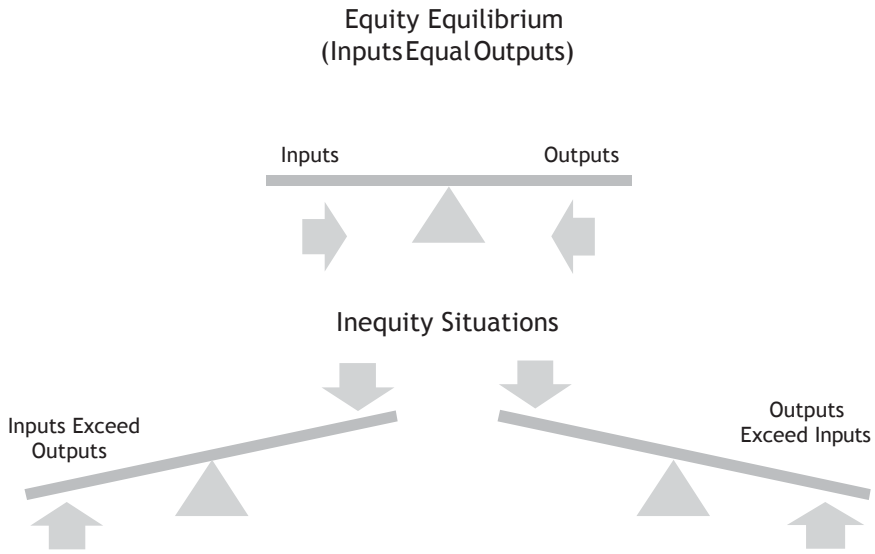


EXHIBIT 5.4
Equity Equilibrium

an inequity exists, people seek to equalize their ratios by increasing or decreasing their inputs or outputs to bring them back to an equity equilibrium.

Equity issues often arise when salary increases are given. Managers may attempt to reward perceived excellent work by giving high performers larger increases. However, as discussed in chapter 12, performance evaluations that reward individual effort with comparably higher salary increases can have detrimental consequences: Those who receive lower increases may feel under-rewarded and may try to restore the equity by asking for additional compensation or by decreasing their outputs through diminished production, quality, or time on the job.

Expectancy Theory

Expectancy theory, first proposed in the 1960s by Victor Vroom, hypothesizes (as illustrated in exhibit 5.5) that motivation is a function of three linked factors: (1) **expectancy**, the belief that one's efforts will result in the desired outcomes; (2) **instrumentality**, the belief that one will receive a reward if expected performance is achieved; and (3) **valence,** the value a person places on the expected rewards. All of these factors are important to employee motivation because if any one is lacking, the worker's efforts decrease to zero (Dubrin 2008).

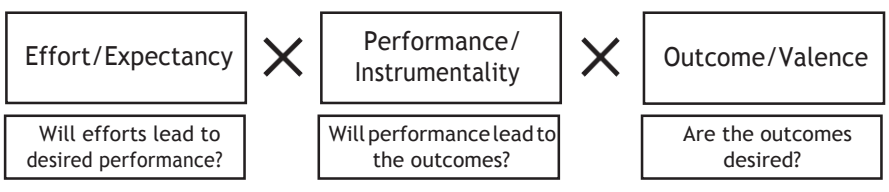


EXHIBIT 5.5
Expectancy Theory

Employees must believe that their efforts will affect the results they seek and that the reward will be given if the output is met. In addition, employees must want the rewards and assign value to them. Managers should judiciously examine reward systems to tie rewards closely to performance and make sure the incentives provided are deserved and desired by employees. Goals and standards should be clearly communicated, and workers should have the skills and abilities to accomplish them. Employees' efforts will diminish if they feel that hard work does not lead to recognition and reward. Likewise, if the rewards are not desired, workers will be less inclined to work diligently.

Goal-Setting Theory

Also originated in the 1960s, **goal-setting theory** proposes that goal-directed work and quantified and clearly defined goals lead to higher performance (Locke 1968). Managers are encouraged to set clear goals that ensure each worker is aware of his expected performance. Groups that set goals achieve higher performance than those that lack goals.

Goal-setting theory evolved into management by objectives (MBO), which involves participative goal setting and was used at one time by many companies (Koontz and Weihrich 2010). In addition, SMART goals (defined in the list that follows) became popular to provide guidance on how to better craft goals (Doran 1981):

S—write *specific* areas for improvement

M—make the goal *measureable,* and quantify the indicators for progress

A—*assign* who will be responsible for the goal

R—make the goal *realistic* given the available resources

T—specify the *time* in which the results will be achieved

Other management writers have extended goal setting to organization-wide efforts. Collins and Porras (1994) promoted the concept of *big hairy audacious goals (BHAGs)*, which establishes difficult, vision-related goals that assist in attaining strategic results. As they state, "A true BHAG is clear and compelling, serves as a unifying focal point of effort and acts as a clear catalyst for team spirit. It has a clear finish line, so the organization can know when it has achieved the goal" (Collins and Porras 1994, 113).

Myths About Motivation

Motivation remains a critical determining factor in organizational success. Yet managers often do not appear to understand its underlying concepts and frequently misapply methods, which leads to lack of motivation and employee

discouragement. Among the myths that managers adhere to are the following (Grenny, Maxfield, and Shimberg 2008; Nitin, Groysberg, and Lee 2008):

- *Money is a motivator*. Providing monetary compensation to motivate employees has limited long-term effects. Money may, in the short term, galvanize attention, but its effects quickly wear off and will not motivate employees across time.
- *Motivated employees can accomplish anything*. Motivation is important but needs to be coupled with the appropriate skills, ability, and relevant training for employees to achieve objectives.
- *More time off motivates employees*. Employees who are motivated tend to work longer hours and do not seek more time off.
- *Motivation can be accomplished through singular efforts*. Motivation involves many facets, and different employees can gain encouragement through different means. Successful motivators use multiple sources of influence, including individual, social, and organizational resources and processes.

Chapter Summary

Many theories and explanations exist for the rationale for and methods of motivation. What all agree on is that there is a need for motivated employees and that most businesses struggle to find the right mix of activities to motivate their employees. Many observers feel that the failure to motivate has been the result of using external factors to stimulate and motivate. Internal, or intrinsic, stimuli seem to better instill motivation than external stimuli do.

A number of common motivational theories are covered in this chapter. Alderfer's ERG theory recasts Maslow's hierarchy of needs from five categories into three simpler and broader classes. It suggests that individuals can experience any category of need without having lower needs fulfilled and that needs may change across a person's life and career.

Herzberg's two-factor theory classifies work factors into two categories: dissatisfiers (maintenance or hygiene factors) and satisfiers. Dissatisfiers do not motivate, because they do not produce satisfaction. Not having them, however, causes dissatisfaction. Dissatisfiers may be working conditions, interpersonal relations, job security, or salary. Satisfiers relate to job content and motivate employees. These factors include achievement, recognition, advancement, and growth.

Job design proposes that job content significantly affects the ability to motivate workers. The structure and content of jobs influence the attitudes, satisfaction, work motivation, learning, and sense of well-being of employees. Jobs that motivate employees should involve work variety, autonomy, feedback, significance, and identity to enrich tasks and the labor of workers.

Equity theory focuses on how perceived fairness affects work behavior. It suggests that employees seek to balance the ratio of their work efforts (inputs) with their outputs and then compare it with that of others. If their ratio compares unfavorably with others', they alter their inputs or outputs to correct the imbalance.

Expectancy theory defines motivation as the multiple of three factors: expectancy, or the belief that one's efforts lead to the desired outcome; instrumentality, or the belief that the desired reward can be obtained through a given performance level; and valence, the value a person places on the expected rewards.

Goal-setting theory suggests that setting challenging and clear goals results in higher performance. Advances from goal-setting theory include MBO (management by objectives), SMART (specific, measurable, assigned, realistic, and time) goals, and BHAGs (big hairy audacious goals).

The actions of managers greatly contribute to the creation of motivated employees. Managers frequently appear not to appreciate the basics of motivation; they misunderstand the effects of money, which acts poorly as a long-term stimulus, and may not realize that linked skills and training must be coupled with motivational efforts to achieve the desired outcomes. Managers may erroneously equate short-term actions and movement caused by external stimuli (e.g., money, threats, benefits, time off) with motivation. Motivation requires a multifaceted, complex approach that ultimately leads to mutual respect and loyalty. Only through improved understanding of the principles and applications of motivation can companies stimulate employees to proper long-term actions.

Chapter Questions

1. Why do managers often use external stimuli to motivate their employees?
2. What are the major differences between Maslow's hierarchy of needs and Alderfer's ERG theory of motivation?
3. Why do dissatisfiers or hygiene factors in Herzberg's two-factor theory not motivate?
4. Why are satisfiers difficult to implement in a workplace?
5. What is an argument against work variety?
6. An employee thinks she is working as hard as everyone else in her department and her results are better than theirs. However, at her annual evaluation, she is given a 1 percent lower raise than most others. Given equity theory, what might be a predicted change in this employee's behavior?
7. Under expectancy theory, if any of the three factors are missing, what is the result?
8. Should money ever be used as a motivator?

Chapter Cases

Micromanaging Leads to Motivation: Illusion or Reality?

Greg knew that he was getting results. He managed a large home health company that he had founded. Activity was a given when he was around. He could see people jump when he yelled during his staff meetings. He was great at getting people back on track by interrupting conversations, identifying people's mistakes, and telling subordinates which decisions to make.

Clearly, he considered himself the "quarterback" of the company: He received the football, and it was his decision to whom he passed it. Greg also enjoyed being the center of attention. He knew he was indispensable and was constantly busy. He started meetings by stating his opinion of what should be done and received almost unanimous agreement. However, his staff had grown from a few people to more than 200. Not only was he spread thin trying to remain involved in most decisions, but employees also eventually stopped showing initiative and waited for his direction.

Encouraged by his top executives, Greg came to realize that his micromanaging was damaging his firm. His actions expressed his unwillingness to trust his employees and were leading to turnover and decreased innovation. He reflected that he had difficulty understanding when to personally engage and when to delegate. An executive coach he hired told him, "Who wants to be in a company where you are not allowed to think?" To shift his management approach, he had to learn to act differently toward his employees. He even considered having his employees rewrite his job description.

Source: Tuna (2008).

Case Questions

1. Using two theories from this chapter, describe six changes in Greg's job description that would lead to better motivation for his employees.
2. What other changes would you make?

Korean Air Executive Motivates Change with Nuts

Heather Cho, a top executive for Korean Air, was in charge of the company's international in-flight service and had set the standards for flight attendants. She had been actively involved in establishing a new corporate

(continued)

(continued from previous page)

identity for Korean Air during her 15-year tenure at the company. She had made her father, the company chairman, proud by her direct involvement and constant efforts.

Imagine her surprise and concern when, aboard a Korean Air plane waiting to fly out of New York, she was served a bag of nuts in first class when the standards explicitly required the nuts to be served on a plate. Heather was enraged. She yelled at the flight attendant and demanded that the plane return to the gate to "get rid" of the lazy employee. After she got the captain involved and identified her position in the company, the plane turned around and returned to the gate. The errant flight attendant was sent back into the terminal, and the plane departed.

The story made headlines across the globe, especially in Korea, where Heather's father apologized and, when asked how the incident could have happened, blamed himself for failing to raise his daughter properly. The airline also issued an apology on Heather's behalf, and she requested forgiveness and promised to take full responsibility for her actions. Ultimately, she resigned from her position at Korean Air. The airline stated publicly that this was an "excessive act" and it would seek to reeducate employees to make certain that service met the airline's high standards.

Source: Adapted from Mullen (2014).

Case Questions

1. What went wrong with Heather's efforts at direct motivation?
2. How could she have used principles of motivation discussed in this chapter to ensure the implementation of Korean Air's high standards for employees?

Chapter Activity

Describe the best and worst job you have had. For each, describe the level of (1) skill variety, (2) task significance, (3) autonomy, (4) feedback, and (5) work identity. If you contrast the best and worst job by these factors, what patterns do you see?

CHAPTER

6

EMOTIONS AND STRESS ON THE JOB

Learning Objectives

After studying this chapter, readers should be able to

- differentiate between emotions and moods;
- explain the composition and impact of individual and organizational emotions and stress;
- distinguish between primary and secondary emotions;
- understand the methods discussed for managing emotions and stress;
- compare the interrelationships and conflicts among individuals, groups, and organizations that result in emotions and stress;
- discuss burnout and ways to avoid it; and
- contrast role- and job-related causes of stress.

Key Terms

- Burnout
- Distress
- Emotional intelligence
- Emotions
- Employee assistance programs
- Eustress
- Hardiness
- Moods
- Primary emotions
- Qualitative overload
- Qualitative underload
- Quantitative overload
- Quantitative underload
- Role ambiguity
- Role conflict
- Secondary emotions
- Stress

Running a successful healthcare organization requires leaders who understand and manage their emotions and stress. Although not identical, emotions and stress are closely related concepts. This chapter discusses the ideas surrounding emotions and stress from organizational and individual perspectives.

Emotions

Emotions are central to our personal and professional lives and inform all of our relationships. An emotional disequilibrium underlies most anxiety and stress-related illnesses and is often the driving force behind positive and negative motivation.

Emotions have been conceptualized by Fink (2010, 3) as

> transient events, produced in response to external or internal events of significance to the individual; they are typically characterized by attention to the evolving stimulus and changes in neurophysiological arousal, motor behavior, and subjective feeling state that engender a subsequent biasing of behavior.

Thus, emotions are brief, intense episodes of a complex range of feelings that lead to physical and mental changes and influence actions and behaviors. Emotions are expressed through verbal, physiological, behavioral, and neural responses to events, actions, circumstances, or stimuli. Emotions and moods can be influenced by biological functions, such as levels of dopamine and serotonin. Likewise, cultural influences affect the types of emotions expressed. In addition, gender influences emotional processing and incidence of emotion-related illnesses, such as major depression, anxiety disorders, and posttraumatic stress (Gregoire 2015).

Emotions Versus Moods

Moods are less intense than emotions but tend to last longer. Moods are also more pervasive than emotions and affect one's perception of life. They can be described as the "background" feelings, though they remain tied to the transient emotions we feel. Completely separating mood from emotion can be difficult (Clark 2005).

Emotions in the Workplace

Emotions and moods can significantly affect individual worker and group behavior and the nature of workplace environments. Emotions drive how people and groups interact and the decisions they make. Negative emotions can damage relationships, reduce the effectiveness of decision making, and cause health problems such as depression and anxiety disorders (Gregoire 2015).

Interestingly, positive emotions can lead to bad decision making as well. For example, overconfidence can be as problematic as a lack of confidence. Medical misdiagnoses occur more frequently among physicians who exhibit overconfidence (Berner and Graber 2008; Boundless 2015).

Managers are challenged in any organizational setting to foster positive emotions and appropriately regulate negative emotions. The ability to

communicate emotions is critical to a properly functioning workplace. Relaying emotion can be as simple as smiling or as involved as constructively expressing concerns. Doing so effectively can directly affect managers' ability to successfully problem-solve and negotiate. It also allows managers to differentiate among the various emotions and understand how to harness their positive effects and minimize their potentially damaging results (Ashkanasy, Hartel, and Zerbe 2000).

Emotions have been categorized into six primary or basic emotions and multiple secondary emotions (exhibit 6.1). **Primary emotions** include love, joy, surprise, anger, sadness, and fear. Primary emotions are what people first experience in a situation. They are instinctive responses that may rapidly appear and then just as rapidly be replaced with **secondary emotions,** which more closely reflect people's mental processing of a situation and the primary emotions it elicited.

Primary emotions are almost impossible to prevent, as they are reactions to external events. People might feel sad or angry about a rude remark. However, they can learn to recognize this primary emotion of sadness or anger and steer it toward a more constructive secondary emotion, such as sympathy. Secondary emotions are of longer duration. Negative secondary emotions, if allowed to linger excessively long, can be damaging to emotional well-being (Seaward 2014).

The ability to express all emotions is helpful and healthy for maintaining positive personal and work relationships. Most people agree that feeling love and joy provides personal benefit. However, expressing surprise, anger, sadness, and fear can be valuable as well, especially if doing so motivates us to address a potentially harmful situation. For example, if you are walking on a road and a car careens into your path, you will feel fear that will motivate you to move out of harm's way.

EXHIBIT 6.1 Primary and Secondary Emotions

Primary Emotion	Secondary Emotions
Love	Affection, lust, longing
Joy	Cheerfulness, zest, contentment, pride, optimism, enthrallment, relief
Surprise	—
Anger	Irritation, exasperation, rage, disgust, torment
Sadness	Suffering, disappointment, shame, neglect, sympathy
Fear	Horror, nervousness

Source: Adapted from Shaver et al. (2001).

Note: Interestingly, surprise does not have a secondary emotion.

Lack of Emotional Control Sets Meeting's Climate

Brad was a driven CEO. He knew how to manage and get the best out of people. At least he thought so. In his first month in the role, he "cleaned house" and fired three low-producing managers. He wanted input and ideas from his managers, and he held department meetings each month to obtain them. At one of the first meetings, he was clearly upset that hospital operations were not doing very well. He asked the managers to suggest solutions. Dan, the director of pharmacy, raised his hand and suggested that hospital costs could be reduced that year by decreasing or eliminating bonuses for members of the C-suite. Brad was shocked that someone would be so brash as to directly target his compensation. He then became angry, slammed his hand down on the table, and said loudly, "That is a stupid idea!" After that response, no one volunteered any further ideas. This made Brad even angrier. He flew into a rage and began to belittle the managers. He threatened that if they did not come up with solutions to solve the hospital's financial crises, he would do their job for them.

What emotions did Brad feel? How did his primary emotion change to a secondary emotion? What could he have done to prevent his negative outburst?

The ability to use emotions intelligently has become a popular management tool. **Emotional intelligence** (EI)—the capacity to be aware of, to control, and to express emotions, as well as to handle interpersonal relationships with empathy and wisdom—is an important characteristic for business leaders. EI has been found to be even more important than a leader's IQ (intelligence quotient) and the biggest predictor of workplace performance (Bradberry and Greaves 2009). Leaders' EI plays a key role in establishing the emotional climate in their organization by how they handle themselves and their relationships. Workers take their emotional cues from their supervisors and top bosses (Goleman, Boyatzis, and McKee 2013). As illustrated by the vignette in the adjacent box, the CEO sets the climate of meetings, and a lack of emotional control can inhibit open discussion.

Leaders who have high EI possess skills related to emotions, such as the following:

- Self-awareness—accurately perceives one's own emotions
- Other-awareness—accurately perceives others' emotions
- Applicability—harnesses emotions and applies them to solve problems
- Regulation—manages emotions and regulates them to adjust to needs

Controlling emotions can be difficult for many. However, individuals can improve their ability to understand and manage emotions. Following are some suggestions for improving one's EI (adapted from N. Rosenthal 2012):

- *Practice interpreting your emotions*. Take time each day to ask, "How am I feeling?" Provide uninterrupted time to think through your feelings.
- *Understand changes*. Recognize that emotions rise, fall, and fade.

- *Seek connections*. Seek connections between your feelings and other times when you felt the same.
- *Connect your thoughts with feelings*. Determine how your thinking connects with and affects your feelings.
- *Listen to your body*. Listen to how your body reacts to stress and interactions.
- *Track progress*. Rate yourself on your overall sense of well-being. In extreme days, note what ideas and associations may be connected to the feelings.
- *Record thoughts*. Write in a journal your thoughts and feelings.
- *Learn your limits*. Learn when to take a break, change a setting, and shift your focus.

Stress

Stress and emotion are tightly intertwined. At times, stress is confused as an emotion (Knowlton 2016). However, the constructs are distinct. Emotions are expressed through neural pathways that "facilitate the appraisal of environmental stimuli," whereas stress is described as a state of mental or emotional strain that arises from "uncertainty introduced by unexpected events," and the uncertainty and potential threat do not explicitly constitute emotion (Contrada and Baum 2011).

In the workplace, the ability to adapt and control emotions dictates the type of stress experienced. Dealing with unwarranted work stress has become a global challenge (Dewe, O'Driscoll, and Cooper 2010). Work in healthcare tends to be very stressful. Caregivers especially are exposed to highly stressful environments thick with heightened emotions. Improperly managed stress that promotes harmful behaviors and has a negative impact on physical and mental well-being can increase absenteeism and turnover (American Psychological Association 2012). Health professionals also experience greater risk for stress-related injuries than do professionals in other industries. For example, surveys show that nurses and physicians are more likely to show symptoms of burnout and be dissatisfied with their work–life balance, which often lead to physical injuries or emotional crises (some of which are described later in the chapter) (Hughes 2008; Shanafelt et al. 2012).

Burnout is a reaction to chronic high stress that may encompass emotional exhaustion, depersonalization, and reduced personal accomplishment (Hughes 2008). Burnout is characterized by a physical or mental collapse caused by overwork and stress, and it has become a serious problem for physicians. These highly trained providers are experiencing emotional exhaustion, cynicism, and a low sense of personal accomplishment, which erode the degree of professionalism with which they practice, diminish the quality of care they

provide, and increase the chance of committing medical errors. Physicians suffering from burnout also experience more broken relationships, alcohol misuse, and suicidal thoughts. Sadly, almost half of US physicians show symptoms of burnout (Shanafelt et al. 2012). Particularly frightening for healthcare professionals and their patients is that individuals experiencing high levels of stress have diminished higher cognitive functions (Fink 2010).

Stress can be caused by a number of work-related factors, including the following (adapted from Dewe, O'Driscoll, and Cooper 2010):

- Goals, deadlines, and standards
- Ambiguous expectations
- Long working hours
- Lengthy travel time
- Lack of skills and training
- Workload
- Lack of authority
- Inadequate pay
- Job insecurity
- Poor supervision

On the other hand, stress is not always negative. Stress can motivate greater effort and focus and can result in improved productivity or mastery of a new skill. Positive stress has been termed **eustress**. It occurs when one responds positively to a stressor, allowing one to see the gap between actual and desired status or attainment. Too much stress or chronic stress can have negative consequences as well; it causes **distress**—persistent, unresolved stress that may lead to anxiety, withdrawal, or depression (Hargrove, Nelson, and Cooper 2013).

Exhibit 6.2 shows the relationship between stress and performance. Increased stress augments performance (eustress) to a point, after which more stress begins to diminish performance and create distress. Ultimately, too much stress can lead to exhaustion, poor health effects, and burnout.

People react differently to varying amounts of stress. As shown in exhibit 6.3, both eustress and distress are affected by cognitive, behavioral, emotional, and physiological influences that are filtered by cultural expectations (Teng 2011). As can be seen from the arrows in the exhibit, each of these factors interacts with and jointly influences stress outcomes. People interpret events in various ways, so they also interpret stress differently. Cognitively, people examine stressors to determine whether they are direct threats, potentially harmful, or mere challenges and then assess their own ability to cope. Those who interpret situations negatively may experience negative emotions that can lead to distress, whereas those who appraise or perceive challenges

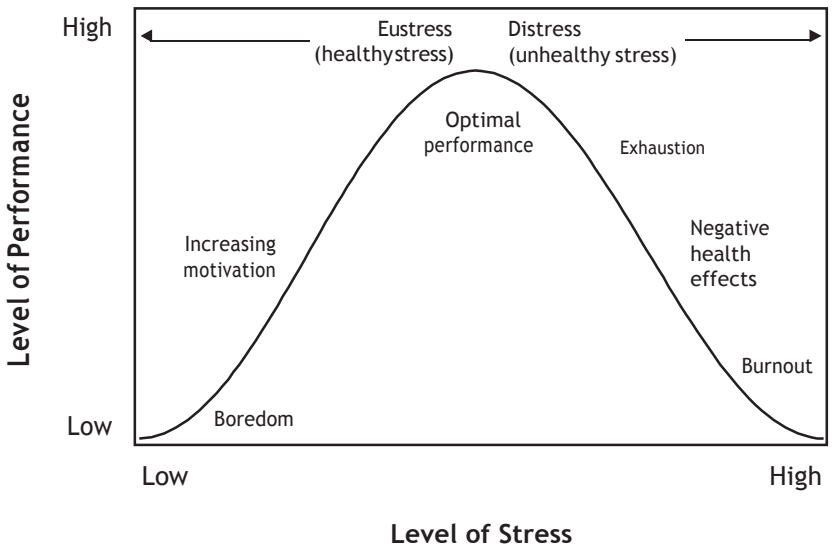


EXHIBIT 6.2 Relationship Between Stress and Performance

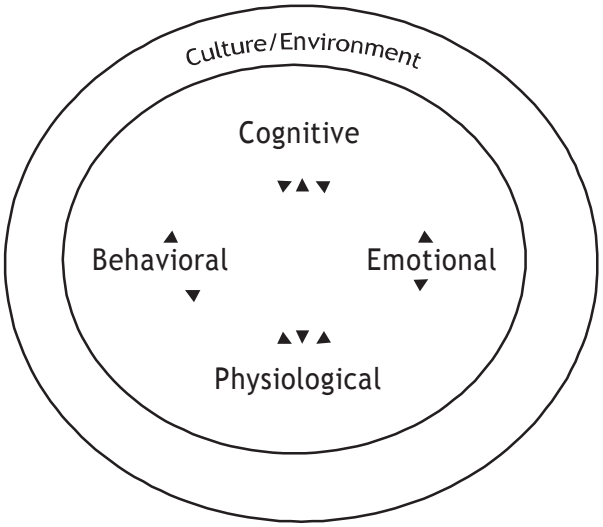


EXHIBIT 6.3 Influences on Stress

positively tend to feel eustress and achieve positive results (Roesch, Weiner, and Vaughn 2002).

The choice of behaviors and actions also affects emotions and stress levels. Choosing to work long hours, limit sleep, avoid problems, and not exercise makes one prone to feeling negative emotions and increased distress. Also, frequent procrastination in making tough decisions can result in negative emotions and stress.

The amount of stress that motivates or distresses varies by person. Some people can endure tremendous stress and find the pressure stimulating. Others wilt under seemingly low levels of stress. Childhood experiences, family obligations, gender, genetic traits, immune disorders, and personality types all influence resilience and susceptibility to stress.

The ability to handle stress, or **hardiness**, represents a sense of control over one's life, a measure of commitment to an important endeavor, a notion of being challenged rather than threatened by change, and the desire to meet challenges. Individuals with a high hardiness factor experience a greater internal locus of control in that they believe their own voluntary actions influence the outcomes they experience (Dobson and Dozois 2008).

Locus of Control

A significant factor that affects individuals is locus of control, a person's perception of what influences or drives outcomes. People have either an internal or an external locus of control. An internal locus of control makes people feel they are in control of what happens to them; an external locus of control makes people believe outside factors (e.g., other people, circumstances) control their lives or their fate. Research has found that those with a strong internal locus of control are more satisfied with their jobs and have better coping strategies for minimizing stress than do those whose locus of control is external (Nelson and Campbell 2012).

Sources of Stress

The American Psychological Association (2012) conducted a survey on the topic of stress; its results are shown in exhibit 6.4. Of note, the factors people identified as causing stress were both personal and work related. Money and work-related stressors accounted for about half of the reasons those surveyed felt stress, while family and personal issues accounted for the other half.

Studies have shown that in organizations, role ambiguity and role conflict commonly create stress for employees (Idris 2011; Shultz, Wang, and Olson 2009). **Role ambiguity** is a lack of specificity and predictability about a job, role functions, or responsibilities resulting from insufficient, misleading, or restricted information about the work role. Role ambiguity occurs when workers do not clearly understand what is expected of them—because of unclear job descriptions, poor training, changing job requirements, or other reasons. **Role conflict**, on the other hand, is the dissonance that arises when employees are faced with two or more incompatible or contradictory job demands. For example, a nurse manager is pushed to run his unit efficiently and save money yet is obligated personally and professionally to make sure his staff achieve and maintain high-quality patient care.

EXHIBIT 6.4 Reasons for and Symptoms of Stress Experienced in the United States

Causes of Stress
1. Money—75%
2. Work—70%
3. Economy—67%
4. Relationships—58%
5. Family responsibilities—57%
6. Family health problems—53%
7. Personal health problems—53%
8. Job instability—49%
9. Housing costs—49%
10. Personal safety—32%

Physical Symptoms of Stress
1. Irritability or ANGER—42%
2. Nervousness or anxiety—39%
3. Fatigue—37%
4. Depression or sadness—37%
5. Lack of interest, motivation, or energy—35%
6. Headache—32%
7. Feeling the urge to cry—30%
8. Upset stomach or INDIGESTION—24%
9. Muscle TENSION—24%

Source: Information from American Psychological Association (2012).

Work-related stress itself has been seen to cause conflict among employees. Some behaviors that arise from work stress and create conflict include the following (adapted from Hospital Employees' Union 2000, 16–17):

- Getting mad at staff in another department because their work was shifted to you
- Accusing a coworker of not doing her fair share
- Being afraid to speak out about work problems because coworkers may abuse or reject you
- Talking behind someone's back or starting rumors
- Blaming your supervisor for work overload
- Sabotaging a coworker's job to get him in trouble
- Making assumptions about someone's relationships at work and home
- Believing a coworker has more power or privileges than others have
- Becoming withdrawn and uncooperative, never smiling or even talking with coworkers
- Ridiculing a person's appearance, speech, or personality
- Giving up on trying to improve things or getting along with coworkers

Furthermore, Donais (2006) has noted, "People often bring their stresses from home into the office leading to further conflict."

Stress can also be produced from work overload and work underload, which can be either quantitative or qualitative. **Quantitative overload** consists of too much work to do in a given period. For example, a physician has more patients in the waiting room than she has the ability to see in one day. **Qualitative overload** arises when the work requires a skill that the employee does not yet feel comfortable using. This type of overload occurs often in training programs when new providers are assigned tasks and procedures they may have practiced only once.

Quantitative underload happens when too little work is available to handle in a period. For example, some shifts in hospital emergency departments see far fewer patients than they have the capacity to treat. **Qualitative underload** exists when the skill requirements for the job are far below the employee's training and ability. This situation may be experienced by a doctoral research assistant who is assigned tasks such as copying and faxing materials.

As the level of stress mounts and persists, strains can result. Strains occur in the psychological, physiological, and behavioral aspects of life. Psychological strains may lead to impaired cognitive function, depression, anxiety, and burnout; physiological effects may include illness, weight gain, high blood pressure, sweating, aches, and sleeplessness. Negative behaviors from excess strain include alcohol overconsumption, smoking, and suicidal actions (Barling, Kelloway, and Frone 2005).

Managing Stress

Organizations can take steps to manage the stress experienced by their employees. Factors that cause stress can be eliminated or reduced, and individuals can be taught to adapt to stress and lessen the negative stress they experience. Of course, stress will never be eliminated completely.

Reducing factors that create stress requires addressing issues surrounding job satisfaction and motivation. As discussed in chapter 5, many of the same changes that encourage motivation can prevent negative stress. For example, the absence of hygiene factors—such as good working conditions and job security—can create dissatisfaction, so hygiene factors should be introduced. Similarly, having enriching work, promoting mutual respect and appreciation, paying equitable salaries, and providing clear operational policies all help minimize workplace stress.

Firms can also train their employees to better adapt to stress. Many organizations provide individual, social, and work support to motivate positive action and decrease destructive stress. For instance, Eli Lilly, a large US pharmaceutical company, has been recognized for its enlightened treatment of workers. It offers employees a bonus program, fair compensation and retirement plans,

learning resources for career development, a flexible work structure that allows job sharing and teleworking, sponsorship of support groups, free gym membership or on-site fitness centers, and a "no-stress" dress code (Eli Lilly 2015).

The Hospital Employees' Union (2000) has suggested that stress prevention policies be established in every healthcare organization. Such policies include the following:

- A definition of work-related stress
- A statement by management that stress is an organizational problem it is committed to tackling
- An agreement on the key factors that cause or contribute to stress, such as excessive workload, lack of support, and lack of control over the job
- A comprehensive list of stress symptoms, to which new symptoms are added as they become known
- Techniques for assessing stressors, such as inspections, confidential surveys, and audits
- Tools for assessing stress hazards, comparable to risk assessments for environmental hazards
- Simple, clear procedures to use when a worker is showing stress symptoms
- The right of every worker to receive training and ongoing information about workplace stress
- A review of the policy at regular intervals

Individual workers can be taught to self-regulate and gain EI; social support systems can be created; and the work environment can be structured to allow greater empowerment, autonomy, and responsibilities to employees (Barling, Kelloway, and Frone 2005; Hughes 2008). For example, Google, a leader in attending to the total well-being of its employees, offers a free course "designed to teach emotional intelligence through meditation" that focuses on improving one's attention, developing self-knowledge and self-mastery, and creating helpful mental habits (Kelly 2012).

Healthcare workers can also take personal actions to relieve stress and avoid burnout. Five ways to do so are as follows (Allhealthcare 2015):

1. Talk it out.
2. Recharge at a retreat.
3. Learn to say "no."
4. Develop a career plan.
5. Nurture relationships.

Firms can assist their employees in overcoming stress by creating a stress-free zone. Allhealthcare (2015) offers these guidelines for an organization interested in dedicating a space for relaxation:

> This can be an entire room or maybe just a corner of the cafeteria. Put up a sign declaring the area "stress-free" and add to the atmosphere by including fresh flowers, yummy food, or peaceful photographs. Anyone can visit the "Stress-Free" zone, but there is a catch: You are not allowed to stress out in the "Stress-Free" zone! If an employee wants to vent, let them go elsewhere. [M]ake the "Stress-Free Zone" a place people want to come to relax.

In addition, most major organizations have created **employee assistance programs** (EAPs), which assist employees with personal problems that may trigger high and continuous stress. EAPs generally provide confidential short-term counseling and referrals for employees who face challenges that, if left unmanaged, could seriously affect their work. Some of the issues handled by EAPs include substance abuse, occupational and emotional stress, health and financial issues, and family problems (Mannion 2004).

Chapter Summary

The ability to control and regulate emotions and stress is a critical competency for all individuals, especially employees. Emotions and stress, although not identical concepts, are closely associated, and managing both can be improved by similar methods.

Emotions permeate daily activities as well as personal and work relationships, and they motivate both positively and negatively. Emotions and moods are related, but moods last longer, are less intense, and function as background feelings. Like emotions, moods can influence individual and group behaviors positively and negatively.

The six primary emotions are love, joy, surprise, anger, sadness, and fear. Primary emotions, which are almost impossible to prevent, are the first, instinctive responses experienced in situations. Primary emotions then transition to secondary emotions, which reflect a person's mental processing of the emotions and situations. Learning to understand and express emotions can help individuals manage their relationships and environment.

EI—the ability to use and control emotions intelligently, with empathy and wisdom—has been identified as a critical leadership competency. Organizational leaders set their working climate through their use of EI. Those with excellent EI have high self- and other-awareness, and they harness and regulate their own and others' emotions.

At times, stress is confused with emotion. Although they are closely related, stress often results from poorly handled emotions. Appropriately handling work stress has become a global challenge. Healthcare workers experience high degrees of stress, which results in increased rates of burnout and dissatisfaction. Stress is associated with many work-related factors.

Stress, however, does not need to be negative. Eustress, or positive stress, can motivate individuals and help them gain a sense of achievement. Distress, on the other hand, is negative stress that occurs when too much stress is experienced over too long a period. An individual's traits may determine the amount of stress she can endure and whether she perceives the stress as positive or negative. The personal cognitive, behavioral, emotional, and physiological factors interact with each other within the person's culture and environment to regulate the effects of stress.

Money, work, and family are major sources of stress. In the organizational context, role ambiguity and role conflict create stress for employees. Stress can also be caused by having too much to do (quantitative overload) or not having the requisite skills to do the job (qualitative overload). Similarly, not having enough to do (quantitative underload) and working under job requirements far below the skills of the employee (qualitative underload) also may cause stress.

Organizations can take actions to help employees manage stress. Work factors that increase stress can be altered, and individuals can be taught to reduce their stress. Most large employers offer EAPs to help employees deal with personal problems, which could lead to negative stress if left unresolved.

Chapter Questions

1. What is the difference between a primary emotion and a secondary emotion?
2. Moods differ from emotions in what ways?
3. How has emotional intelligence (EI) been found to be beneficial in a work setting?
4. Why could recording your thoughts and feelings in a journal increase your EI?
5. One particular definition is given for stress. Do you think it describes what stress is to you? Why or why not? Can you find another definition that more closely matches your sense of stress?
6. How does burnout differ from stress?
7. What are the symptoms of eustress (positive stress)?
8. What are the five factors that influence stress?

9. How does role ambiguity relate to role conflict?
10. How can qualitative overload be addressed?
11. What are some ways employers can reduce stress for their employees?

Chapter Cases

Bad Driving—Road Rage

As human beings, we differ from animals in that we can determine our secondary emotions. Yet, interestingly, the initial reactions of animals and humans to stimuli are often similar. We both may get angry and fight or flee. However, humans have the ability to process our initial emotions and direct our perceptions and feelings to secondary emotions. One of my experiences while driving illustrates how perceptions and cognitive thoughts can influence emotions.

I was driving on a relatively crowded freeway, staying mostly in the passing lane because I was in a hurry and exceeding the speed limit. I arrived at a group of cars traveling slowly in a caravan. The car in the left lane would not pull over to let me pass. In fact, the older lady in the driver's seat appeared completely unaware that I wanted her to depart from the lane. She was busy combing her hair and applying makeup.

Oh, I was angry! I immediately began constructing a nasty story about this lady. She was thoughtless and oblivious and probably did not even deserve to have a driver's license. My emotions started boiling over. I edged up on her car and turned on my bright lights. Well, that finally got her attention, and she changed lanes.

I was now going to show her my disgust and anger by giving her my ugliest face as I passed her. As I drew alongside her car, to my surprise I saw my angel Aunt Mildred behind the wheel. Oops! She was the perfect aunt, always willing to help as a volunteer at service organizations. Well, my thoughts about the other driver changed dramatically. I also noticed my emotions change. Instead of being angry and combative, I was embarrassed and made a commitment to be more careful about the stories I create about others.

Case Questions

1. What caused my initial emotions?
2. Could I have done something to have prevented these emotions?
3. What triggered my secondary emotions?
4. Given this example, what could you do to create more positive emotions?

Healing Hospital Conflict

A few years ago, a patient was admitted to the hospital for a stem cell transplant but seemed to be experiencing all the symptoms of a heart attack. Giving a person the drugs needed to perform a stem cell procedure is very risky if the patient is unstable. An electrocardiogram (EKG) had been recorded for the patient, but the cardiologist had not arrived by the time the oncology team came to see the patient.

The attending physician, an oncologist with a bad temper, was told about the patient's chest pain, glanced at the EKG, and told the nurse that the readings did not concern him. The nurse faced a dilemma: Should she try to delay the transplant until the cardiologist arrived, or go along with the oncologist?

Nurses are not licensed to order tests or medications but are the "final check" on the decisions doctors make for patients. The nurse chose the brave, but more stressful, option and asked for a delay. In the hallway, the oncologist yelled at her and arrogantly asked her why. To him, she was just a nurse.

Such confrontations increase the stress and tensions for nurses. Physicians hold more power than nurses do, so even if nurses are right, rude treatment by physicians will make them think twice before speaking up in the future. Generally, no structure is in place for nurses to resolve errors made by physicians. The majority of physicians recognize and correct mistakes if nurses point them out. However, if doctors refuse to change their order, nurses feel pressure to cooperate and implement the order. Even though nurses have a legal obligation to act, failing to implement the order risks the ordering physician's anger and even possible discipline or termination.

Some health systems are seeking to improve how physicians and nurses work together. The University of Virginia requires interprofessional education for all nursing and medical students. Training and courses are shared to allow nursing and medical students to learn together and gain respect for each other's areas of expertise and responsibilities. Teamwork is emphasized.

So what happened to the patient who needed a stem cell transplant? The cardiologist arrived at the end of the oncologist's temper tantrum and, after examining the patient, determined that the patient was not having a heart attack and the procedure could continue.

Source: Adapted from Brown (2013).

(continued)

(continued from previous page)

Case Questions

1. How does the power differential in a healthcare setting increase the stress and tension for workers?
2. What organizational structures could be established to lessen the stress caused by conflict?
3. What could physicians do to diminish the stress and conflict in hospitals?

The CEO Case of Quantitative Overload and Qualitative Underload

Leon was recently promoted as the regional director for a large public health system. He was a conscientious and hard worker. His reputation as an excellent leader centered on his ability to understand in detail what was going on in his department and, after a series of earlier promotions, his agency. Now he was in charge of multiple agencies across an expansive geographic area.

His philosophy could be expressed as, "Whatever one measures, improves." In this spirit, he designed a monthly report for all of the managers to complete. The report took each manager about ten hours to finish and often reached 30 pages. He then held monthly conference calls during which he asked specific questions regarding the data. If managers were unable to answer his questions, they were frequently invited to "personal meetings." These meetings were rumored to often get tense, because Leon liked to "go for the jugular" and delve directly into the problem areas, at least as he perceived them.

After about six months, he had instilled a mixture of awe and fear in his managers. None wanted to be called into his personal meetings. He had little authority to directly fire his managers, but he did reassign two of them to areas of lesser responsibility. The others wondered when they would be next. However, the data collection and the preparedness level of managers to answer even the most trivial questions had improved dramatically.

Overall, Leon felt that people had gotten his message and were managing better. Nevertheless, he had concerns about the high salary costs the organization was experiencing. The nursing clinics seemed to be operating efficiently, but the three hospitals over which he had control did not appear to be able to manage their worked staff hours very well. The numbers seemed to fluctuate radically over the weekends. He had

never worked in a hospital, but he felt that if he had enough information, he could reduce the overtime and excess staffing that continued at each hospital. In his conference calls, he had asked about the reasons for the weekend overages and had gotten conflicting information from the different hospital leaders. He had also met with each leader, and he still believed the leaders were not managing their worked staff hours appropriately on the weekends.

In frustration, Leon decided to devise a weekend manpower monitoring report (shown on page 90) to track the weekend staff-hour management. He required the CEO of each hospital to send him the report at 8:00 a.m. on Mondays so that he could have the information on a timely basis. However, this necessitated the CEOs and each hospital's chief financial officer (CFO) and human resources director to come in on Sunday evenings to collect and analyze the data, which required three to four hours to complete each week. This added responsibility took valuable time away from the hospital leadership team's family time and heightened their frustration.

One of the CEOs, Steve, faithfully came into the office with his other executives for four weeks and submitted the reports. However, in week 5, the CFO of his hospital was sick and could not come in on Sunday evening. Rather than turn in a partial report, Steve did not turn in anything on Monday morning. He and his colleagues waited for the dreaded call from Leon asking where the data were. Each day of the week passed with no call. The next Sunday, they decided not to come in and did not turn in a report the following week.

After five weeks of not submitting a report, Steve received a call from Leon's administrative assistant asking if he and his team had overlooked sending the reports.

Case Questions

1. What type of qualitative and quantitative overload and underload were taking place in this case?
2. How did the reporting structure affect emotions and stress?
3. Could Leon's approach and the level of stress he imposed on his managers induce improved performance in the short term? In the long term?
4. After studying chapter 6, what would you recommend to improve Leon's management style and, ultimately, the work environment and performance?

(continued)

Weekend Manpower Report									
	Worked Hours			Inpatient Census			Work/Workload Ratio		
	Friday Evening	Saturday	Sunday	Friday Evening	Saturday	Sunday	Friday Evening	Saturday	Sunday
Nursing Unit 1									
Nursing Unit 2									
Nursing Unit 3									
Nursing Unit 4									
Nursing Unit 5									
Nursing Unit 6									
Nursing Unit 7									
Nursing Unit 8									
Nursing Unit 9									
Nursing Unit 10									
etc.									
Workload Unit									
Admitting									
Dietary									
Maintenance									
Respiratory Therapy									
Radiology									
Laboratory									
Pharmacy									
Other									

(continued from previous page)

Chapter Activity

Measure your own stress levels by completing the free quiz titled "Measure Your Stress" at www.psychologistworld.com/stress/stresstest.php (Devilly 2004). Then answer the following questions:

1. Which factors increase your stress level?
2. Which areas should you improve to manage your stress better?

CHAPTER

7

PARADIGMS AND PERCEPTIONS

Learning Objectives

After studying this chapter, readers should be able to

- evaluate the meaning of the terms *paradigm* and *paradigm shift;*
- perceive how attitudes and perceptions form and influence behaviors;
- discuss the fundamental attribution error and its impact on perceptions;
- describe stereotypes, halo effects, and similar-to-me effects and the damage they can cause if they are not recognized and dealt with;
- summarize how the primacy and recency effects can influence decision making; and
- compare and contrast different forms of commitment and their benefits.

Key Terms

- Affective commitment
- Continuance commitment
- Fundamental attribution error
- Halo effect
- Job commitment
- Normative commitment
- Paradigms
- Paradigm shift
- Perceptions
- Primacy effect and recency effect
- Similar-to-me effect
- Stereotypes

How we perceive events is tied directly to our attitudes and cultural backgrounds. Furthermore, what we understand and perceive becomes our reality. This chapter discusses the ways we see events and experiences and the paradigms and filters that allow us to have distinct perspectives even when confronted by the same situation. Our way of thinking also creates potential biases that can negatively prejudice our decisions. Understanding how employees see the world and what affects their frame of reference allows managers to improve their decision making and more fully engage employees.

Paradigms

All humans see the world through lenses crafted from their life experiences. These lenses are our **paradigms**, which filter how we perceive events (how we see the world) and affect how we make decisions. From our experiences, we make connections between actions and outcomes and develop expectations about how the world works. Paradigms color our expectations about people's behavior and direct our actions in organizations.

Paradigms help direct the focus of our attention and our interpretations of situations. According to Kuhn (2012), the way we see the world dictates

1. what we choose to study and research,
2. what types of questions we ask,
3. how we structure our questions, and
4. how we interpret results.

Established paradigms facilitate decision making by allowing us to determine in advance the relationship between cause and effect. For example, a sizable number of parents in the United States have refused to vaccinate their children for common communicable diseases. As a result, epidemics of childhood diseases such as measles have broken out in the country. Public health officials perceive that these parents endanger not only their own children but the health of the nation as well. Many parents who decide not to vaccinate are well educated but allow their perception that vaccines may be linked to autism and other developmental maladies to dictate their thinking. In some schools in Orange County, California, 50 to 60 percent of kindergartners have not received the required vaccinations. Their parents' paradigm projects a dangerous, untrusting world where parents desire "to raise their children in a natural, organic environment." These parents are suspicious of pharmaceutical companies and big businesses.

A Paradigm of Expected Restaurant Service

I moved to Korea for an extended period for work. The first time my wife and I went to a Korean restaurant together, we were seated, given a menu, and then . . . nothing. We sat and sat, waiting for the waitress to take our order. We began commenting on how poor the service was, and we speculated that it might be a result of the diners not including tips. Finally, after about 20 minutes I made a noise and got the waitress's attention. We did not speak Korean, and the waitress spoke little to no English.

She took our orders, and we soon had our food. We still were not happy with the poor service. The next day, I went to work and related to my administrative assistant, who was Korean, my story of the restaurant experience. She laughed and informed me that in Korea it is considered rude for a waitress to come to a table before the customer is ready. Diners should decide on their meal choices and then signal for the waitress to take their orders.

Much of their argument, however, is not based on science but on feelings forged by their experiences. As one parent stated, "Vaccines don't feel right for me and my family" (Healy and Paulson 2015).

Throughout our lives, we collect assumptions that construct our paradigms. A lack of awareness of these underlying assumptions can keep people from understanding others. Most of the time, at least initially, these assumptions help us to improve interactions and facilitate social and organizational interchange. However, problems arise when assumptions, which we established in the past and are now unquestioned (and even unrecognized), become mismatched with current reality and influence our behavior negatively. Improper or misplaced paradigms can cause incorrect perceptions and poor judgment.

As the box on page 94 shows, even common experiences such as being served at a restaurant involve perceptions. Prior dining experiences clearly influence the assumptions held of how a server should act.

Paradigms differ among humans because everyone perceives events and situations differently. We can view the same scene but understand totally different concepts. As is the case with parents who refuse to have their children vaccinated, reality depends on the perspective of the beholder, and consequent actions and behaviors are directly tied to that reality. In healthcare, as illustrated by the vignette in the box below, patients often have perspectives that differ from those of service providers. Even if the providers are certain they are right, the patients' perspectives are their reality and must be considered.

When beliefs fail to match reality, it is time to undergo a **paradigm shift**. Changing a person's paradigms can alter her decisions, prepare her for uncertainty, and enhance her ability to learn in the organizational setting (Covey 2004; Senge 2006).

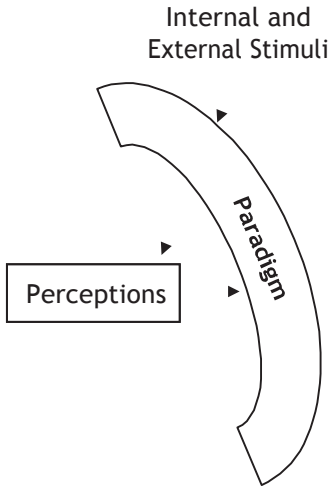
Perceptions

Exhibit 7.1 illustrates the ways in which stimuli, perceptions, and paradigms interact. **Perceptions** are the ways people experience, process, and interpret stimuli. These stimuli may originate from many sources—the weather, traffic, personal interactions, signs, and numerous others. Humans filter the stimuli through their paradigms and arrive at perceptions. The

A Patient's Perspective

As a hospital CEO, I received many complaints from patients about the service they had experienced. Part of my improvement process was to meet with the heads of departments in which the services had been rendered to discuss the patients' complaints. Frequently, someone in the affected department would state that what the patient said did not really happen and then would proceed to tell a totally different story. Again and again, I would remind staff that what actually happened from their perspective did not matter; what mattered—and had to be addressed—was the reality in the patients' mind.

EXHIBIT 7.1
Interaction of Stimuli, Perceptions, and Paradigms



perceptions, in turn, provide feedback that helps modify or reinforce the paradigm.

Personal characteristics also affect what an individual perceives. Individuals' attitudes, motives, personality, education, interests, past experiences, and expectations can influence what their perceptions. This filtering often results in inaccurate and differing perceptions. The fact that people can observe the same situations or receive the same stimuli yet understand them in totally different ways has long been seen in healthcare organizations. For example, the perceptions of top managers tend to differ widely from those of staff personnel. High-level executives bring radically distinct paradigms to the work environment as compared with staff's, and each group can perceive the direction and success of their organization very differently (Walston and Chou 2011).

The process of generating perceptions is multifaceted. Living in a complex world that constantly bombards them with an extensive amount of information, individuals must select, organize, and interpret the stimuli. Experiences and paradigms guide them to select and ignore different information. Often, this process occurs without thought, as people hear and attend to only the stimuli that interest them or support what they seek. For example, people shopping at the grocery store are likely to buy much less food if they have eaten prior to visiting the store than if they shop while hungry. Likewise, an orthopedic surgeon may focus on surgery-related matters and ignore a patient's overall medical condition.

Once selected for attention, information is organized into recognizable patterns and interpreted. Some of the patterns may be opposites, while others may reflect cause-and-effect relationships. Opposites occur when we contrast one experience with another. We know how we have acted in certain

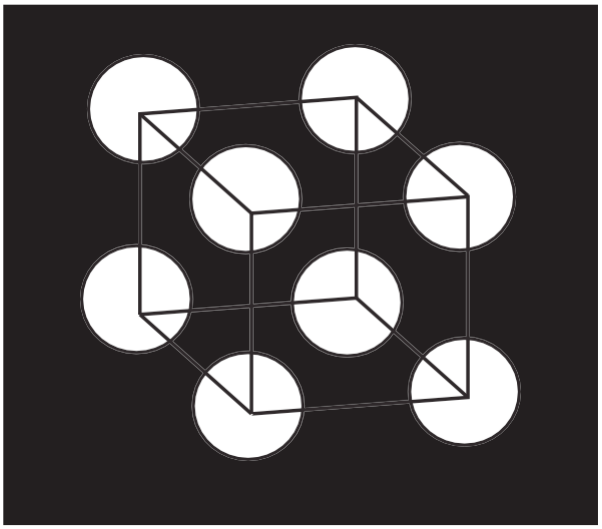
circumstances and contrast that action with the behavior of others. Cause-and-effect patterns allow us to attach meaning to the source of the actions. Understanding cause and effect helps us explain the past, comprehend the present, and forecast the future.

People seek order and establish causal relationships. Of course, with our limited perspectives, our interpretations may fail to be accurate or may be interpreted differently by distinct parties. For example, in 1979, Israel and Egypt signed a historic treaty that provided for mutual recognition, normalization of relations, and peace between the two countries. However, the perception of why the governments were willing to sign varied according to their own perspectives (Air University 2015):

> The Egyptians attribute their willingness to sign a treaty with Israel as due to their inherent disposition for peace; Israelis explain Egyptian willingness to make peace as resulting from a deteriorating economy and a growing awareness of Israel's military superiority. On the other hand, Israelis attribute their own orientation for accommodation as being due to their ever-present preference for peace. Egypt, however, explains Israel's compromises regarding, for example, Sinai, as resulting from external pressures such as positive inducements and threats of negative sanctions by the United States. In addition, some Egyptians attribute Israel's undesirable behavior, such as establishment of Jewish settlements on the West Bank of the Jordan River, as stemming from Zionist expansionism. If Israel should not place settlements in that territory, Egyptians might account for such desirable behavior as being due to external constraints, such as Western condemnation of settlements. Israelis, on the other hand, explain undesirable behavior, such as Egypt's past tendency to issue threats to drive them into the sea, as resulting from Egypt's inherent opposition to a Jewish state in the Middle East. When Egyptians ceased to make such threats, Israelis attributed this desirable behavior as emanating from external circumstances, such as Israel's relative military superiority.

Part of the problem with our perceptions is that we never have complete information. Although we can perceive physical objects and the environment relatively objectively, information about people and social interactions is often subjective and open to personal interpretation. At best, our experiences and background provide fragmented evidence that we connect and from which we draw conclusions. As demonstrated in exhibit 7.2, we can interpret different outcomes from the information given. This drawing is made up of only short lines and circles, yet most who view the diagram perceive a three-dimensional cube embedded in the darkened box. We take the fragmented information presented and then extrapolate what we think we should see. Similarly, people tend to draw conclusions when presented with limited information. A Ted Talk by Daniel Simons (2011) highlights the way people see the world as it really is not.

EXHIBIT 7.2
Extrapolating from Limited Information



Perceptions can be very helpful in making proper, prompt decisions. However, incorrect or misaligned perceptions can cause problems. Covey (2004, 200) estimated that "over 90 percent of all communication problems are caused by differences in either semantics or perceptions." Improper perceptions can wrongly bias our actions and behaviors. Too frequently, we establish patterns based on single or infrequent accidental or random incidents. In fact, the patterns we perceive may actually be accidental and random. For example, we may flip a coin six times and encounter six straight heads. From this singular event, we may predict that the coin flip will always come up heads.

People also miscalculate their and others' abilities. Gamblers often state they have the ability to influence the game or have figured out how to beat the system. Yet casinos' games are based on averages and invariably win over time.

Following are common perceptual problems that can bias decisions:

- Fundamental attribution error
- Stereotypes
- Halo effect
- Similar-to-me effect
- Primacy effect
- Recency effect

Fundamental Attribution Error

Fundamental attribution error occurs because people tend to have different perceptions of how their own and others' actions and behaviors are influenced. People attribute their own success to personal traits (e.g., their

EXHIBIT 7.3
Fundamental Attribution Error

	Source	Success or Failure Attributed			
		My Success	My Failure	Others' Success	Others' Failure
Internal Attribution	Disposition, intelligence, character and personality traits, values, motivation, or ability	X			X
External Attribution	Physical setting, task difficulty, organizational structure, economy, or luck		X	X	

wonderful personality, strong values, high motivation, unique ability), whereas they attribute their failures to external factors (e.g., the work setting, organizational structure, the economy, bad luck) (exhibit 7.3). However, when people consider the success or failure of others, the attributions switch: Success is primarily attributed to external factors, while failure is blamed on personal characteristics. For example, say a nursing supervisor receives a report of a serious patient safety error. Through fundamental attribution error, the common tendency is to identify the person responsible, attribute fault, and administer punishment. Attributions to the person who caused the error may be expressed as, "He is irresponsible," "He doesn't think," or "He doesn't have the ability to do this job." However, if the supervisor commits a similar error, she may attribute it to external factors, such as a heavy workload and the confusing medication reporting system.

The healthcare quality improvement movement calls for shifting from a culture of blame (personal or internal attribution) to a system focus (external attribution), which indirectly addresses the problems of fundamental attribution error. Errors are almost always the result of system failures, not individual motivation and ability problems (Phelan 2001). Managers need to recognize the normal attributional faults that exist and adjust their perspectives.

Stereotypes

Perceptual difficulties can also arise from the use of **stereotypes**—the categorization of people on the basis of characteristics such as race, gender, age, religion, and occupation. Simplified and standardized behaviors or traits are assigned to and associated with those categories or types of individuals (Your Dictionary 2015).

Stereotypes are not necessarily bad; everyone establishes them to simplify their world perspective and reduce mental effort. Stereotyping is seen in every industry, including healthcare. Research has found, for example, that positive

stereotyping reflects on physicians as being compassionate and nurses as being both compassionate and team players (Betra 2013). Adler (1991) noted that stereotypes can be helpful when they are

- consciously held,
- descriptive rather than evaluative,
- accurate,
- a first best guess about a group before obtaining direct information, and
- modified when observation and experience are obtained.

Nevertheless, stereotyping can also contribute to work dissatisfaction and poor communication (Mandy, Milton, and Mandy 2004). People often express their cynical attitudes by stereotyping people. For example, individuals may describe "suits" (managers) as untrustworthy or a particular race as lazy.

An additional danger of stereotypes is that they often become embedded in a culture and become difficult to change. Stereotypes frequently are based on limited information, mostly anecdotes. More often than not, stereotypes are found to be incorrect but are very resistant to being modified. Furthermore, they can lead individuals to make poor decisions, especially when issues of social justice and prejudice are involved (Osland et al. 2007).

Halo Effect

The **halo effect** can also influence decisions and behaviors. The halo effect is present when one characteristic or trait, positive or negative, dominates in the evaluation of people or products. For example, when Apple introduced the iPod to great acclaim, sales of Apple's other products increased dramatically. Because of the halo effect, the quality and popularity of this one product drove sales for the company's other devices (Pingdom 2012).

The halo effect may also be occurring with foods labeled "organic." People often assume (mistakenly) that these foods are more nutritious, so they end up consuming more calories than they would have otherwise (News-Medical.net 2011). Similarly, when people are seen as very knowledgeable or highly respected in an area, their other traits may be perceived as highly positive. This effect is often seen with physicians and professors because their degrees and positions frame the opinions of others as, perhaps inappropriately, deferential.

Similar-to-Me Effect

The **similar-to-me effect** is at play when individuals and groups favor and select people who are physically and professionally similar to themselves. This effect can unintentionally influence hiring decisions, annual evaluations, and promotions. People relate to and can more easily communicate with others who share like interests, values, experiences, and social backgrounds. Although this relatability can lead to greater cohesion, it might also create homogeneous

management teams that may discriminate against those with different characteristics and limit diverse opinions, which can stifle creativity.

Managers need to understand that this bias occurs with everyone. Actions can be taken before and during the hiring, evaluation, and promotion processes to recognize the similar-to-me effect's potential and to dampen its influence. Helpful questions to ask in these situations include the following (reprinted from Dartmouth College 2010):

- Am I basing my rating on documentation of my observations of the Employee's behavior, or am I making judgments based on my perceptions?
- Am I looking at each of this Employee's competencies separately, or have I generalized about his or her performance?
- Have I looked at this Employee's competencies over time, or have I generalized according to initial perceptions of her or him?
- Have I recognized any biases I may have so I do not let them influence my judgments?
- Have I rated this Employee on his or her actual behavior or have I rated her or him compared to other individuals?

Primacy Effect and Recency Effect

The **primacy effect and recency effect** influence people's ability to recall information because they tend to most easily remember the first (primacy) and most recent (recency) items presented. In line with these effects, our perceptions are often dominated by the first or last impression we have of others. The old adage "You have only one chance to make a first impression" should be coupled with the thought that "Your last impression may be critical." Both the primacy effect and the recency effect should be recognized, and efforts should be taken to moderate them.

The primacy effect may be a determinant in whether people achieve goals tied to rewards. Research has shown that the first reward given may have an oversized impact on future behaviors (Shteingart, Neiman, and Loewenstein 2013).

This principle similarly has application to good communication. The most important messages should be positioned at the beginning of conversations and then restated at the end. If intermingled in the middle, the messages will not be readily recalled by the people to whom the message is directed. In emergency and high-risk situations, understanding the primacy and recency effects can be particularly important (Reilly and Markenson 2010).

Cultural Differences

Cultures dramatically affect perceptions and attitudes. We see and interpret situations through our distinct cultural perspectives, and cultural expectations differ significantly. Without an understanding of the different cultures

at play in our environment, we may make incorrect judgments. For example, business interactions in the Northeast region of the United States tend to be formal and brusque, whereas businesspeople in the South often place great attention on social hospitality. Southerners doing business in New York City may initially be put off by the brash attitude their counterparts may display.

Symbols and numbers can also mean radically different things to different cultures. In Hong Kong's primary language, Cantonese, the word for prosperity, *faat,* sounds like the English word *eight*. This connection once motivated a rich businessman to pay $5 million for a car license plate with just the numeral 8. The next year, Chinese people in Hong Kong were mystified when a European paid $4.8 million for a license plate with the number 7, as this numeral has little significance to Chinese culture or fortune (Adler 1991).

Perception is culturally determined and tends to be difficult to change. Recently, I was involved in a negotiation between a university and a Korean government entity that went on for almost a year. The parties were deciding on the language for a large loan that would not be paid back if the university did not become profitable within five years. Most of the terms had been agreed on, but the parties could not come to a consensus on language regarding the disposition of the loan. The university wanted the Koreans to "forgive" the loan if it was not able to pay it back. The Koreans refused to accept this contingency.

After significant discussion, the university realized that the Koreans' reluctance was based on their interpretation of the word *forgive,* an unacceptable term to Koreans. Although it is commonly used in the United States to denote that payment of owed money is no longer required, the Koreans were defining forgiveness as "to stop feeling anger toward someone and to stop blaming someone and to pardon someone." Clearly, if the university did not pay back the loan, the Koreans would never forgive them. The Koreans might not collect the loan, but hard feelings and anger would exist. Once the different meanings were understood, a mutually acceptable term was introduced and the negotiations proceeded.

Job Commitment

All companies want to increase the level of commitment their employees experience toward their jobs. The perceptions and attitudes employees hold about the job affect the quality, efficiency, and effectiveness of their work.

A discussion of the difference between satisfaction and commitment is worthwhile here. Job satisfaction comprises the attitudes toward work, whereas organizational commitment represents employees' feelings toward their company or employer. Although the terms are tightly related, some observers suggest that job satisfaction precedes job commitment (Van Scotter 2000).

Specifically, **job commitment** is the degree to which an individual identifies with and is attached to an organization. Commitment becomes a stabilizing force that provides direction for employee behavior and increases

support for the goals of the organization and employee involvement and retention (Meyer and Herscovitch 2001). Much of a manager's long-term success hinges on developing strong employee commitment.

Commitment is said to have three components (adapted from Dressler 1999):

1. **Affective commitment** is the "desire" portion of commitment and involves the emotional attachment to the organization through acceptance and attitude toward the organizational goals and values. Employees demonstrating a high degree of emotional commitment feel immersed in their company and identify with it. Employees remain because they *want* to.
2. **Continuance commitment** is the "need" portion of commitment and comprises the mutual relationship between employee and organization. The commitment arises from the exchange and benefits both parties receive and the costs that would incur in changing employers. People continue with an organization because leaving is perceived as too costly. Employees remain because they *need* to.
3. **Normative commitment** is an obligation-based commitment that includes the feeling of duty and meeting of group norms. The moral and ethical obligations employees feel drive the decision. Employees remain because they *ought* to.

Dressler (1999) also noted that organizational leaders can enhance their employees' commitment by taking the following actions:

- *Commit to people-first values.* Value employees through talk and action. Document these values and hire managers who will live them.
- *Clarify and communicate your mission.* Employees need to understand the organization's mission and values and how employees contribute to them. Build a tradition of following the mission.
- *Guarantee organizational justice.* Establish fair and transparent policies and actions. Provide means for extensive two-way communications among employees and managers.
- *Create a sense of community.* Emphasize teamwork, and allow employees to work across organizational boundaries.
- *Support employee development.* Train staff, enrich jobs, and empower employees. Promote from within, and provide a degree of job security.

Patient Satisfaction

One perceptual area that has become increasingly important in healthcare is the measurement of patient satisfaction. For decades, healthcare organizations

have surveyed their patients to ascertain their satisfaction with the services provided. National companies such as Press Ganey, National Research Corporation, Gallup, and HealthStream have made patient satisfaction surveys big business. These surveys became more important after 2006, when the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality collaborated to implement the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and tied the results to hospital compensation. HCAHPS is administered to a random sample of a hospital's adult patients 48 hours to 6 weeks after discharge and consists of 27 questions, which cover the following topics (CMS 2014):

- Communication with nurses and doctors
- Responsiveness of hospital staff
- Cleanliness of the hospital
- Degree of quietness in the hospital
- Pain management
- Communication about medicines
- Discharge information
- Overall rating of the hospital
- Whether the rater would recommend the hospital

Chapter Summary

Our decisions, actions, and behaviors are directed by how we see the world. Paradigms are lenses through which we perceive the world. Paradigms help us recognize situations and make decisions, but they can be harmful if mismatched with current reality. In these situations, we need to effect a paradigm shift and rebase our assumptions and perspectives.

Perceptions are the ways people experience, process, and interpret stimuli. Humans receive stimuli from numerous sources, which are filtered through their paradigms and lead to the formation of their perceptions, which then feed back to modify or reinforce their paradigms. Many factors influence what individuals perceive and include attitudes, motives, personality, education, interests, experiences, and expectations. People's perceptions vary widely as a result. One problem with our perceptions results from the constant lack of complete information. This issue is especially prevalent with social interactions, in that we almost always have fragmented and subjective information from which to form our perceptions. We then make judgments on limited experiences, which frequently are wrong.

Several sources of bias include the application of fundamental attribution error, stereotypes, the halo effect, the similar-to-me effect, and the primacy

and recency effects. Each is the product of incomplete information and personal experience that may create biased, prejudiced outcomes. Fundamental attribution error occurs when people attribute others' success to external factors and others' failures to personal, or internal, characteristics. People reverse this framework of attribution when they consider the reasons for their own successes and failures: They attribute their success to their personal, internal characteristics and their failures to external factors.

Stereotypes can either serve an organization positively or create problems when people are categorized into groups on the basis of their characteristics and behaviors, and traits are assigned to the groups. The dangers of stereotypes include their negative impact on social justice and prejudice and the fact that they become embedded in cultures and are difficult to change.

The halo effect takes place when one very positive or negative characteristic overshadows the evaluation of a person or thing. Other traits, positive or negative, are subsumed by the dominant one. Therefore, people often make erroneous judgments as they extend their perceptions of one trait to elevate or diminish the others.

The similar-to-me effect also can introduce unintentional negative consequences. People relate to and communicate more easily with people like themselves. Therefore, managers tend to hire, promote, and give better evaluations to individuals with whom they share similarities. Unless managers make a conscious effort to be aware of this effect, it can skew their decisions about hiring, evaluations, and promotions.

The primacy effect and recency effect increase the influence of what is communicated first or last. The first and last information we receive tends to dominate our memory and have a greater effect on our perceptions.

Cultural differences significantly influence our perceptions and attitudes. Perceptions are culturally determined and can be difficult to change.

Companies seek to increase their workers' job commitment, as it has a direct relationship to the quality, efficiency, and effectiveness of their employees' work. Job commitment involves the degree to which an individual identifies with and is attached to an organization, which becomes a stabilizing force and directs employee behavior and reduces turnover. Commitment has three components: (1) affective commitment is the desire to belong to an organization, (2) continuance commitment is the need to continue the work relationship when leaving is perceived as too costly, and (3) normative commitment is a sense of obligation to an organization. These components combine to generate the overall level of job commitment.

Perceptions and attitudes affect the relationships in and the outcomes of organizations. Managers need to understand the causes and underlying factors of their own and their associates' perceptions and attitudes. Managers can lead better if they recognize the biases that all humans experience to

some degree. Managing revolves around establishing accurate and common perceptions that contribute to positive attitudes and outcomes.

Chapter Questions

1. How do paradigms filter what we perceive?
2. When is a paradigm shift necessary?
3. How do paradigms and perceptions interrelate?
4. How does the problem of incomplete and subjective information affect perceptions?
5. The fundamental attribution error concept suggests that we are far more critical of others' failures than our own. Why?
6. When can stereotypes be positive?
7. Why do management team members often seem very much alike?
8. If you are invited to interview for a job, when should you request to be interviewed in the interview schedule? Why?
9. How does job commitment become a stabilizing force and direct employee behavior to provide greater support for organizational goals?
10. Which type of commitment—affective, continuance, or normative—may be strongest in work settings? What factors may affect the strength of each?

Chapter Cases

Night Staffing and Job Commitment

Lauretta was a night-shift nursing supervisor and had tremendous problems covering the evening and night shifts. She was constrained by a union contract for what she could pay nurses to work evenings. The contract clearly stated that a person working the night shift was compensated an extra $1.00 per hour. However, the hospital had not had enough nurses on staff to cover all of its shifts for at least the past three years, so Lauretta had to beg nurses, day after day, to work extra shifts and cover nights. Also, nurses called in sick about once a week, and Lauretta had to find replacements within a matter of hours. Sometimes, replacing a nurse who called in sick was impossible and the night shift was forced to work understaffed, which increased the stress and frustration for those working.

The hospital administration had received numerous complaints and organized a task force to examine the problems raised by replacing

sick employees and those who quit. In the first meeting, the major issues were listed. Some participants felt that the only solution was to pay a higher dollar amount (differential) for the night shifts. Management was against only higher pay, as it had raised the shift differential from $0.50 to $1.00 only two years ago but the problem remained. Others felt strongly that the satisfaction level and attitudes of the nurses needed to be determined first; they proposed a survey be administered.

Lauretta was not convinced any positive movement would result from the task force. She had worked at the hospital for 20 years and did not want to leave. However, in the past two years, many of her close friends at the hospital either retired or took positions elsewhere. Although in the past she might have stayed to be with her friends, this was not as important a factor now. She began looking at other jobs in the community and found that, in each case, she would start at a salary lower than her current pay. She continued to be frustrated with her job and was uncertain what to do.

Case Questions

1. From an organizational commitment perspective (affective, continuance, and normative commitment), what kept Lauretta at her current job?
2. Refer to chapter 5 and the discussion on equity theory. How did Lauretta's perception of her inputs and outputs affect her feelings and behavior?
3. What could management have done to increase her organizational commitment?

Employee Perceptions at HealthT Inc.

Connery was HealthT Inc.'s corporate chief operating officer and knew that the perceptions of HealthT employees and providers directly affected the organization's bottom line by influencing productivity and quality. As a new company, it had the opportunity to design its own employee and provider questionnaire. The company operated 82 hospitals located in 28 states and was divided into six divisions.

This dispersion created unique management challenges for Connery. He wanted to be able to compare the hospitals and to identify the CEOs who were doing the best job. With hospitals in so many unique environments, Connery wanted to have an employee perception metric, as he believed strongly that such a metric would highlight the best CEOs

(continued)

(continued from previous page)

who worked for him. He presented this idea to his management team, and the team agreed that having an employee perception survey would be beneficial. However, his idea raised a number of questions that he had not considered, including the following:

1. What amount of money has been budgeted for these surveys?
2. How frequently should the survey take place?
3. Who should conduct the survey?
4. Should the provider and employee surveys be different and administered separately?
5. Which areas of provider and employee perceptions are important to HealthT?
6. How can the company ensure a high survey response rate?
7. What kind of biased responses might result and need to be prevented?
8. How should the survey results be used each year?

Each question was discussed in some detail. The company had incurred a lot of bank debt during its formation. Therefore, only a small amount of money was budgeted to obtain employee and provider perceptions. The human resources director, Pauline, indicated that only $500,000 had been allocated for this endeavor. With 82 hospitals, that worked out to $6,098 per hospital per year. Pauline had previously checked with prominent survey companies and found that most hospital employee surveys cost about $10,000 per survey, which would include a custom survey design, administration, and analysis. However, the survey firms generally offered a 30 percent volume discount if the same survey was administered at all of a system's hospitals.

Discussion then ensued about how frequently the survey should take place. Three members of Connery's management team had previously worked at hospitals that had conducted employee and provider surveys. Each was vocal about the need to survey more than once a year. They proposed semiannual surveys at a minimum and believed quarterly surveys were ideal. As they explained, once-a-year surveys did not provide adequate information for managers to act on but became only a kind of "report card." A heated discussion then erupted about why the surveys should be done in the first place, what their real value was, and how these factors might differ for corporate and hospital personnel.

The issue of who should conduct the surveys was less controversial. Most wanted a reputable national company to conduct them. However, one member of the team, who worked at one of HealthT's largest hospitals, thought the hospitals should have the option of doing their own surveys. The difficulties this suggestion presented were debated. Problems were identified, such as the potential lack of standardization, potential selection bias, and greater difficulty in collating data across all hospitals.

Everyone agreed that different surveys should be administered for employees and providers. The company employed only a small percentage of the physicians associated with HealthT hospitals; most physicians were independent practitioners. The group believed that physicians often had different perspectives than employees did and that some of the survey questions should be distinct. Therefore, the two surveys would need to be separate. Also, the mode of administration would need to be different, as the system's intranet could provide electronic surveys for employees, but most physicians were not connected to it and would need to receive and complete the surveys by mail.

As the discussion wrapped up, the important employee and provider perceptions were listed.

Important employee perceptual areas:

1. Employee demographics (department, position, tenure)
2. Meaningfulness of work
3. Amount of challenge in a job
4. Amount of stress felt at work
5. Equity of pay
6. Influence of their opinion on coworkers
7. Quality of relationship with supervisor
8. Ability to grow professionally
9. Opportunities for promotion
10. Appropriateness of supervision
11. Satisfaction with employee benefits
12. Satisfaction with work
13. Degree of pride in company's reputation
14. Potential for job seeking outside the company
15. Amount of employee motivation to meet company goals
16. Appropriateness of the variety and number of tasks
17. Willingness to refer a friend to work for the company

(continued)

(continued from previous page)

Important provider perceptual areas:

1. Provider demographics (specialty, position, age, gender, location of practice, size of group or solo practice, employment status)
2. Comparison of clinical services reputation with that of other area hospitals
3. Comparison of ancillary services reputation with that of other area hospitals
4. Comparison of food, housekeeping, and billing with that of other area hospitals
5. Plans to change practice
6. Satisfaction with call situation
7. Satisfaction with income
8. How close to capacity was their practice
9. Extent of electronic health record use
10. Likelihood of leaving for another practice

Following the compilation of these lists, the managers contemplated what would need to be done to ensure a high response rate. Jack, the Western Region vice president, said he believed they needed responses from at least 60 percent of all employees to avoid the bias that would occur if only the most happy and most unhappy responded. Pauline suggested that the response rate was not the best way to judge the survey's accuracy, but the representativeness of the response was critical. A representative response by gender, age, department, and tenure should be achieved, she said, by randomly selecting representatives in these categories. However, most of the group felt this approach would be too difficult.

Another factor affecting the response rate was the survey's length. More responses would be achieved if the survey was not too long. Therefore, a small number of questions needed to be designed. The guideline set by the group was that the survey should take no longer than five minutes to complete. Another idea was to provide a reward for those who participated—perhaps by holding a drawing afterward to award one iPad to a selected survey participant at each hospital. Furthermore, it was suggested that employees would be more likely to complete the survey if they understood that their opinions would be heard and action would be taken on the basis of their feedback.

The question of potential bias flowed out of the previous dialogue. Both Jack and Pauline were concerned about having a biased response from the providers' survey. They thought that getting physician specialists to respond would be much more difficult than getting primary care physicians to respond and that hospital-based physicians would be most likely to complete the survey. In addition, Pauline wanted to restrict responses from managers, as they tended to respond more frequently and positively. She thought only a random sample of managers should be taken.

The final question, how the survey results should be used, generated intense conversation. Connery, who originated the survey idea, wanted to use the survey as one indicator to identify the top CEOs in the company. The regional vice presidents wanted to be able to use the data to set annual goals for their CEOs. Only Pauline asked how the surveys would be used by the CEOs to improve their hospital operations. Her comment made Connery realize that he had not thought about local use, and he could see from their previous discussion that greater response and support would result if employees could see the results used locally.

After three hours, the meeting concluded. Pauline was asked to develop recommendations for Connery based on all of the comments and thoughts. She was to submit a report and recommendations to him within one week.

Case Questions

1. What are the conflicting aspects of putting together the employee and provider surveys?
2. How does perception affect the responses and response rate of employee surveys?
3. If you were Pauline, what would you recommend to Connery?

CHAPTER

8

POWER AND INFLUENCE

Learning Objectives

After studying this chapter, readers should be able to

- distinguish between power and influence,
- understand the different sources of power and influence tactics,
- discuss how referent power can be gained,
- describe the zone of indifference and its meaning to organizational trust,
- discern the short- and long-term advantages and problems using both positive and negative influence tactics,
- appraise the function and antecedents of organizational politics, and
- understand the negative effects of abuse of power and sexual harassment.

Key Terms

- Coercive power
- Expert power
- Formal authority
- Harassment
- Influence
- Organizational politics
- Power
- Referent power
- Reward power
- Sexual harassment
- Zone of indifference

Power and influence are conditions that many desire, but these conditions often carry negative connotations in today's work environment. Those who lead must hold sufficient power and influence to get things done. Power and influence can create access to needed resources and key decision makers. Yet power and influence can become especially troublesome and destructive if poorly managed. Thus, knowledge, understanding, and successful application of power and influence are critical to managerial skill.

Power and Influence Defined

Power and influence are connected, and at times the terms are used synonymously. However, they are not the same. **Power** often is portrayed as the capacity to influence others by control over valued resources. Individuals with power have the ability to get others to do what they want. Anderson and Brion (2014, 69) explained it this way:

> Power is broadly defined as asymmetric control over valued resources. Power, as most commonly defined, is therefore inherently relational, in that power exists only in relation to others, whereby low-power parties depend on high-power parties to obtain rewards and avoid punishments.

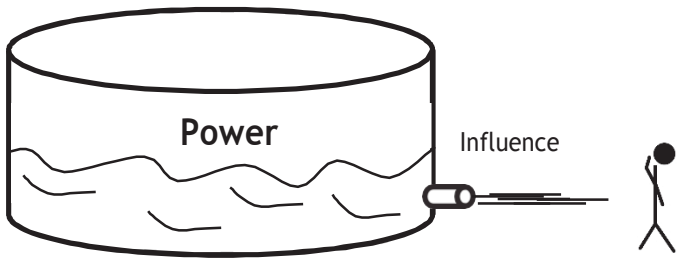
Because "power exists only in relation to others" and involves the ability to control rewards and punishments, the greater the power, the greater the influence. **Influence**—the process of persuading others to do something—is triggered when power is exercised. Influence, then, becomes effective only when the entity possessing it concurrently holds enough power.

Exhibit 8.1 illustrates the conceptual difference between power and influence. Power, as the capacity to influence (a person or people), is the amount of water stored in the tank. Influence is the pressure of water behind the spigot, which depends on the height and quantity of water in the tank. As with water pressure, the degree of influence depends on the amount of power.

Having power is critical to being effective as a leader. It provides increased job security and the ability to successfully influence others. Those without power often lack autonomy and control; they can be susceptible to unfair treatment and experience low job satisfaction and morale. Power comes from gaining control over resources, which can be very broadly defined as (Anderson and Brion 2014, 69)

> anything of value on which others depend, such as money, information, access to important people, or decisions. It can also apply to personal characteristics. That is, individuals can be construed as controlling a valued resource if they possess personal skills, knowledge, or expertise that others need.

EXHIBIT 8.1
Power vs. Influence



Thus, resources can include both physical assets, such as money and people, and immaterial characteristics, such as positions of formal authority; relationships in social networks; political coalitions and alliances; and superior individual traits such as personal skills, social skills, task competence, knowledge, and expertise. Greater power is obtained as more of these assets are gained.

Holding a position of authority does not necessarily equate to power. **Formal authority** refers to the right to influence someone. However, a person may hold a position and formal authority but have no or little power. As shown in the box on this page, receiving a title alone may not deliver power. On the other hand, most positions in an organization convey a level of power (if that power is not squandered).

The degree of power from formal authority depends on the strength of a manager's **coercive power** and **reward power**, which can be exercised by either positive or negative incentives. Managers can coerce employees with negative, punitive actions; this coercive power uses the threat of force to make someone compliant. Punishments can range from fines to demotions to public scoldings to loss of raises and bonuses. Coercive power generally has the benefit of generating fast results.

Reward power, on the other hand, consists of the promise of positive incentives—such as bonuses, raises, promotions, and time off—for work well done. The use of reward power may take longer to yield results. The extent to which a boss implements both coercive and reward power dictates the boss's level of power.

Likewise, power can be garnered from the strength of personal relationships from social networks, political coalitions, and alliances. Although these relationships may be tied to or initiated through a formal position, the power comes from the strength of the relationships with other powerful individuals. Relational power produces **referent power**, which originates from being trusted and respected. This interpersonal

Big Desk but No Power

Amir finally finished his master's degree in healthcare quality. He joked that the past three years were the best two years of his life. He did have a lot going on and had to retake a couple classes. Done was done, however. His father owned a midsized healthcare consulting firm, and he had been promised a job when he finished his degree.

As promised, the week after graduation, his father appointed him as the regional director of offices located in three Middle Eastern countries. The firm conducted a fair amount of business in each of the countries and employed five consultants and staff, who worked in these areas and would report to Amir.

Amir was excited, especially when his father showed him his office, which had a very big desk. Amir really had arrived! Well, he had arrived, but he quickly found that the consultants, although polite, often ignored his directives and failed to inform him of their activities. They seemed to have a "back channel" with his father, and if Amir pushed his authority too far, his father intervened and told him to let the consultants do what they wanted.

One month into his new job, Amir realized he had a very nice desk but not much influence. He could spend the morning reading the paper and often would collate the activity files from the staff to report to his father. Well, that desk really looked good, anyway.

power motivates people to do what you—the one with the power—desire because their trust and respect for you cause them to want to follow you.

Furthermore, power can come from individual characteristics and abilities. Referred to as **expert power**, this type of power arises from experiences, skills, talents, or knowledge. Often, people demonstrate their expertise through graduation certificates, reputation, or membership in respected associations and groups. The degree of expert power a person holds is directly related to others' recognition of that individual's expertise.

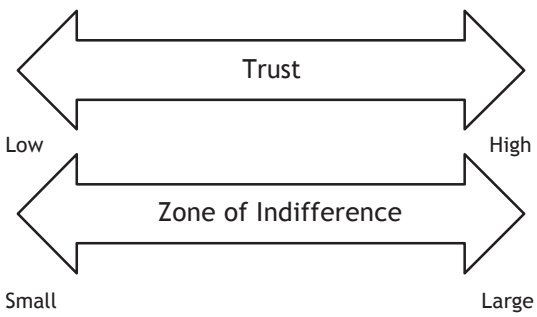
Zone of Indifference

The ability to influence is also affected by which tasks employees are asked to perform. The range of acceptable tasks employees are willing to do without questioning the rationale of the direction is called the **zone of indifference**. For example, duties that are clearly written in a job description usually fall into the zone of indifference. However, tasks outside of the job description, such as personal shopping for the executive and "volunteering" at a leader's favorite charity, may or may not enter the zone of indifference.

As shown in exhibit 8.2, the zone of indifference varies according to the degree of trust an employee has in her employer. A trusting employee may have a large zone, while a cynical, nontrusting employee may have a very small zone. As stated long ago about the zone of indifference (Barnard 1938, 168–69),

> If all the orders for actions reasonably practicable can be arranged in the order of their acceptability to the person affected, it may be conceived that there are a number which are clearly unacceptable, that is, which certainly will not be obeyed; there is another group somewhat more or less on the neutral line . . . and a third group unquestionably acceptable. This last group lies within the "zone of indifference." The person affected will accept orders lying within this zone and is relatively indifferent as to what the order is so far as the question of authority is concerned.

EXHIBIT 8.2
Trust and the Zone of Indifference



The zone of indifference may be affected by the level of power a leader wields. In general, the greater the power of the leader, the more tasks his employees will accept. As mentioned earlier, this relationship may be the result of the use of rewards and punishments.

Influence Tactics

A critical determinant of managerial effectiveness resides in the capacity to influence subordinates. To a large extent, the success of a leader rests on her ability to influence those in her organization. The breadth of an individual's influence varies, as discussed earlier, not only by the amount of power she holds but also by the influence tactics she learns and exercises. Leaders may use a number of influence tactics, both positive and negative. Yukl (2002) identified a number of influence tactics and categorized them as either positive or negative.

Positive influence tactics include

- rational persuasion—using logical arguments and factual information;
- inspirational appeals—using emotional requests or proposals to arouse enthusiasm by appealing to values and ideals;
- consultation—seeking participation in decision making or planning;
- exchange—offering to share potential rewards and/or reciprocate the favor; and
- personal appeal—drawing on a person's loyalty and/or friendship.

Negative influence tactics include

- ingratiation—using pleasant words or friendly behavior to make someone feel positive toward something;
- pressure—using demands, threats, inspections, and intimidation to encourage behavior;
- coalition—using support and aid from others to persuade others; and
- legitimacy or upward appeals—using approval from higher management to gain compliance.

Wise leaders assess each situation as it occurs and choose among the tactics that are most effective at influencing those targeted. Picking an appropriate influence tactic can strongly affect desired outcomes. Positive influence tactics tend to not harm relationships when used. Conversely, negative influence tactics can strain relationships and damage reputations. However, the use of both can influence behavioral changes and actions in others (Hallet 2014). As shown in

Which to Use: Positive or Negative Tactics?

Jeff was a polished healthcare executive who used the participative management approach extensively with his employees. When he needed to influence the physicians on his medical staff, he generally began with rational persuasion and then moved to inspirational appeals and consultation. He had been successful with this style and had been recently promoted as a result.

He and his spouse, along with their four preteen children, were now driving 1,200 miles to relocate for his new position. It was approaching noon and they needed to stop for lunch. Last night for dinner, Jeff had asked his children where they wanted to eat, which resulted in four opinions and a 15-MINUTE argument. He had tried rational persuasion and consultation but finally told the upset children that the car was stopping at the next restaurant, no matter what it served. Later that night, he and his wife talked about the problem of trying to gain consensus with four stubborn children.

Jeff and his wife needed to decide what form of influence they should use to avoid the conflict that occurred earlier. They could just make all the decisions, pressure the children with threats, or even try ingratiation. However, using these tactics on the children always seemed to backfire. Yet using positive tactics invited visible conflict and took a long time. What should Jeff do?

the adjacent box, opportunities to choose tactics occur in both our business and personal lives. Negative tactics often seem to be more direct and take less time to yield results, but they can harm relationships. Positive tactics, on the other hand, frequently take more time, are messier, and invite visible conflict.

After a leader chooses an influence tactic, the response of the subordinate determines its success or failure. The subordinate may resist the effort to alter his behavior, perhaps by refusing to do so, ignoring the leader, making excuses for not complying, seeking a higher authority to pull rank on the leader, delaying action, or pretending to comply but quietly seeking to sabotage the outcome. The follower can also choose to be unenthusiastic or apathetic regarding the requested change. The follower may behave as desired, but the activity may be undertaken with a sullen and even cynical attitude. Of course, the ideal result is full commitment of the follower. The follower accepts the influence and voluntarily does what is asked.

Depending on the perspective of the manager and the situation, the last two results might be considered successes—at least in the short term. The requested behaviors are accomplished in both scenarios. In certain circumstances, this situation might be acceptable, but all too often it results in visible compliance but inappropriate behaviors when unsupervised.

Influence Strategies

Exhibit 8.3 displays six influence strategies leaders can choose from to affect their followers' behaviors. Leaders should recognize the different strategies and understand the situations in which these strategies might be used. Furthermore, learning these strategies allows leaders to realize when these strategies are being used to persuade them.

EXHIBIT 8.3
Six Influence Strategies

Influence Strategy	Definition	Example
Reciprocation	People return a favor.	Pharmaceutical companies offer gifts to physicians.
Consistency/ Commitment	If people commit to an idea or goal, they are more likely to comply.	Ask those making reservations to call if plans change, and wait for a response.
Social Validation	People are more likely to do things they see others do.	Show a list of neighbors who already contributed to a fund.
Liking	People are more likely to be persuaded by others they like.	From the same city as the client; recognize that salespeople with an attractive appearance may be more persuasive.
Authority	People tend to obey authority figures.	Having higher-level titles and wearing proper attire for leadership can signal authority.
Scarcity	Perceived scarcity increases demand.	Use phrases such as "limited time only" or "limited supply" for persuasive messaging.

Source: Information from Cialdini (2004).

All organizational members, leaders, managers, and staff use persuasive strategies and power to influence people and achieve both personal and organizational goals. At times, as suggested, this behavior can be adopted for personal gain and result in harm to others. However, the outcome depends on the motives and skills of the individual exercising the influence strategy.

Organizational Politics

An inherent part of power and influence that commonly occurs in organizations is organizational politics. **Organizational politics** has been defined as "informal approaches to gaining power through means other than merit or luck" (Dubrin 2001). Most people see organizational politics negatively, as often those using it are seeking personal gain. Self-serving behaviors may include circumventing the chain of command for approval of a project, following inappropriate channels to gain special treatment, or directly lobbying a manager prior to a promotion decision. These political activities can undermine perceived fairness,

and employees not politicking may feel jealous and resentful if they receive an unfair allocation of the organization's rewards and recognition.

Organizational politics repeatedly manifests in the conflicts, power plays, and interpersonal intrigues that frequently replace constructive organizational activity. In almost every organization, politicking is continually active, but it is mostly invisible to all but those directly involved. Most firms today tacitly sponsor political behavior because of the competition embedded in their systems and structures. Employees are expected to collaborate in pursuit of a common goal yet compete with others for limited resources, status, and career advancement. Political behavior is a normal response to the tensions produced between employees and their organizations. Politics almost always is present when work standards and budgets are being set, in the course of daily supervision, and in the pursuit of opportunities and careers—all of which can invite sophisticated forms of gamesmanship and political maneuvering (Morgan 1996). Politicking often arises around the allocation of scarce resources, such as promotions, budgets, and perquisites. Many organizations manage in a competitive environment, which arrays individuals in rivalry, disagreeing about how to allocate the resources.

However, politics can be used ethically and profitably. Sustainable organizational politics does not require winning at any cost but revolves around maintaining positive relationships while still achieving results. Potentially destructive organizational politics clearly exist, and the skilled manager will seek to minimize their negative effects, such as the amount of wasted time individuals can spend in political behavior.

Negative organizational politics is more likely to occur during significant organizational change or when times of scarcity breed competition among organizational groups. To curtail overly political behavior, leaders should be open with information, model cooperative behavior, and make very clear that political machinations are not rewarded or tolerated. Furthermore, clear feedback to employees about their performance helps diminish organizational politics (Rosen, Levy, and Hall 2006).

Overall, the level of politics in an organization is affected by both individual and organizational factors. Both sets of factors determine the degree to which organizational politics occurs in a company (exhibit 8.4). Individual factors include the political skills people possess, their internal locus of control, how invested they are in their firm, and their expectations of how successful they will be. The level of organizational politics increases as individual factors rise in intensity.

Likewise, organizational factors influence the degree of organizational politics. The scarcity of resources, such as when financial incentives or promotions are limited, makes organizations more political. Increases in role ambiguity also create organizational politics: Ambiguity about job responsibilities,

EXHIBIT 8.4
Individual and Organizational Factors That Lead to Organizational Politics

performance evaluations, and promotions leads to political actions such as impression management, which involves people seeking to actively manage and control those impressions others form of them.

Democratic decision making can augment political behavior. As many people participate in the decision-making processes of a firm, more people are available to be influenced and politics increases (Dubrin 2011; Ferris et al. 2000; Valle and Perrewé 2000).

Abuse of Power and Sexual Harassment

The accumulation of power can be a great motivator for many managers. However, all too often, managers abuse their power. Such behavior creates a hostile work environment that causes fear, low initiative, turnover, and poor performance. Sadly, abusive bosses rarely recognize their contributions to the problems and react by escalating the abusive behavior, which may spiral into more severe employee problems followed by greater abuse (Pinder 2008).

Continued abusive behavior can become **harassment**, which is a common occurrence in the workplace (Richman et al. 1999). The term *harassment* refers to both psychological harassment and sexual harassment. Psychological harassment has been given various names, such as bullying, victimization, and generalized workplace abuse (Aquino 2000; Einarsen et al. 2003). Overall, harassment refers "to repeated and systematic hostile acts, which are primarily of a verbal or non-verbal, rather than physical, nature" (Salin 2009, 27).

What one supervisor might think is funny and friendly teasing can be highly offensive to another staff member. For example, one aging manager frequently called the only black staff supervisor in the organization "dwarf." The offending manager thought his name calling was humorous, while the supervisor tried to act as though it did not bother her. (The manager retired before a harassment claim was filed against him.)

Harassment can take many forms and come from a variety of sources. As the box below shows, harassment may include actions on social media that contribute to creating a hostile work environment, such as "unfriending" on Facebook.

An important subset of harassment is **sexual harassment**. The US Equal Employment Opportunity Commission (2009) defines sexual harassment as "unwelcome sexual conduct . . . when submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment." For example, a supervisor may make sexual advances toward a subordinate, whose job may be implicitly or explicitly threatened if he or she does not submit to or engage in the non-work-related activity initiated by the superior or aggressor. It can occur between parties of the opposite sex or the same sex, as well as between colleagues. All forms of sexual harassment are illegal and can severely damage a work environment.

Sexual harassment is one of the worst abuses of power in organizations. It is primarily a power issue, wherein a person with more power uses it to obtain sexually related favors from someone with less power. In most modern nations, the employing organization is legally responsible for the actions and behaviors of its managers and bears the risk for their misbehavior. A workplace can become a hostile environment from sexual harassment if employees (managers especially) use sexual innuendos and jokes, place inappropriate pictures where they can be seen, fondle one or more staff members, use crass gestures, and make unwanted sexual overtures (Pinder 2008).

To diminish sexual harassment, companies should have a written policy that clearly prohibits all forms of abusive behavior. For example, the Hospital of the University of Pennsylvania's sexual harassment policy is displayed in

Facebook Unfriending Deemed Harassment

In 2015, a court in Australia ruled that unfriending a coworker on Facebook could be considered a factor in workplace bullying. Rachael Roberts, a real estate agent, charged her colleague, Lisa Bird, with 18 allegations of harassment, which included purposely delaying administrative work, damaging Roberts's reputation with clients, treating Roberts worse than Bird treated others, and unfriending Roberts on Facebook. The judge found that eight of the allegations were substantiated, including the unfriending action.

The implication of the ruling is that although unfriending by itself should not be considered harassment, actions on social media may be used to substantiate harassment and a hostile work environment.

Source: Whitten (2015).

EXHIBIT 8.5
Hospital of the University of Pennsylvania's Policy on Avoidance of Sexual Harassment in the Workplace

Pennsylvania Hospital seeks to maintain a workplace free from sexual harassment. Actual verbal or physical conduct or perceived conduct with the intent to harass, disrupt or interfere with another employee's work performance or which creates an intimidating, offensive or hostile work environment is strictly prohibited. The purpose of this policy is to reaffirm Pennsylvania Hospital's position that sexual harassment will not be tolerated in the workplace and to identify the resources available to concerned individuals.

Sexually harassing conduct in the workplace, whether committed by management, supervisory or non-supervisory personnel, physicians, coworkers or others is prohibited. Such conduct may include but is not necessarily limited to:

- Sexual flirtations, touching, physical advances or propositions;
- Verbally abusive language of a sexual nature;
- Sexually graphic or suggestive comments about an individual's dress or body;
- Sexually degrading words to describe an individual;
- The display in the workplace of sexually suggestive objects or pictures, including nude photographs[; and]
- Comments that are perceived to be sexual in nature.

Source: Excerpted from Hospital of the University of Pennsylvania (2008).

exhibit 8.5. It clearly expresses that sexual harassment is not tolerated and describes examples of prohibited behaviors in the organization.

Furthermore, organizations should advise employees of proper behaviors, provide methods to resolve any harassment they might encounter, and require all employees to report harassment they believe has occurred. For instance, the Hospital of the University of Pennsylvania (2008) requires the following:

> Any employee who believes that he or she has been subjected to sexual harassment as defined by this policy has a responsibility to report such conduct as soon as possible to his/her supervisor. Any supervisor receiving a harassment complaint, or who becomes aware of conduct that violates this policy, must report the matter to the Human Resources Department. If the supervisor is the person acting in a harassing manner or if the employee for any other reason is uncomfortable speaking with the supervisor, the employee should immediately notify the Human Resources Department. In extraordinary circumstances in which all other avenues are unavailable, the employee may contact the Chief Human Resources Officer directly.

Organizations have the responsibility to investigate and follow up on their findings. Again, the Hospital of the University of Pennsylvania (2008) mandates that the following actions be taken:

> All complaints of harassment will be investigated as promptly as possible under the circumstances and in a confidential manner. If an employee is not satisfied with the handling of a complaint or the response to the complaint, then the employee should promptly bring the complaint to the attention of the Chief Human Resources Officer. In all cases, the employee who filed the complaint and the subject of the complaint will be advised of the findings and conclusions of the investigation within a reasonable time after completion of the investigation. In instances where it is anticipated that an investigation may take some time, interim measures designed to prevent any further alleged harassment may, if appropriate, be put into place immediately, pending the outcome of the investigation.

Protecting employees from all forms of harassment, especially sexual harassment, helps create a productive work environment. Harassment should not be tolerated in any organization.

Chapter Summary

Power and influence function both positively and negatively in most firms. Leaders must have sufficient power and influence to achieve results. Holding power is critical to being an effective leader.

Power and influence are related but not interchangeable concepts. Power is the capacity to influence others, while influence occurs when power is exercised. Power comes from gaining control over resources and demonstrating superior individual characteristics.

An individual who holds a position of authority does not necessarily have power. Formal authority from a position conveys the right to influence someone. However, the degree of power depends on the actual strength of a manager's coercive and reward power. Coercive power is a motivation approach that relies on threats of fines, demotions, public scoldings, and loss of monetary rewards for poor results. Reward power motivates through promises of bonuses, raises, promotions, and other awards for good results. Power can also come from referent and expert power. Referent power arises from the strength of relationships with other powerful individuals. This interpersonal power motivates people to act because of their respect for the power holder. Likewise, expert power motivates compliance through people's respect for the experiences, skills, talents, and knowledge of the power holder.

Influence operates in a zone of indifference, which consists of the tasks employees are willing to do without questioning. Tasks outside of this zone may be objectionable to the employee. The scope of the zone of indifference varies according to the degree of trust the employee has in his supervisor and the amount of power the supervisor holds.

Managerial effectiveness is tightly tied to the capacity to influence subordinates. Skilled managers use influence tactics to appropriately motivate employees. As with power, influence tactics can be both positive and negative. Positive tactics include rational persuasion, inspirational appeals, consultation, exchange, and personal appeal. Negative tactics consist of ingratiation, pressure, coalition, and legitimacy or upward appeals. The proper influence tactic for the given situation should be used, as negative tactics tend to strain relationships and damage reputations.

Six influence strategies are recommended for affecting subordinates' behaviors: reciprocation, consistency and commitment, social validation, liking, authority, and scarcity. All organizational members use influence strategies. Their outcomes often depend on the motives and skills of the individual who exercises the influence strategy.

Organizational politics is an inherent part of power and influence. Organizational politics can be self-serving and undermine perceived fairness. As such, it repeatedly manifests in conflicts, power plays, and other intrigues in organizations and is implicitly sponsored because of the competitive nature of most firms. Politics frequently emerges during the allocation of scarce resources when parties disagree on where the resources should be allotted and during significant organizational change. The degree of organizational politics varies by individual and organizational factors.

A dysfunctional abuse of power occurs with harassment. This behavior, which happens far too often, creates a hostile work environment and increases fear, turnover, and poor performance. Harassment refers to repeated and systematic hostile acts and can take many forms. One important subset of harassment is sexual harassment. Sexual harassment is one of the worst abuses of power that can occur in an organization. To diminish its occurrence, organizations should establish written policies that prohibit all forms of abusive behavior and not tolerate this type of behavior. Employees should be informed to report any instance of sexual harassment, and firms should establish policies for its reporting, investigation, and disposition.

Chapter Questions

1. What is the difference between power and influence?
2. Why is power so important to leaders?
3. How does authority become power?
4. What are the downsides of using coercive power? What are its benefits?
5. How does having extensive social networks help garner power?
6. Who establishes a zone of indifference for employees?

7. How are coercive power and negative influence tactics related?
8. When should different influence strategies be used?
9. In what ways is organizational politics destructive?
10. In your opinion, why do abusive bosses often fail to recognize their role in the abuse?

Chapter Cases

The Proposed Metropolitan Hospital Restart

One year ago, Teresa, a hospital CEO, approached her supervisor, Kent, the health system's regional vice president, with an idea to build a new hospital in an adjoining community. She explained the many advantages to him. For example, the hospital she operated was located in a bedroom community outside the larger metropolitan area, which did not have a hospital. Locating a hospital there would allow the parent system to better negotiate managed care contracts and attract a larger population to its services. Teresa also explained that a number of physicians located in the metropolitan area had approached her to ask why the system hadn't already established a hospital in that community.

She recognized that planning, designing, and constructing a new hospital would require a lot of up-front work on her part, including the need to affiliate with many of the physicians in the area and other surrounding communities.

Kent responded enthusiastically and authorized seed money to begin the development. Teresa understood that final funding would depend on the financial projections and obtaining commitments from local physicians to admit to the new hospital. She spent hours and hours on the project over the next four months, refined her projections, and gathered letters of support from 25 of the 30 physicians she personally visited. In addition, many gave Teresa checks—in amounts ranging from $20,000 to $50,000—to invest in the new hospital. In total, she held almost $400,000 worth of checks in a safe deposit box, to be retained until the system made a decision and either invested the money in the project or returned it to the physicians.

After many hours spent with the strategic planner, the hospital's chief financial officer, and regional personnel, Teresa developed the pro forma on page 127 for the hospital.

She felt confident that her estimates were conservative, as she had carefully vetted her assumptions with all key personnel. The hospital would show a loss its first year, effectively break even its second year, and then make a significant profit thereafter.

Metropolitan Hospital Proposed 5-Year Pro Forma						
		Year 1	Year 2	Year 3	Year 4	Year 5
Gross Revenues						
	Inpatient	17,500,000	19,250,000	21,175,000	23,292,500	25,621,750
	Outpatient	22,000,000	26,400,000	31,680,000	38,016,000	45,619,200
Deductions						
	Inpatient	10,500,000	11,550,000	12,705,000	13,975,500	15,373,050
	Outpatient	8,360,000	10,032,000	12,038,400	14,446,080	17,335,296
Net Revenues						
	Inpatient	7,000,000	7,700,000	8,470,000	9,317,000	10,248,700
	Outpatient	13,640,000	16,368,000	19,641,600	23,569,920	28,283,904
TOTAL NET REVENUE		20,640,000	24,068,000	28,111,600	32,886,920	38,532,604
	Salaries and wages	8,250,000	8,910,000	9,622,800	10,392,624	11,224,034
	Benefits	2,722,500	2,940,300	3,175,524	3,429,566	3,703,931
	Contracts	4,050,000	4,252,500	4,465,125	4,688,381	4,922,800
	Supplies	6,125,000	6,492,500	6,882,050	7,294,973	7,732,671
	Other	1,288,000	1,378,160	1,474,631	1,577,855	1,688,305
TOTAL EXPENSES		22,435,500	23,973,460	25,620,130	27,383,400	29,271,742
PROFIT (LOSS)		(1,795,500)	94,540	2,491,470	5,503,520	9,260,862
Margin		(0.087)	0.004	0.089	0.167	0.240

(continued)

(continued from previous page)

However, as Teresa was finalizing the proposal, Kent announced that he was stepping down. A new regional vice president, Chris, was appointed. Chris had been a peer of Teresa's, and the two had even dated, but she broke off the relationship after a short time when she felt he was too controlling. She dreaded meeting with him, now her boss.

During Teresa's first meeting with Chris, she presented the proposal for the new hospital. He did not seem impressed, but at the end of the meeting he suggested that if she went to dinner with him, she could probably convince him of the proposal's merits. As politely as she could, Teresa refused. In response, he requested that she send him all of her information and said he would "have to think hard about it." Later, he called to tell her to return the checks to the physicians and said his staff would review her numbers and reevaluate the proposal.

Teresa was incensed but followed her new boss's direction. She told the physicians when she returned their checks that Chris might visit them later to talk about investing. She felt she had been undercut and her credibility was diminished in the eyes of the physicians. She was also concerned that acceptance of her work might be conditional on her relationship with Chris.

Six months later, Chris, having validated Teresa's projections, sent his assistant to visit the physicians who had initially contributed checks to the project. Surprisingly, only three of the physicians showed any interest, and the visits generated less than $75,000 in potential investment. Chris was upset and wanted to know what went wrong.

Case Questions

1. What went "wrong"?
2. Could Chris's behavior be considered sexual harassment? If so, what should Teresa do?
3. What application does this case have to power and influence?

The ER Physician and the ER Nurse

Dr. P was a great emergency room (ER) physician. He had worked at Eastern Hospital for about ten years and now was serving as the president of his six-member ER group. He had the type of personality that put patients and staff members at ease. He was a devoted father and active in his church. Therefore, it came as a shock to the hospital CEO when the ER director pulled him aside to inform him that Dr. P was having an

affair with one of the ER staff nurses. By all accounts it was consensual, but the ER director wanted to know if there was any action she should take. After discussing the matter for a few minutes, both concluded that because the affair was consensual and Dr. P did not really supervise the nurse, the only thing they could do was try not to have them work the same shift. However, both felt uncomfortable speaking with either Dr. P or the nurse. They felt the relationship was really "none of their business."

The affair appeared to go on for about six months, until Dr. P's wife discovered their behavior and demanded that he either break off the affair or she and the children would immediately leave him and she would file for divorce. After deep emotional struggles, Dr. P agreed to terminate the relationship. The nurse was upset, as she felt she had been promised marriage as soon as Dr. P divorced his wife. She became even angrier when Dr. P, who primarily worked the day shift, asked that she be scheduled only nights so that he would not be together with her, as he had promised his wife.

The CEO was even more surprised when, a week later, he received notice that the nurse had filed a sexual harassment case with the hospital's human resources department and with the Equal Employment Opportunity Commission. She claimed she only continued the sexual relationship because of implicit threats Dr. P made, and by reassigning her to nights, the ER director contributed to the harassment.

Case Questions

1. Was this sexual harassment?
2. What should the CEO have done when he found out that a person with quasi-supervisory authority had a relationship with a subordinate?
3. Why might the ER director think the charge of sexual harassment was unfair?

Power of a Contract

IHD was an international hospital company with hospitals in three different Central and South American countries. Cliff, IHD's chief operating officer, had worked for the corporation for more than eight years and invested countless hours making the hospitals profitable. IHD was a privately held company with big plans but minimal financial backing. Cliff had built and was supervising ten hospitals that offered general acute

(continued)

(continued from previous page)

care. The hospitals differentiated their care from that of their competitors by offering an "American"-style clinic practice, hiring only US-trained physicians and obtaining Joint Commission accreditation. Over time, this strategy was successful.

Cliff was dedicated to helping his company succeed. For instance, when he had to terminate a CEO in one of the larger hospitals, he could not find the right replacement immediately, so he moved to the location for six months to take the reins until he felt most of the major problems had been addressed and a competent CEO could be found. He also traveled extensively and was on the road about 40 percent of the time, visiting different IHD hospitals in all three countries. Cliff was the lynchpin that made the company successful. At least this is what he was told many times by the majority owner and CEO.

The CEO and Cliff had a good relationship. They frequently met to talk about the hospitals' operations and challenges. The CEO also gave Cliff the highest possible evaluations and, when money was available, significant bonuses. Cliff felt he could trust his boss.

However, in Cliff's ninth year, as a result of activities of corrupt officials in one country, IHD was seriously considering divesting the six hospitals it owned in that country. This concerned Cliff, as it would leave him only four hospitals to run. While these discussions were ongoing, Cliff was approached by another US company that was buying a system of 11 hospitals in Chile and asked if he might be interested in becoming its divisional CEO and supervising its international facilities. After doing due diligence, and given the uncertainty with IHD, Cliff could see that this would be a great opportunity for him, as he would have a significant increase in salary and prestige.

Prior to accepting the offer, Cliff decided to meet with his boss to let him know about the planned move. He explained the circumstances, the offer, and his plan to resign and take the new position. The CEO responded by thanking him for his efforts but then pulled out Cliff's employment contract, which included a noncompete clause. The CEO threatened to sue Cliff to enforce the contract and even enjoin the other company if he accepted the position, claiming that IHD would lose all of its investment in him if he left.

Cliff was shocked that the CEO would treat him this way. The contract did have a noncompete clause for areas surrounding the company's hospitals, but Chile was a very long way from any of its current markets. He met with an employment attorney for advice and was told that the

noncompete clause was probably not enforceable, as the location was far from IHD's hospitals. However, the lawyer told Cliff that a recent client with a similar situation was sued, along with the hiring company. Rather than fight in court, the hiring company terminated the client's offer of employment, which left him without a job. Cliff now had a dilemma. He needed to continue to work, but he felt betrayed by his boss.

Case Questions

1. Was this a misuse of power by the CEO?
2. How do the principles of power apply in this case?
3. What should Cliff do?

CHAPTER

9

LEADERSHIP THEORIES AND STYLES

By Britt R. Berrett and Stephen L. Walston

Learning Objectives

After studying this chapter, readers should be able to

- appraise the five major leadership theories and their leadership styles,
- discuss the importance of having a clear vision for transformational leaders,
- realize the difficulty in precisely defining leadership,
- distinguish trait theory from other leadership theories,
- understand the Blake and Mouton managerial grid,
- perceive the differences between leaders and managers,
- explain the components of contingency theory,
- discuss transactional leadership and path–goal theory,
- appraise transformational leadership and its current importance in management thought,
- relate the critical importance of charisma in transformational leadership, and
- perceive the need for succession planning in transformational leadership.

Key Terms

- Authentic leadership
- Behavior theory
- Contingency theory
- Ethical leadership
- Great man theory
- Leader–member exchange theory
- Path–goal theory
- Servant leadership
- Situational leadership
- Trait theory
- Transactional leadership
- Transformational leadership

Today's healthcare industry needs good leaders. Escalating costs, concerns regarding quality of care, and limited access for some patient populations plague healthcare internationally. Greater competition and regulation, coupled with demands for increased accountability, are common challenges, and leadership is desperately needed to change existing structures and processes and adapt to the new demands and conditions. Too often, organizations maintain cumbersome bureaucracies and embedded, powerful, self-interested groups. Dynamic leaders are required to create agile, patient-focused, and cost-effective systems of care.

The perspective of what leadership is and where it originated has evolved over the past century. Understanding the development of leadership theory allows us to see the evolution in who leaders are and what creates them. Since the turn of the twentieth century, the study of leadership theory has included five major schools of thought (Antonakis, Cianciolo, and Sternberg 2004):

1. Trait
2. Behavior
3. Contingency, contextual, or situational
4. Transactional
5. Transformational

Each theory is reviewed in this chapter, and the last—transformational theory—is considered in more depth to address its unique and highly applicable insights.

Defining Leadership

Originally, a leader was someone who held a title, such as a head of state, king, magistrate, or military commander (Bass 1995). Use of the term *leader* extends as far back as Old Testament stories of prophets, priests, chiefs, and kings. Other great literary and religious volumes—such as those written by Shakespeare, Tennyson, Asoka, Confucius, Plato, and Aristotle, along with texts describing the lives of numerous pharaohs and Greek heroes—ruminated on the role, characteristics, and nature of the leader (Northouse 2007). Historically, one constant prevails: The leader's position differentiates this individual from the other members of society.

The term *leadership,* however, is a relatively new addition to the English language. It first appeared only within the past 200 years (Yukl 1981) and denotes a set of characteristics or behaviors unique to a leader. Although a relatively new concept, leadership has become a prominent area of business study. For example, a survey conducted by Burns (1995) identified more than 130 definitions of leadership; the world-famous New York Public Library has

tens of thousands of biographies, monographs, and newspaper clippings on the topic.

However, defining it has been difficult. Many years ago, Warren Bennis (1959) stated the following:

> Always, it seems, the concept of leadership eludes us or turns up in another form to taunt us again with its slipperiness and complexity. So we have invented an endless proliferation of terms to deal with it . . . and still the concept is not sufficiently defined.

An even older definition that remains applicable is, "Leadership may be considered as the process (act) of influencing the activities of an organized group in its efforts toward goal setting and goal achievement" (Stogdill 1948). As seen in the theories discussed throughout this chapter, the concept of influencing a group of people toward achieving goals is thoroughly intertwined with leadership.

Contemporary leadership study can be divided into five overlapping periods, which align with the five types of theory introduced earlier: the trait period (1920s to 1940s), the behavioral period (1940s to 1960s), the contingency or situational period (1960s to present), the transactional period (1970s onward), and the transformational period (1980s onward) (Antonakis, Cianciolo, and Sternberg 2004; Van Maurik 2001).

Trait Theory

Trait theorists of the 1920s defined a leader as one endowed with superior characteristics and traits that differentiate him or her from the followers. The conventional wisdom during this period held that "history is handmaiden to men; great men actually change the shape and direction of history" (VanWart 2005).

The common reference to the **great man theory** (Antonakis, Cianciolo, and Sternberg 2004) ascribed the shaping of history to exceptionally gifted individuals with certain dispositional characteristics (Zaccaro, Kemp, and Bader 2004). The traits most prominently mentioned in early literature include physical characteristics (e.g., height, appearance, energy level), personality (e.g., self-esteem, dominance, emotional stability), and ability (e.g., verbal fluency, intelligence, originality, social insight) (Yukl 1981).

Critics of **trait theory** suggested that leadership traits might be effective on the battlefield or in public life but not necessarily in other settings (Chemers 1995). Ultimately, most felt that traits had only a weak impact on determining whether people become leaders. One study attempted to identify superior traits of performers but concluded that the single unique characteristic was that they were tall (Van Maurik 2001).

Today, the popular literature still frequently considers the question of whether a leader is born rather than made (nature versus nurture) and explores specific traits exhibited by contemporary leaders. For instance, Sir Bernard Ingham, president of the British Franchise Association, in a 2001 interview, attributed the success of former UK prime minister Margaret Thatcher to five qualities or traits: ideological security, moral courage, constancy, iron will, and low need for love. Some have even hinted at the existence of a leadership gene (Van Maurik 2001).

Behavior Theory

By the 1940s, the focus of leadership theory shifted from a leader's traits to a leader's behavior and marked the beginning of **behavior theory** in the study of leadership. The great man perspective was replaced by ranges of leadership styles available to a manager. Fueled by the sudden entry of the United States into World War II, the military needed to train officers and noncommissioned officers as quickly and effectively as possible (Van Maurik 2001). The military presumed that leadership could be taught, so it engaged theorists to identify the ideal type of leadership behaviors.

Work by researchers at The Ohio State University and the University of Michigan resulted in a large-scale, comprehensive analysis of leadership behaviors. The Ohio State researchers broadly defined two categories of behavior: employee-oriented (consideration) leadership and production-oriented (initiating) leadership (Antonakis, Cianciolo, and Sternberg 2004; VanWart 2005).

The University of Michigan study also categorized leadership behaviors and emphasized relations-oriented behaviors in a third category, called *participative leadership*. Participative leadership was described as "managing group processes constructively, especially information flow, meetings, and decision-making" (VanWart 2005).

The intent of these two studies was to discover what leadership behaviors lead to effective group performance (Schriesheim and Kerr 1976; Yukl 1981). Blake and Mouton (1965) built on these works and presented one of the first theories that applied a behavioral orientation to leadership. Their theory used two dimensions—concern for people and concern for production—on a "managerial grid." Their evaluative tool suggested that leaders exhibit both types of behavior at the same time with varying levels of activity while others function with little or no regard for either (Van Maurik 2001). The managerial grid arrays leaders according to their level of concern for people and production (exhibit 9.1). The ideal leader displays high levels for both factors, while impoverished leaders show little for either. To ascertain numerical scores, individuals answer survey questions that represent their level of concern for people and production.

Henry Mintzberg (1973) added to the study of behavior theory by defining leadership roles that exist within a team, such as figurehead, leader, liaison, monitor, disseminator, spokesperson, entrepreneur, disturbance handler,

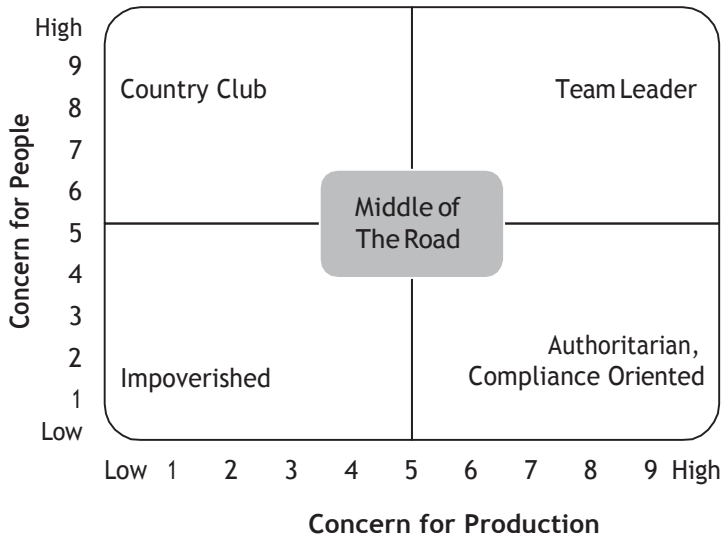


EXHIBIT 9.1 Blake and Mouton's Managerial Grid

Source: Adapted from Blake and Mouton (1965).

resource allocator, and negotiator. Mintzberg's work also highlighted the differences between managers and leaders. Leadership and management are frequently seen as complementary but require different competencies. Managers have subordinates; leaders have partners. Managers seek to do what is right, plan and budget, organize and staff, control and solve problems, and produce order. Leaders, on the other hand, desire to do what is right, establish a vision of the future, innovate, inspire, motivate, and produce change (Porter-O'Grady and Malloch 2016).

Contingency Theory

By the 1960s, leadership theorists began to focus on the situation and environment in which a leader functions (Antonakis, Cianciolo, and Sternberg 2004). **Contingency theory** suggests that the best leadership style depends on the situation and context (Chemers 1995). Different situations require different kinds of leadership (Northouse 2007). Three situational features include leader–member relations, task structure, and position power (Schriesheim and Kerr 1976). Contingency-oriented leadership theories also address leadership decision-making style as it relates to group performance and morale. The most effective style of leadership is dictated by the characteristics of the situation (Antonakis, Cianciolo, and Sternberg 2004; Chemers 1995; Yukl 1981). As shown in the box on page 138, leader–member relations and position power leadership styles can be adopted through a variety of means.

"Pop" leadership literature began to emerge when Kenneth Blanchard translated earlier work on leadership theory into stylized contingency theory

An Informal Indicator of Leadership Style

As part of consulting engagements, I would often visit hospitals. In preparation for these trips, I would request to view the healthcare organization's newsletters for the previous six months. Although not a scientific approach to fact-finding, the frequency with which the hospital CEO's picture appeared in the publication was an uncannily accurate way to quickly gauge his or her leadership style. Those with limited photos often were much more participative, and conversely, those who appeared recurrently were more authoritarian.

wrapped in popularized writings, publishing such titles as *The One Minute Manager* (Blanchard and Johnson 2003), *High Five!* (Blanchard and Bowles 2000), and *Whale Done!* (Blanchard et al. 2002). Through his books, Blanchard suggested that the leader's style is most effective when it meets the demands of the situation confronting the leader (Van Maurik 2001).

Ayman (2004) summarized the premise of contingency theory as follows: "Most of the theories and models in the contingency approach consider the situation as the contingent factor that interacts with the leader's characteristics, be they traits or behaviors." Furthermore, effective leadership is said to be contingent on the ability of a leader to match her style to the right situation (Northouse 2007).

Transactional Leadership and Situational Leadership

Transactional leadership is the theory that embraces a more sophisticated approach to situational and contingency variables. This theory examines the influence and behaviors of those being led (Wren and Swatez 1995) and their interactions with leaders. Transactional theorists identify the leader–follower relationship as the "interaction of persons with different levels of motivation and power potential, including skill, in pursuit of a common, or at least a joint, purpose" (Burns 1995). However, the use of rewards and power in transactional exchanges is rooted in the principles of contingency theory (Pearce, Yoo, and Alavi 2004).

Leadership study pioneer James MacGregor Burns (1978, 17) observed that most leadership research was focused on transactional interactions: "Leadership, unlike naked power-wielding, is thus inseparable from followers' needs and goals. The essence of the leader-follower relation is the interaction of persons with different levels of motivation and of power potential, including skill, in pursuit of a common or at least joint purpose." The environment was thought to play an important role in the emergence of a leader and organizational leadership (Bass 1990).

Situational leadership theories help direct leaders in how to behave in different circumstances. Situational leadership suggests that effective leaders need to understand their environment or situation and respond with a style that matches the existing need. Much of modern leadership training has been

based on this concept (Silverthorne and Wang 2001). According to the work of Hersey and Blanchard (1969), the core premise of this theory is that effective leaders must adapt their leadership style to their organizational context, and to do so, they must be capable of using different leadership styles and align them appropriately with their current situation. Key environmental factors include their subordinates' abilities, maturity, relationships, and motivations and the nature of the tasks and goals confronting them (Hersey, Blanchard, and Johnson 1996). As discussed in chapter 11, leaders delegate differently depending on their subordinates' needs, situations, and abilities.

Different leadership theories have evolved from situational leadership perspectives. Three that have received significant attention are Fiedler's contingency theory, the path–goal theory, and the leader–member theory. In addition, transactional leadership theory includes specific theory models such as path–goal theory (House 1996), leader–member exchange theory (Graen and Uhl-Bien 1995), and equity theory (Adams 1965). Path–goal theory explores how leaders motivate subordinates to accomplish designated goals (Northouse 2007) and is discussed in more detail later in this section.

Fiedler's contingency theory integrates the people, process, and situation to suggest that effective leaders balance their task and relationship motivation depending on three situational elements: (1) the leader–follower relationship, or the extent to which the leader demonstrates friendliness with subordinates and gains their trust and respect; (2) the degree of structure in the work; and (3) the position power of the leader, which entails the amount of formal power and influence to reward and punish (Fiedler 1964). The theory proposes that the autocratic decisions and directive styles by which leaders tell followers what to do are more likely to work when the leaders know exactly what to tell their subordinates (Chemers 1995).

The **path–goal theory** of leadership considers both employee and environmental factors to suggest which leadership style would be most effective. According to this theory, a leader's primary role is to set clear goals and remove obstacles that impede those goals (House 1977). It suggests the following four leadership styles that a leader can employ depending on the situation (Barker 1992; Rue and Byars 2009):

1. *Directive*—sets clear expectations and goals for employees; suggested for ambiguous tasks
2. *Supportive*—shows concern for employees; suggested for stressful and unpleasant work environments
3. *Participative*—seeks input and suggestions for decisions; suggested for when employees are highly invested and decisions or work may be ambiguous
4. *Achievement oriented*—sets goals for and demonstrates confidence in subordinates; suggested for work that is nonrepetitive and unclear

Good leaders recognize and fill in what is missing in the environment or their subordinates. In effect, successful leaders adjust their leadership behaviors to meet their employees' abilities contingent on the nature of work and group dynamics (exhibit 9.2). Behaviors may include setting and clarifying the goals and standards as well as the rewards for achieving them, mentoring and coaching, supporting through concern and friendly behavior, encouraging teamwork, inviting participative decision making, representing the group, and providing a vision.

Different leadership behaviors are overlaid onto subordinates' and tasks' characteristics. The theory seeks to enhance employee performance and satisfaction by focusing on employee motivation. A unique view of the transactional interchange between leaders and members is part of the **leader–member**

EXHIBIT 9.2 House's Path-Goal Leader Behaviors

Path-goal clarifying	Communicates what is expected, sets performance standards, schedules activities, rewards positively or negatively on the basis of performance
Achievement oriented	Sets challenging goals, drives improvement and excellence, demonstrates confidence in employees' abilities, encourages pride in work
Work facilitation	Mentors and coaches to improve employees' skills, removes barriers, facilitates and empowers employees' work
Supportive	Acts friendly, shows concern for employees, treats them as equals
Interaction facilitation	Communicates and encourages teamwork, resolves conflict, promotes positive relationships among employees
Group-oriented decision making	Invites decision-making participation, obtains and shares needed information for decisions
Representation and networking	Acts as a representative for the organization, fills ceremonial roles, develops and maintains relationships with influential parties
Values based	Creates and shares a vision, demonstrates confidence to achieve the vision, provides feedback

Source: Adapted from House (1996).

exchange theory. This theory presents a complex, relationship-based approach to leadership, making the interaction between leader and member the focal point of the leadership process. Group members make contributions and continue with these interactions because they perceive a mutual benefit (Graen and Uhl-Bien 1995).

Both equity theory and expectancy theory, discussed in chapter 5, attempt to determine the conscious choices and expected rewards by both leader and follower. These leadership theories provide insights into how leaders interact and function. The dynamics of transactional leadership have been expressed in terms of leaders and followers through a psychological contract between the leader and followers that depends on both parties' expectations and actions. The leader contributes value to those who are led, and in exchange, members reciprocate and return value to the leader. The degree and significance of this social exchange is the foundation of transactional leadership theory (Hollander 1987).

Transformational Leadership

Many contemporary observers felt that transactional theory did not transcend the satisfaction of self-interest in leadership. **Transformational leadership** has been seen as the bridge to cover that gap.

In contrast to leadership theories that posit that leaders and followers enter into transactional relationships to effect change, transformational leadership theory suggests leaders inspire and motivate followers to pursue outcomes centered on a sense of purpose and an idealized mission (Sashkin 2004). This theory better addresses the skills needed to lead today's workforce with its focus on visionary, charismatic, and inspirational leader characteristics. It has been used extensively by modern researchers to understand why some organizations create high-performing work environments and some do not (Kouzes and Posner 2006).

Burns's (1978) early work expanded transactional leadership theory to develop the transformational leadership framework (Antonakis, Cianciolo, and Sternberg 2004). He stressed that transforming leaders empower individuals and organizations to embrace the mission and vision. In so doing, leaders champion and inspire their followers (Burns 2003). The nature of this effect is important as transformational leaders engage in activities that do not merely change the performance but, in fact, also change the very essence of the organization.

Although no grand or unifying theory provides common direction for researchers on transformational leadership, most scholars agree that one central and unique theme defines the practice of transformational leadership: the creation of a vision (Antonakis, Cianciolo, and Sternberg 2004). A vision is an organizational goal or state of being that transcends previously held conceptual

frameworks (Kouzes and Posner 2006). Today, the study of transformational leadership and its acceptance in healthcare is a natural extension of the study of organizational behavior, theory, and design in the industry. As such, this theory embraces the process of empowerment and the hope that "transforming leaders champion and inspire followers . . . that they might become leaders themselves" (Burns 1995).

Transformational leadership differs from transactional leadership in that "transformational leaders engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (Burns 1995). In other words, transformational leaders embrace a dynamic relationship that elevates both leader and subordinate. Their interactions are more than just transactions; they result in a transforming relationship. As illustrated by the box on pages 143–44, top-performing hospitals have visionary leaders who develop deep relationships with their employees, communicate effectively with them, and motivate them.

Charisma

Transformational leadership explains how leaders inspire others to perform beyond expected standards. Leaders do so by developing an emotional attachment between themselves and their followers (Avolio and Yammarino 2002). Originally conceived by Max Weber (1958, 77) in his work on charismatic leadership, this view contends that the leader has the ability to inspire followers to an "attitude that is revolutionary and . . . transcends everything."

Charismatic leadership is central to the theory of transformational leadership, as leaders command strong emotional ties and excite, arouse, and inspire their subordinates (Bass 1995). The elements that characterize charismatic leaders are present in transformational leaders. However, transformational leaders are more than inspirational, as they also play the roles of teacher, mentor, coach, reformer, and revolutionary. The transformational leader seeks to engage the full person of the follower and, in so doing, elevates those influenced to a higher level of performance (Bass 1995). Thus, transformational leaders are able to attract, retain, and promote others and thereby create a succession of transformational leaders. Conger and Kanungo (1998) concluded that charismatic leaders are perceived as more effective, are given higher performance ratings than other leaders are, and at the same time have followers who are more motivated and satisfied.

Components of Transformational Leadership

Transformational leadership comprises the following specific characteristics (adapted from Antonakis and House 2002; Bass 1995):

- *Charismatic leadership (or idealized influence)*. Transformational leaders behave in ways that make them role models for their followers.

These leaders are admired, respected, and trusted. Followers identify with them and want to emulate them; the leaders are viewed by their followers as having extraordinary capabilities, persistence, and determination. The leaders are willing to take risks and are consistent rather than arbitrary. They can be counted on to do the right thing, demonstrating high standards of ethical and moral conduct.

- *Inspirational motivation*. Transformational leaders behave in ways that motivate and inspire those around them by providing meaning and challenge to their followers' work. Team spirit is aroused. Enthusiasm and optimism are displayed. Leaders get followers involved in envisioning attractive future states; they create clearly communicated expectations that followers want to meet, and they demonstrate commitment to goals and the shared vision.
- *Intellectual stimulation*. Transformational leaders stimulate their followers' efforts to be innovative

HCA STORY

By Britt Berrett

In 2005, Hospital Corporation of America (HCA) was the largest private hospital company in the world, with 189 hospitals and outpatient facilities throughout the United States and Europe. Hospitals owned and operated by HCA performed 140,365 newborn deliveries, or 5.18 percent of all deliveries nationwide. In the same year, HCA hospitals performed 12,518 open-heart bypass surgeries, or 4.7 percent nationwide, and 31,128 joint replacements, or 6.17 percent nationwide. In total, HCA hospitals treated 1,765,704 inpatients, or 4.76 percent nationwide. These same hospitals treated 14 million total patients; employed 190,000 nurses, technicians, and other healthcare workers; credentialed an estimated 37,000 active staff physicians; cared for 5.3 million emergency room patients; and provided an estimated $1.9 billion in uncompensated care (PRNewswire 2006).

As part of an extensive internal study of organizational performance conducted that year, HCA evaluated its 189 hospitals to determine the characteristics of top performers. The goal of the study was "to identify best practices that could increase employee engagement, patient satisfaction, and physician satisfaction throughout the HCA system" (Wolf 2008, 39). It was theorized that high-performing facilities (HPFs) could be identified and performance characteristics could be effectively shared throughout the organization. Eleven HPFs were identified through a performance matrix, which included employee engagement, patient satisfaction, nursing measures, employee turnover, and comparative financial measures. Each of the identified facilities demonstrated top levels of performance overall and with consistency in a three-year period from 2002 to 2004 (Wolf 2008).

These facilities included the following:

- Medical City Dallas Hospital, Dallas, Texas
- Greenview Hospital, Bowling Green, Kentucky
- Hendersonville Medical Center, Hendersonville, Tennessee
- Horizon Medical Center, Dickson, Tennessee
- Medical Center of Plano, Plano, Texas
- Methodist Ambulatory Surgery Hospital North West, San Antonio, Texas
- Redmond Regional Medical Center, Rome, Georgia
- Round Rock Medical Center, Austin, Texas

(continued)

(continued from previous page)

- Skyline Medical Center, Nashville, Tennessee
- Texas Orthopedic Hospital, Houston, Texas
- West Houston Medical Center, Houston, Texas

HCA undertook a series of on-site visits to these 11 hospitals, conducting nearly 160 personal interviews with senior leadership and directors or managers, 64 focus groups that included more than 700 staff, and almost 2,000 surveys (Wolf 2008). From these sources, the HCA team identified seven central characteristics of HPFs: visionary leadership, consistent and effective communication, selection for fit and ongoing development of staff, agile and open culture, service as job one, constant recognition and community support, and solid physician relationships.

HPFs have significantly higher employee engagement scores, with almost four times as many engaged employees as at low-performing hospitals (5.68 versus 1.63). (The term *engaged employee* is defined by Gallup as an individual who is actively involved in the organization's success and performance [Coffman and Gonzalez-Molina 2002].) Engaged employees are more profitable, more customer focused, safer, and more likely to withstand temptations to leave than nonengaged employees are.

HPFs also see significantly greater employee retention, enjoying 7 percent lower turnover than low performers do. Turnover from 2000 to 2004 decreased by 3.9 percent in HPFs and increased 1.4 percent in their low-performing counterparts. Notwithstanding the financial impact of staff turnover, the cultural implications represent a significant issue for an organization (Wolf 2008).

Finally, on average, HPFs enjoy superior financial performance, exceeding low performers over the course of the study by a 5 percent margin. The identification of these characteristics of HPFs makes this study a significant contribution to the literature.

According to a separate internal report (HCA 2005), HPFs generate $15 million more in average profits than their low-performing counterparts do, measured by earnings before interest, taxes, depreciation, and amortization (EBITDA) per facility; achieve $32,000 more in revenue per bed than low performers do; and achieve higher average EBITDA as a percentage of net revenue by six basis points compared to low performers (Wolf 2008).

and creative by questioning assumptions, reframing problems, and approaching old situations in new ways. Creativity is encouraged. Individual members are not publicly criticized for their mistakes. Followers are included in the process of addressing problems and finding solutions. Followers are encouraged to try new approaches, and their ideas are not criticized because they differ from the leaders' ideas.

- *Individualized consideration.* Transformational leaders pay special attention to each follower's needs for achievement and growth by acting as coach or mentor. Followers and colleagues are developed to achieve successively higher levels of potential. Individualized consideration is practiced when new learning opportunities are created and a supportive climate is in place. Differences in individual needs and desires are recognized. The leader's behavior demonstrates acceptance of individual differences (e.g., some employees receive more encouragement, some

more autonomy, others firmer standards, and still others more task structure). A two-way exchange in communication is encouraged, and "management by walking around" work spaces is practiced. Interactions with followers are personalized (e.g., the leader remembers previous conversations, is aware of individual concerns, sees the individual as a whole person rather than as just an employee). The considerate leader listens effectively and delegates tasks as a means of developing followers. Delegated tasks are monitored to see if the followers need additional direction or support and to assess their progress; ideally, followers do not feel they are being checked on.

Transformational leaders are able to motivate subordinates to higher levels of performance by raising the importance of certain goals, demonstrating the means by which to achieve them, and enticing subordinates to transcend their self-interests to fulfill those goals (Conger and Kanungo 1998). Such leaders transform the needs, values, preferences, and aspirations of followers from self-interests to organizational interests (Shamir, House, and Arthur 1993) because they have the ability to motivate and convince their followers to invest additional work and energy into accomplishing extraordinary things (Fuller et al. 1996). Leaders who possess the attributes described in transformational leadership theory experience the staff's heightened enthusiasm for and excitement about shared organizational priorities. Not only are transformational leaders better performers themselves, but the people associated with them are better performers and are more satisfied with the performance of their leaders (Cross, Baker, and Parker 2003).

Healthcare today requires strong transformational leaders. The rapid change and uncertainty that exist in the industry established the need for flexible, competent, charismatic leaders to move their organizations forward. By 2008, about half of US healthcare systems had responded to this call by instituting executive leadership programs (McAlearney 2008). As discussed earlier, the changes will only occur with skilled leaders who can establish and maintain a long-term vision that moves their organization to manage the health of populations (Buell 2011). Even financial executives are now expected to provide "a clear vision of success," become inspirational leaders to motivate teams, and actively engage coworkers at every level (Madden 2015, 42). To this end, the American College of Healthcare Executives (2015) has developed a competencies assessment tool, which is subdivided into the following competencies:

- Communication and relationship management
- Professionalism
- Business skills and knowledge
- Knowledge of the healthcare environment
- Leadership

Succession Planning

To sustain an organization, transformational leaders embrace succession planning as a critical element of their leadership behavior. Effective succession planning results from an organization's ability to discern which employees will develop and meet organizational needs and which will not fulfill the company's desired return on its investment (Lamoureux 2007).

The value of succession planning is discussed in a report by Development Dimensions International (DDI), a nationally recognized leader in human resource development. It found that the workforce recognizes and appreciates the organization's efforts to promote from within and develop its own people. Employee morale improves, and staff are encouraged to take on responsibility, assume risk, measure outcomes, and grow through their achievements. The DDI report concluded that "growing from within allows an organization to meet both long-term and emergency leadership needs at all levels—it ensures continuity of management" (Byham 2008, 3).

In addition, a 2003 report by the US Government Accountability Office stated that "leading organizations identify, develop, and select successors who are the right people, with the right skills, at the right time for leadership and other key positions" (Mihm 2003, 1). It identified key practices for effective succession planning that strengthen current and future organizational capacity. Six of the demonstrated practices are as follows (adapted from Mihm 2003):

1. *Receive active support of top leadership*. Effective succession planning and management have the support and commitment of top leadership. Top leaders not only use these programs to develop, place, and promote individuals but also demonstrate support through adequate funding and staff resources to operate effectively over time.
2. *Link to strategic plan*. Succession planning and succession management are viewed as strategic tools that focus on current and future needs and develop high-potential staff to meet the organizational mission over the long term. These efforts are integrated with strategic planning.
3. *Identify talent from multiple organizational levels, early in careers, or with critical skills*. High-performing employees are identified in multiple levels in the organization. Succession planning efforts develop knowledge and skills that are critical in the workplace.
4. *Emphasize developmental assignments in addition to formal training*. Succession planning highlights development or "stretch" assignments in addition to more formal training components. Assignments place candidates in new roles or unfamiliar job environments to strengthen their skills and competencies and broaden their experience.
5. *Address specific human capital challenges, such as diversity, leadership capacity, and retention*. Leading organizations are aware of changing

organizational needs and demands. Shifting workforce demographics requires agility in responding to diversity needs as well as anticipation of impending retirements. The retention of high-potential staff is important to succession planning.

6. *Facilitate broader transformation efforts*. Succession planning and related management efforts provide resources for organizations to implement change by selecting and developing candidates who embrace a change agenda.

All five theories of leadership add value and assist in understanding what leadership is and how it functions. Exhibit 9.3 provides a brief summary of each theory along with servant, authentic, and ethical leadership models.

EXHIBIT 9.3 Summary of Leadership Theories and Models

Trait	1920s to 1940s	Leaders are endowed with superior characteristics and traits.	Great man
Behavior	1940s to 1960s	Leaders are characterized by how they behave regarding employee orientation, production, and relations.	Managerial grid
Contingency/ Situational	1960s onward	Leaders apply different styles of leadership in different situations.	"One-minute manager"
Transactional	1970s onward	Leaders are examined in terms of the influence and behaviors of those being led and their interactions with leaders.	Path-goal theory, leader-member exchange theory, equity theory
Transformational	1980s onward	Leaders use the strength of their vision and personality to inspire followers to change expectations, perceptions, and motivations to achieve common goals.	Charisma, succession planning
Servant	1970s onward	Leaders seek to serve and improve the lives of their employees, customers, and stakeholders.	Vision, trust, charisma
Authentic	2000s onward	Leaders exhibit a positive moral perspective characterized by high ethical standards that guide their decision making and behavior, as well as consistency among their values, beliefs, and actions.	Self-awareness, self-regulation, transparency, authentic behavior
Ethical	2000s onward	Leaders demonstrate ethical conduct through their personal actions and relationships and promote such conduct to subordinates.	Credibility, authenticity, ethically appropriate

Servant Leadership

Servant leadership has been considered an extension of transformational leadership and participative management but is more a values-based view of leaders' optimal behavior and motives than a traditional leadership theory. Rather than leadership being a tool for self-aggrandizement, service is the core function of leadership and a moral and ethical imperative (Russell and Stone 2002). Leadership from a servant leader perspective requires decision makers to lead from a moral perspective that guides their behaviors. "Becoming servant leaders engages us in personal, internal self-change and changes our outward behavior" (Fairholm 1997, 149).

The concept has existed for millennia. Lao-Tzu, a Chinese philosopher who lived in the fifth century and is considered to be the father of the Chinese religion Taoism, admonished leaders to serve. He is credited with saying, "The highest type of ruler is one of whose existence the people are barely aware. The Sage is self-effacing and scanty of words. When his task is accomplished and things have been completed, all the people say, 'we ourselves have achieved it'" (Heskett 2013).

In the modern era, the servant leadership concept began to receive attention after Robert Greenleaf's (2003) "The Servant as Leader" was published in 1970. Leaders who practice this leadership style tend to be more highly regarded by their subordinates, are more productive, and feel better about themselves and their work, compared with leaders who are not "servants" (Grant 2014). Some believe servant leadership is the best model through which to address the many dysfunctional facets of the US healthcare system. Healthcare leaders using a servant leadership style typically engender trust and teamwork among stakeholders that enable lower-cost and more efficient healthcare delivery (Trastek, Hamilton, and Niles 2014).

However, practicing this style can be difficult, and some observers claim that it is rarely done (Heskett 2013). Often, leaders' rewards and incentives encourage self-promotion rather than selfless service. Yet great transformational leaders who leave important legacies encapsulate the principles of servant leadership. Iconic leaders such as Abraham Lincoln, Martin Luther King Jr., Mahatma Gandhi, and Nelson Mandela sacrificed their personal comfort and goals for the good of their country. They were other-centered, rather than self-centered, and were respected and honored. Leaders can achieve results with autocratic behaviors, which may seem an easier approach, but as shown in the box on page 149, subordinates may end up celebrating the passing of autocratic leaders.

Authentic Leadership and Ethical Leadership

Other, more recent models of leadership that have emerged from the desire for more positive forms are **authentic leadership** and **ethical leadership**

Unfortunate Legacy of an Autocratic Style

People exhibit different styles of leadership, and the memories they leave often reflect not just the results they achieved but also the way they treated their subordinates. Those not exhibiting the values and traits embodied in servant leadership may end up with an unfortunate legacy.

In the 1950s, Harry Cohn was the president of Columbia Pictures. He was known as an extreme autocrat and managed through intimidation. He was accused of being an absolute monarch and of deploying listening devices to spy on his employees. He screamed at employees and sexually harassed stars. When he died in 1958, 1,300 people reportedly attended his funeral, many of whom are said to have commented that they attended not to honor Cohn but to confirm that he was really dead.

Source: Chadwick (2015).

(Brown, Treviño, and Harrison 2005; George 2003). Without explicit models that establish standards for authenticity and ethics, some believe that holding leaders ethically accountable is difficult (Folger and Cropanzano 2001). Both build on many aspects of transformational and servant leadership and extend the emphasis on values-based leadership performance. Authentic leadership, although still formative, has been defined as (Walumbwa et al. 2008, 94)

> a pattern of leader behavior that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalized moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development.

Ethical leadership continues to be refined from previous leadership models. This general framework has focused primarily on a leader's behavior toward subordinates (Bass and Bass 2008) and has been defined as "the demonstration of normatively appropriate conduct through personal action and interpersonal relationships, and the promotion of such conduct to followers through two-way communication and decision-making" (Brown, Treviño, and Harrison 2005, 120).

Similar to other leadership models, ethical leadership is characterized by those who demonstrate trustworthy, fair, and honest behaviors, but it expands the ethical focus by promoting ethical conduct in employees and colleagues. Ethical leaders are "both a moral person and a moral manager" (Brown and Treviño 2006, 597). Ethical leadership has been identified as important for our struggling, often amoral, business environment (Frisch and Huppenbauer 2014).

Chapter Summary

Leadership is a group phenomenon involving the interaction between two or more persons. The interaction includes a process of influence whereby the leader exerts intentional influence over the followers.

Leadership study comprises five recognized theories or schools of thought, which include trait, behavior, contingency or situational, transactional, and transformational. Transformational leadership has become increasingly accepted today, as leaders' roles focus on inspiring and motivating followers. Followers are empowered and inspired by the organizational mission and vision under transformational leadership.

The concept of leadership has changed over time. Originally, leaders were kings, magistrates, or military commanders, with their position differentiating them from others. In the English language, the word *leadership* is relatively new and denotes characteristics or behaviors, but it has been difficult to define.

Trait theory was popular in the 1920s and suggested that leaders possessed superior characteristics and traits. "Great men" were born and changed history. These individuals had greater physical and mental prowess than others. Many observers still attribute leadership success to superior traits, even though the theory has fallen out of favor with most.

Behavior theory became accepted in the 1940s and focused on the behaviors of leaders. Encouraged by the military's desire to train leaders for World War II, academics developed a range of leadership styles available for practice. Leadership behavior that led to effective group performance was identified. One popular framework for behavior theory was Blake and Mouton's managerial grid, which examines the level of leadership concern for both people and production. The difference between a manager's and a leader's behaviors was also highlighted.

In the 1960s, contingency or situational theories became widespread. This set of leadership theories recognized that different leadership styles were needed for different situations and that effective leadership depends on matching a leader's style and characteristics to the given circumstances.

Transactional leadership theory, emerging in the 1970s, dealt with the leader–follower relationship along with levels of motivation, power, and skill. Under transactional theory, other models—such as the path–goal theory, leader–member exchange theory, and equity theory—arose.

Transformational leadership evolved from previous leadership theories and embraced the process of empowerment to allow leaders to transform and inspire followers. Under this theory, leaders and followers work together to improve their motivation and ethics. This dynamic becomes a transforming relationship, elevating both leader and subordinate. Charisma is a central aspect of a leader with transformational style, as it emotionally bonds followers and leaders. Charismatic leaders profoundly affect employees because of the force of their personal abilities. Aside from charisma, transformational leadership includes inspirational motivation, intellectual stimulation, and individualized consideration. Transformational leaders can motivate employees to higher performance and align followers' needs, values, preferences, and aspirations with organizational interests. Succession planning is a critical element of transformational leadership.

Chapter Cases

It's All About the Title—but It's Not

By Britt Berrett

Angie was an exceptional catheterization laboratory technician who was respected by her teammates. When the director of the cath lab took another job, Angie was the natural choice to take the director's position. She was asked to step into that role but with an interim title.

(continued)

A concept that has evolved from participative and transformational leadership is servant leadership. Servant leaders are other-centered, rather than self-centered, and lead from a values and ethics perspective. Rather than leadership being a tool for self-aggrandizement, service is the core function of this style and is a moral and ethical imperative. Leaders should examine their motives and seek to provide long-term benefit to their stakeholders.

Two additional leadership models—authentic leadership and ethical leadership—have emerged in recent decades. Both build on past models and present ideal values-based leadership characterized by transparent, credible, and genuine behaviors.

Chapter Questions

1. Why do you think people highlight leadership traits to explain the success of leaders?
2. What is the central theme of transformational leadership? Why do you think this is the critical aspect of the theory?
3. Why is it difficult to define leadership?
4. Under trait theory, can leadership be taught? Why or why not?
5. How does behavior theory overlap with transformational leadership?
6. How did the United States' entry into World War II affect the research and beliefs about leadership?
7. What is an optimal position on the Blake and Mouton managerial grid? Why?
8. What is the major premise of contingency theory?
9. Path–goal theory considers that leadership characteristics are modified by what factors?
10. Why is charisma so important to transformational leadership?
11. How is servant leadership an extension of transformational leadership?

(continued from previous page)

Within days, she was in my office to discuss why her coworkers wouldn't follow her direction. It was her opinion that she needed the permanent title for anyone to listen to her. She kept having to tell people, "This is what we will do, because I am the boss." They would nod their heads as if they agreed, but often they did what they wanted anyway.

I explained that, instead of using the interim title as a stick to beat over their heads, Angie should look for common challenges and frustrations that they could solve as a team. Most certainly, there would come a time when tough decisions would need to be made and her role and title would be necessary, but day-to-day collaboration was the best way to solve problems and make decisions. The team would learn to trust her judgment, and when a crisis came, they would respect her decision about how to handle it.

Angie returned to the cath lab and brainstormed with her team about their frustrations. She began working with and listening to the employees. With their input, she established a vision of where the department should go and what they all could do to improve patient satisfaction and clinical quality. Over time, she built a reputation as a team player and an advocate for staff. Many employees commented that she seemed to gain a lot of charisma and looked to her for advice and expertise. Annoying issues that had plagued the cath lab were addressed, and she soon became the permanent director of the department—title and all.

Case Questions

1. Why did people not "obey" Angie initially?
2. What leadership style did Angie adopt in the beginning?
3. What did she do to change the attitude of the employees?
4. What leadership theories might apply in this case?

Inspiring Employees: The Turkey Entitlement

Every year, the hospital provided free turkeys to employees during the Thanksgiving holiday. Eventually, the tradition became an entitlement and a significant financial obligation. Rather than perpetuate the entitlement mentality, the executive team transformed this time-honored tradition into a meaningful and purposeful event.

Instead of distributing gift coupons for staff to cash in at the local grocery store, the organization arranged for a refrigerated semi truck to be parked in front of the hospital during Thanksgiving week. Wearing freezer

mitts and warm jackets, each member of the executive team personally participated by handing a frozen turkey to each employee. In return, to impress on staff the importance of gratitude, each employee was required to write down what he or she was thankful for before receiving a turkey. Not only was this perceived as a cherished interaction and discussion between employee and executive during the distribution, but the activity was used as a tracking process to ensure that only one turkey was distributed per employee.

A tense moment occurred when a belligerent employee arrived at the table in front of the turkey truck. She wasn't going to write down what she was thankful for and demanded her "damn" turkey. The CEO was covering that shift and graciously refused to give her a turkey, inviting her to head on home. She was stunned. And so were the rest who were gathered around. But the word quickly spread throughout the organization that this activity represented the season of gratitude and was not an entitlement. To be sure, the CEO smiled and was kind, but the message was clear.

As a result, many employees who had previously avoided the Thanksgiving tradition requested that their free turkeys be donated to a local food bank. A table was set up and their turkeys were set aside with a note of gratitude from the food bank.

After the event, the expressions of gratitude were stapled onto the wall adjacent to the cafeteria. The expressions were priceless, giving thanks for parents, children, servicemen and servicewomen, bosses, teammates, faith, friends, and so on. Soon, the area became a congregating point and a source of inspiration and appreciation.

What had evolved into an entitlement for employees was transformed into an expression of gratitude and an inspiration to do more for others.

Case Questions

1. How was this CEO a transformational leader?
2. What was required to achieve what he did?
3. How did his actions inspire others? What were the results?

The Case of the Bad Boss

Perry was one of the worst bosses Lia had ever worked for. Perry had arrived from the main corporate office only six months ago to become the regional vice president for clinical operations, but already many staff members had polished their resumes and were looking for other work. It

(continued)

(continued from previous page)

was hard for Lia to identify exactly what bothered her about Perry until she read an article in *U.S. News & World Report* that listed the following ten things bad bosses say (reprinted from Green 2013):

1. "You're lucky even to have a job."
2. "Just figure it out."
3. "I received an anonymous report . . ."
4. "I don't have time for your performance evaluation, but you're doing fine."
5. "That's a dumb idea."
6. "That dress really flatters your figure."
7. "Just do what I tell you to do."
8. "What's wrong with you?"
9. "Your job is what I say it is."
10. "You're so much better at this than Bob is."

Many of these statements reminded Lia of Perry. Then a specific incident that happened one December day crystalized in Lia's mind the problems she had with Perry. Lia's company operated satellite offices in Asia, and one of her responsibilities was to arrange and allocate housing for expatriates working at one of these satellite sites. Constant turnover of personnel and shortages of good apartments always seemed to be issues on this campus. Therefore, senior personnel were often placed in a smaller apartment with the promise to be moved to a larger one when it became available. Lia felt she did a good job of juggling the needs and sensibilities of senior staff with cost concerns.

Six months earlier, Scott, a senior-level orthopedist, and his spouse had agreed to relocate to the site and were told they could have the only apartment available in the senior housing unit, which had the best apartments. However, three weeks before they were to arrive, a senior administrator decided to transfer to the campus and moved into the apartment. Scott and his spouse were placed in a much smaller and older apartment near the site and were promised a better apartment when one became available.

Now, Perry was in charge of the entire site and had gotten to know many of its employees. He especially liked two junior employees, a couple who were friendly and had recently completed their master's degrees—an accomplishment that impressed Perry.

When the next senior-level apartment became available, Lia submitted the request to move Scott and his spouse into it. However, Perry

told her he had already promised it to the young couple, in compliance with his new policy that couples who both worked for the company would receive priority treatment. Lia was flabbergasted. She reviewed both parties' contracts and found that only Scott, the senior employee, was promised the larger apartment. In fact, the young couple's contracts did not even mention the size or type of apartment they were to be housed in.

Lia presented the terms of the contracts to Perry, emphasizing that the firm was contractually obligated to give the larger apartment to Scott. She also mentioned that allocating apartments was her job. Perry reddened and told her, "Your job is what I tell you it is." Lia tried to convince Perry that what he had promised was not correct. Finally, Perry realized he should not have promised the apartment to the young couple but had already announced his decision. He told Lia, "Just do what I tell you to do."

Lia tried one more strategy. She suggested the company might face legal problems if Perry persisted in his decision. Perry replied, "What's wrong with you? I'm the boss, and this is the way it is!"

Case Questions

1. What characteristics did Perry lack that prevented him from being a transformational leader?
2. What is wrong with using the ten sayings mentioned in the case?
3. Why does it take strength to admit one is wrong? Why must a transformational leader be willing to admit responsibility?

Chapter Activities

1. Read chapter 15 of Stephen Covey's (2006) *The 8th Habit,* titled "Using Our Voices Wisely to Serve Others." Write a two- to three-page paper on how you can improve your leadership style to serve others and what effect these actions might have on your career.
2. Read "Google's Quest to Build a Better Boss," at www.nytimes.com/2011/03/13/business/13hire.html (Bryant 2011). What models of leadership theory are found in Google's design?
3. Read the Governance Institute's white paper "Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards" at www.jointcommission.org/assets/1/18/wp_leadership_standards.pdf (Schyve 2009). Compare what the paper proposes leaders do in healthcare organizations with the leadership theories presented in this chapter. How are they similar and different?

10

ORGANIZATIONAL CULTURE

Learning Objectives

After studying this chapter, readers should be able to

- summarize the components of organizational culture;
- relate how rituals, routines, and stories help create and reinforce a culture;
- appraise the concept of power distance and its relative importance in different cultures;
- identify the concept and application of uncertainty avoidance among cultures;
- distinguish cultures that stress individualism from those that stress collectivism;
- contrast between masculine and feminine organizational behaviors and preferences; and
- analyze cultural assessments and the way cultural change takes place.

Key Terms

- Cultural assessments
- Individualism versus collectivism
- Masculinity versus femininity
- Organizational culture
- Power distance
- Rituals and routines
- Stories
- Symbols and structures
- Time orientation
- Uncertainty avoidance

Organizational culture is a critical element in organizational performance and in the success or failure of a business. Establishing and maintaining a positive culture has become a major task for organizations today. The values and mission of a company should be the foundation of its culture. However, many firms fail to ingrain their written values and mission into the actual behaviors and actions of their employees and end up with a culture that distracts from what they want to accomplish. As can be seen in the box on pages 158–59, the toxic culture created by HealthSouth CEO Richard Scrushy

A Toxic Culture at HealthSouth

After nearly two decades of growth and the appearance of success at HealthSouth, a large for-profit chain of rehabilitation clinics, almost its entire management team was found guilty of fraud, conspiracy, obstruction of justice, and money laundering. The toxic culture that allowed corruption to occur and the company to cover it up is a window into the effects of culture on organizational performance.

Richard Scrushy, the founder of HealthSouth, is an important factor in the culture that developed at HealthSouth. The culture was ruled by intimidation, fear, and arrogance. Scrushy was a micromanager who demanded that his employees report to him on virtually all aspects of the business. It was almost always deteriorated into an opportunity for Scrushy to identify someone's failure and publicly berate him or her. Interviews with associates of Scrushy, as well as a review of the litigation history of HealthSouth, paint a picture of an executive who ruled by top-down fear, threatened critics with reprisals, and paid loyal subordinates well (Abelson and Freudenheim 2003). For example, he would criticize staff about missed profit goals and would demand two-minute presentations from them, complete with numbers. Afterward (if he allowed them to sit down), he would berate them for the way they had presented the information. The toxic culture fostered an environment that allowed fraud, which almost shuttered the company and led to criminal convictions for most of the company's senior management.

Although organizational culture is an important factor in the functioning of any group, there is not a universally accepted definition. For our purposes, organizational culture is

> the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (Schein 1984, 3)

More simply, culture is often summed up as "the way we do things around here" (Lundy and Cowling 1996).

Culture creates the "background music" that directs employee decisions and delineates what is acceptable and unacceptable in a firm (King and Demarie 2014). Members of organizations tend to think and act similarly and seem to demonstrate distinct personalities that are rather persistent over time. For example, the HealthSouth culture during Scrushy's tenure did not allow for frank and open conversations with him regarding problems facing the company. Employees accepted the unwritten directives to hide bad news and never contradict the boss. Their actions were consistent over time, and only dismissal of most of the top managers altered the prevailing culture.

Components of Organizational Culture

Understanding and managing organizational culture are important skills for leaders. Competence in these skills includes knowing the answers to the following questions:

1. What makes up organizational culture?

(continued from previous page)

to finish), he would launch into hard-nosed questions and frequently utter the dreaded phrase, "That was the stupidest thing I ever heard" (Helyar 2003). This behavior was also exhibited toward physicians and others if they crossed him. He had no tolerance for criticism and responded quickly when he perceived a personal slight. After leading HealthSouth for 19 years, he had almost single-handedly molded the organizational culture into one of compliant, cowering, and excessively eager-to-please managers.

Scrushy felt a need to honor his name and donated heavily to schools and communities, which named facilities and programs after him. In addition, he built a small museum in Birmingham, Alabama, HealthSouth's headquarters, as a tribute to his hard work. It included the furniture he used when he founded HealthSouth and a life-sized statue of himself. He owned multiple mansions, airplanes, and boats; jewelry worth several million dollars; and property worth more than $22 million (Farrell 2004).

In 2009, his life changed dramatically when he was found guilty of fraud in a civil court, which ordered him to pay $2.9 billion in restitution and sent him to prison for almost seven years for his illegal activities. Today, he continues to blame many of his problems on those who reported to him and claims he is innocent. It is interesting to speculate how a healthy culture might have resulted in different decisions at HealthSouth.

2. How is it created?
3. How can it be maintained?
4. What causes it to change?

Organizational culture develops and is maintained through symbols, heroes, rituals and values (Hofstede, Hofstede, and Minkov 2010). Over time, organizational members develop similar values and beliefs, as they share similar experiences. Likewise, organizations tend to retain those employees who hold or develop similar values and act in similar ways.

Values, linked with organizational ethics and moral codes, form the core of culture and drive the norms for what actions are accepted and not accepted. Organizational values must direct the goals that should be pursued and the appropriate standards for behaviors and processes to achieve the goals. Strong, effective cultures exist when employees' actions are aligned with organizational values. When this alignment occurs, strong cultures create highly functioning companies and produce outstanding outcomes (Patnaik 2011).

Rituals and routines are collective social activities that reinforce organizational values by engendering active participation from organizational members. Rituals and routines consist of ordinary actions and protocols (e.g., coffee breaks, greetings, dress codes, conduct of meetings), as well as infrequent events (e.g., retirement ceremonies, office sports betting pools, retreats). Rituals help build social bonds among members, and to that end, many organizations have some type of initiation ritual and routine.

Values are also supported or damaged by the stories told in an organization. **Stories** describe the culture's values in action or demonstrate the violation of those values. For example, for many years, employees in one organization told the story of the day the chief financial officer hit a patient's husband during an argument and the story of the chief operating officer seen mowing his

lawn on a workday during a spate of financial cutbacks in the organization. Negative stories like these detract from expressed values. On the other hand, positive stories—such as one about a top leader stopping in a busy airport to help carry a young mother's luggage—reinforce a company's caring values.

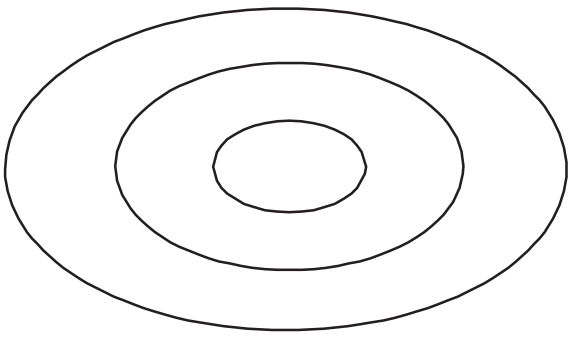
Storytelling has been recognized as an important vehicle for instilling values, as it can highlight examples of service and devotion. People remember stories more easily than written values or mission statements. Stories also carry more emotional context and can more significantly influence individuals. Organizational members who wish to be influential leaders, then, should learn to tell positive, constructive stories.

In addition, storytelling can be an effective means of promoting culture by differentiating between the organization and its competitors, conveying a sense of member identity, enabling a sense of commitment, shaping member attitudes and behaviors, and enhancing the stability of the organization (Brady and Haley 2013). Stories contribute to self-worth and self-knowledge and "weave the threads of social relationships" (Zipes 2012, 4).

Similarly, **symbols and structures** are meaningful to culture. Symbols include images, events, activities, or objects that help identify, characterize, or represent an entity, an idea, or a quality and are woven into the fabric of most organizations. Organizational symbols may include the type of clothing worn on-site, the size or physical layout of offices, the pictures or other images placed in the environment, or the nature of personal interactions that take place in it. They acquire meaning in organizations by their repeated connection to values, as viewed through the eyes of organizational members. Symbols often tell us much of what we understand about our own organization.

Structures can also reflect and influence culture. The choice of structure defines how people are divided, grouped, controlled, and coordinated. A company can choose a tall, hierarchical reporting structure that may have small spans of control and highly centralized decision making, or it can opt for a flat, decentralized reporting structure defined by large spans of control

EXHIBIT 10.1
Components of Organizational Culture



and more decentralized decision making.

All of these components of organizational structure, shown in exhibit 10.1, affect expectations and reporting requirements and may generate barriers to communication and productivity (see adjacent box).

Korean Culture Structures Stifle Productivity

The culture in Korea is very strong but detrimental to productivity. In fact, in 2014, Korea was named one of the worst places for worker productivity. Its culture influences how organizations are structured and how workers communicate and project busyness.

In Korea, corporate reporting structures are top-down and rigid. Organizations are structured much like military units, with authoritarian leadership that demands constant and often unnecessary reports to senior directors. Work teams are required to brief their department heads weekly, and if a director wants to know something—no matter its relevance—a team leader is forced to report on it. The constant cycle of impromptu reporting creates an environment with little strategic work and a lot of paper shuffling, firefighting, and endless audits and presentations.

Corporate communication in Korea is also affected by culture. Most workers feel pressured to eat and drink with each other and customers well past work hours. The socialization among groups leads to factions within companies, fueling suspicion, competition, and poor communication across teams and units. In addition, the availability of fast Internet and technology has eliminated much verbal conversation, as electronic messages prevail. One poll showed that more than 30 percent of employees regularly used work time for games, Internet surfing, texting, and phone calls.

The Korean culture also encourages people to look busy: "Being busy is the desired state and worn as a badge of honour." Therefore, Korean employees remain on-site beyond regular hours to give the impression of working hard, but they have some of the lowest productivity in the world. Staying late is a test of loyalty, social pressure, and performance. Actual work often slows to fill the expected overtime. This is how a culture can create visible forms and functions and still produce suboptimal outcomes.

Source: Adapted from Kocken (2014).

Cultural Differences

Comparing cultures can be difficult, but certain dimensions have been identified that allow an understanding of differences. Power distance, uncertainty avoidance, individualism versus collectivism, time orientation, and masculinity versus femininity are dimensions often used to examine country cultures but are also applicable to business cultures. These dimensions are defined as follows (Hofstede, Hofstede, and Minkov 2010):

- **Power distance**—the way power is distributed and the degree to which individuals accept the inequity of power distribution. Low power distance equates to high power distribution and equality. High power distance results in powerful bosses, leader-only problem resolution, and top-down direction. Asian countries, in general, are home to high–power distance companies.
- **Uncertainty avoidance**—the degree to which members feel uncomfortable in ambiguous and uncertain situations and take action to avoid them. Groups with high uncertainty avoidance tend to have inflexible codes of conduct and exhibit intolerance toward unorthodox behaviors and ideas.

- **Individualism versus collectivism**—the preference for personal gain (individualism) over benefits for the group (collectivism). Individualism exists in a loosely knit social framework in which responsibility is primarily to the self, whereas collectivism is seen in a tightly knit society whose members look after each other.
- **Time orientation**—the degree to which members are willing to defer satisfaction and focus on achieving long-term, rather than short-term, outcomes.
- **Masculinity versus femininity**—the preference for achievement, heroism, assertiveness, or material rewards (masculinity) over cooperation, modesty, caring, and quality of life (femininity).

The Hofstede Centre (2016) demonstrates an interesting application of these dimensions in comparing countries.

Cultural assessments are a tool many companies use to compare their culture with their mission and values. A gap analysis, which uncovers areas of organizational culture that do not align with organizational mission and values, can be conducted and action plans can be developed to rectify these problem areas. As discussed, cultures are complex, and changing a culture is a multidimensional process that may take many years to yield desired results. However, the effort is worthwhile, as organizations that achieve a compatible culture are more likely to meet the expectations set by their mission and values.

Leaders can ascertain the proper alignment with the following questions, posed in the form of a 1- to 5-point Likert-type scale, where 1 represents not at all and 5 represents all of the time (adapted from Osland et al. 2007):

- Can people in the organization easily identify its dominant values?
- Does the hiring process consistently select people who fit into the company culture?
- Do socialization and training occur for new employees to help them quickly understand the culture and values?
- Are employees who do not live the organizational values asked to leave?
- Are people rewarded for following the key organizational values?
- Do leaders and managers signal the desired values and norms by their behaviors and actions?
- Do managers measure and hold people accountable for key values?

Cultures must adapt and yet maintain alignment not only with an organization's values but also with its environment. Firms that do not adjust their cultures to new environmental challenges can falter. For example, in the late 1990s, Walmart and Circuit City were identified as having cultures that

allowed them to be market leaders and produce remarkable financial earnings (Cameron and Quinn 1999). However, by 2008, Circuit City had filed for bankruptcy, having failed to adapt to the new competitive environment ushered in by online shopping. As one analyst stated, "Circuit City was incredibly successful in the 1980s and 1990s, but they never changed after that" (Hamilton 2008). Likewise, Walmart's continued dependence on low-income employees and customers and its obsession with cutting costs have damaged its relationships with employees and its ability to keep its shelves stocked (Quednau 2015; Saporito 2013). Some observers now predict Walmart's failure (Hoium 2014) in the face of the prosperity of Costco, a major Walmart competitor (Lutz 2014).

Healthcare is now pressured to change on many fronts to improve, and numerous healthcare organizations are trying to make their cultures fit the new demands. Structural changes have not been, and will not be, adequate to achieve the improvements needed in healthcare; they must be coupled with appropriate cultural change. The many interconnections that define complexity in healthcare make these changes difficult, because healthcare contains both organizational and professional cultures, as discussed in chapter 1 (Prenestini 2013). However, studies have demonstrated, for example, that improving aspects of physicians' professional culture is more likely to produce positive, desired changes than offering physicians economic incentives to align with organizational culture (Janus 2014).

One transcendent effect of organizational culture is its impact on organizational justice through the perceived value of fairness. As discussed in chapter 4, distributive, procedural, and interactional justice make up organizational justice. Within a culture, members develop an understanding of what constitutes fairness. Note that fairness only exists in the context of culture. If power distance is high, mandates from higher authorities may be accepted as fair. This concept is evident in Asian cultures, where old age and high position are respected. In this type of structure, a leader's directive, even if arbitrary, may be accepted in the culture as fair and just and thus followed without hesitation. In cultures with lower power distance, the same action may be deemed unacceptable and unfair. Arbitrary decisions may be protested and resisted in these cultures. Leaders should understand the culture and make certain employees feel they are treated fairly, as employees who perceive the presence of organizational justice are happier and are more likely to remain at a firm. In an unjust organization, employees who do not quit often take more sick days and may even resort to workplace violence, theft, sabotage, or other counterproductive behaviors (Osland et al. 2007).

Companies may likewise see otherwise valuable employees as a poor fit for the culture and terminate them for cultural insensitivity, of which the employees may not even be aware. For example, the leading 2015 scorer in

the Korean Basketball League, American Davon Jefferson, was released from his contract two days after he was seen stretching while the Korean national anthem was played before a playoff game; all the other players were standing at strict attention (*Korea Times* 2015).

With cultures often having different perceptions of organizational justice, it is not surprising to learn that organizations frequently have serious problems merging employees from distinct firms and their contrasting cultures. Differing cultures account for more than 30 percent of failed mergers. Some of the mega-mergers that have failed as a result of dissimilar cultures include automakers Daimler and Chrysler, software companies Novell and WordPerfect, communication giants AOL and Time Warner, telecommunication firms Sprint and Nextel, and computer makers Hewlett Packard and Compaq (Jacobsen 2012). The following quotes from company leaders in these failed endeavors highlight some of the issues:

> I remember saying at a vital board meeting where we approved this, that life was going to be different going forward because they're very different cultures, but I have to tell you, I underestimated how different. It was beyond certainly my abilities to figure out how to blend the old media and the new media culture. (Arango 2010)

> The two sharply different cultures have resulted in clashes in everything from advertising strategy to cellphone technologies. (Hart 2007)

Companies that seek to merge should seriously consider their cultural differences and plan for integration teams to handle the task of reducing or eliminating culture clashes. Those firms that managed their cultural mergers well have succeeded, such as Toyota Motor Corporation and the General Motors plant in Fremont, California (Shook 2010).

Changing a Culture

Organizational leaders have a primary role in fostering a productive, vibrant culture in their company. As stated, cultures are embedded deeply in the fabric of organizations and are difficult to change. The change process can last years, but the formation and maintenance of a culture is an ongoing process.

Rather than seek to change cultural values, experienced change agents first change behaviors. Addressing culture change begins with defining "the things we want to do, establish the ways we want to behave and want others to behave, provide training and do what is necessary to reinforce those behaviors" (Shook 2010). As appropriate behaviors are adopted across and

up and down the organization, attitudes and values follow.

To be effective, leaders must be fully engaged and lead cultural change by example. Change comes to those areas that leaders consistently pay attention to, measure, allocate resources to, and control; what employees see as being constantly addressed communicates which values are really important. As the adjacent box shows, lip service—or telling employees what is important—is not sufficient.

Employees quickly recognize the actual values and the resultant expected behaviors by the criteria their bosses use for employee evaluations, the types of questions their leaders ask, the items placed on agendas, the emotions their leaders express in which settings, and the way crises are managed.

The US Department of Veterans Affairs (VA) has, for many years, sought to improve its culture but seems constantly battered by controversy and scandal (Pearson 2014). Many observers believe a negative culture exists in the organization, "with bad habits building up to create a bureaucratic mess unique in the federal government" (Brodey 2015). The solution to change this culture offered by the US Congress is to make firing employees easier than it was in the past. It is unclear whether this adjustment will positively shift the VA's work culture.

Stupid Boss + Stupid Employee

The CEO of a large personnel staffing company read a news article about how workers become unproductive if they do not balance family and work life. She was so impressed that she sent out a companywide e-mail along with an attachment that showed the equation

A stupid boss + A stupid employee = Overtime.

She then called a meeting to state that the organization's culture needed smart bosses and smart employees; to stress the importance of work-life balance; and to explain how this balance, or lack of it, directly affected efficiency at the workplace. Most employees came away from the meeting excited that the company was now publicly committed to recognizing that they had lives away from work and efforts needed to be made to change the company's culture to balance these sometimes conflicting demands.

However, a month later, staff were given the forms to use for their annual performance evaluations. They were surprised to see that two of the key criteria were "What time does the employee leave work?" and "On average, how many hours per day are worked?" The more hours and the longer days an employee worked, the higher the number of points given. These questions clearly conveyed what was important: not *what* you do but *how long* you stayed at work.

This seemed unfair and inconsistent with what the CEO had recently said. Therefore, in response, someone wrote on the anonymous company board: "If stupid boss + stupid employee = overtime, then why are we rewarding the stupid people?"

The CEO was, of course, upset about this message but could not verbally express her anger because it would directly contradict what she had previously communicated to staff. Instead, she called a meeting of all employees and made a passionate speech about the importance of sacrifice and how there was no room at the company for those who did not love to work and spend extra time at work.

So much for work-life balance. Staff began to wonder if "a stupid boss + any employee = turnover"—especially theirs.

Source: Story told to author by an associate.

That said, cultures can and do change. Numerous books have been written promoting cultural change processes by placing a focus on leaders to build and embed the appropriate values and beliefs in their organizations. Rather than firing "bad" employees, Schein (2010) suggested providing leaders with six primary and six secondary approaches to effect cultural change. Leaders can apply the following primary levers to directly affect their organizational culture:

- *Pay attention to, measure, and control those behaviors and outcomes important to change.* Leaders cannot focus on everything, so select the key indicators that signal the desired changes and then track, trend, monitor, and reward or discipline on the basis of these indicators.
- *React to critical incidents and crises with a view of how management's behavior will affect the culture.* Reacting with consistent, values-laden actions emphasizes and reinforces the desired cultural behaviors.
- *Allocate resources to the effort to enhance organizational change.* Give personnel the means and resources to motivate and drive the desired changes. Generate surveys and data that will help leaders understand the progress and perceptions of employees and other stakeholders.
- *Model, teach, and coach the desired behaviors and culture.* Know that the leader is the "barometer" of the organization, whom people watch to gauge how well things are going. Take time to teach and coach individuals, groups, and teams.
- *Allocate rewards and status to encourage cultural change.* Provide rewards—both monetary and intrinsic—to those who model the desired cultural behaviors.
- *Recruit, select, and promote employees who foster the desired culture and "excommunicate," or terminate, those who distract from it.* Establish hiring mechanisms that test for cultural fit of new employees. Also, be willing to act decisively and terminate employees who refuse to live the desired cultural values.

Schein's (2010) six secondary approaches, if applied meaningfully and appropriately, serve as mechanisms that assist in changing and embedding culture in an organization. These mechanisms do not necessarily require specific behaviors and actions by leaders; they do involve employee processes, stories, and statements that can effect cultural change. They include the following:

1. Design and structure of an organization
2. Systems and procedures used in an organization
3. Company's rites and rituals
4. Design of the physical space, facades, and buildings
5. Stories, legends, and myths told in the organization

6. Formal statements containing organizational philosophy, values, mission, and vision

Too often, leadership direction is not identified in cultural change, and organizations seem—culturally speaking—to randomly wander. To be effective, leaders must select those mechanisms and levers that encourage proper behavioral and cultural change. In this way, subordinates can identify with and adopt their organizational values and beliefs.

Chapter Summary

Organizational culture is a significant factor in the success or failure of a firm. It is composed of patterns of basic assumptions that groups make, as well as acceptable behaviors and actions. Over time, organizational members develop similar values and beliefs that form the core of their culture. Strong, effective cultures exist when employees' actions are aligned with their firm's values. Rituals and routines are collective social activities that reinforce organizational values and culture. In addition, the stories that organizations generate and the symbols they create can instill values.

Cultures can be classified into the dimensions of power distance, uncertainty avoidance, individualism versus collectivism, time orientation, and masculinity versus femininity. These factors can provide a means to compare organizations as large as countries or as small as groups.

Cultural assessments can be conducted on organizations to ascertain areas that align and do not align with the desired organizational mission and values. Changing a culture to the ideal model takes time and is very difficult to achieve. Companies that do not adapt their cultures to new environments or operational climates are especially prone to failure. Healthcare faces many pressures today that require a realignment of many organizations' culture.

An important aspect of a healthy culture is the presence of organizational justice. Companies that promote distributive, procedural, and interactional justice embed the concept of fairness, which leads to a positive culture. Employees who feel fairly treated are more likely to remain at the organization, take fewer sick days, and act appropriately.

Differing organizational cultures also account for the failure of many mergers. An estimated 30 or more high-profile failed mergers directly resulted from cultural differences. Companies seeking to merge should seriously consider potential cultural clashes and design means to integrate the different cultures.

Leaders have a primary role in improving their organization's culture, which is a continuous, complex process. Defining appropriate, healthy behaviors can be an important step in beginning to change a culture. Leaders also must

Chapter Case

A Culture of Violence

Eastern Medical Center (EMC) struggled with its quality indicators, consistently ranking in the bottom quartile of its corporation's quality measures. A number of interventions—training, motivational talks by respected authorities, and financial incentives—were offered. A consulting firm, brought in to work with the quality improvement employees, noted that the organization's culture did not support quality. However, the consultants' proposed interventions were too expensive to implement, far exceeding the medical center's budget, so nothing more was done. As expected, no change occurred in the dismal quality outcomes.

The CEO was frustrated. He gave a vocal saying that people should "man up" and deal directly with problems. One year after the consulting firm's visit, the CEO took his own advice and fired the chief nursing officer

demonstrate new behaviors by example and use both primary and secondary mechanisms to motivate change.

Chapter Questions

1. What happens to an organization's culture if the actions of its leaders differ from their expressed, written values and mission?
2. How do behaviors reflect an organizational culture?
3. How do values interact with an organization's culture?
4. How can positive storytelling help a culture?
5. How do uniforms serve as symbols?
6. Why does the acceptable power distance vary across different cultures?
7. What would a cultural assessment gap analysis contain?
8. Provide an example of a firm whose culture may have contributed to its deteriorating market position, as its environment changed but its culture did not adjust to match the new environment.
9. Many academic medical centers have merged with community not-for-profit hospitals and struggled to combine their workforces. Think of three ways the cultures of these two types of organizations might differ.
10. What is the difference between the primary and secondary mechanisms that Schein (2010) suggested?

(CNO) and quality leader. After a national search, a new CNO and quality leader were hired. The CEO had great expectations, and during the first six months after the new employees' arrival, the quality indicators did record a small increase. However, beginning in the seventh month, the indicators fell back to the previous year's levels. As a result, the EMC board met and fired the CEO.

Sally was hired three months later as the new CEO. The board stressed that changing the medical center's culture was a top priority. Sally had previous experience in organizational development and felt she had the right skills to create a healthy culture at EMC. She also recognized the challenge and difficulty in changing a culture.

After only three weeks, an incident occurred that left Sally wondering what to do and made her realize just how damaging EMC's culture was. She was visiting the medical imaging department when an overhead page called her "stat" to the operating room (OR). This was the first time in her career that she had been paged "stat" in a hospital. She quickly walked to the OR to see what the urgent call was about.

Steve, the OR director, met her at the entrance and escorted her into his office. He explained that a few minutes earlier, an orthopedic surgeon had become enraged at one of the circulating nurses in an operating suite. The surgeon swore at the nurse, and when the nurse did not move fast enough, the surgeon threw a scalpel at her and threatened her with another. The nurse was now out of the room and out of danger, and the surgeon was expected to finish the procedure in about 15 minutes. Steve was angry and wanted to know what Sally was going to do about the situation.

Sally quickly called her assistant and found out that this surgeon was known to have a bad temper and to frequently berate employees and create problems. One time, he was not happy with what had been dictated in the nursing notes for one of his patients, so he tore out the notes, crumpled them up, and threw them in the trash. He also was consistently behind in his dictation, and his Medicare billings were always months late. However, he was the third-highest revenue producer in the hospital, friends with many of the EMC board members, and considered "untouchable."

Sally felt strongly that she had to address the issue, but she had a couple of decisions to make. First, should she confront the surgeon when he finished the procedure? If so, what should she say? Should she inform the medical staff and use their disciplinary procedures?

(continued)

(continued from previous page)

She also wondered whether allowing this type of behavior had directly affected the inability of the previous leadership to change EMC's culture and quality outcomes.

Sally met with the surgeon after he finished the procedure and asked him what had happened. The doctor explained his anger toward the nurse and said he inadvertently let a scalpel slip out of his hand, which landed close to the nurse. He did not intend to hit her; he just wanted to get her to act more efficiently, he said. Prior to the meeting, Sally had called the chief medical officer and asked him to investigate the case. Sally informed the surgeon that such behavior was not appropriate and that the medical staff would be investigating the incident and making disciplinary recommendations.

The surgeon was shocked. How could they do this to him? He stressed that he was his patients' advocate and was only trying to get better care for them. This type of public scrutiny would embarrass him, he said. "Maybe," he threatened, "I should take my practice to one of the other hospitals in town." Sally calmly reassured the surgeon that he was appreciated but said he could not yell, use vulgar language, or threaten the employees.

The medical staff recommended a six-month probationary period for the surgeon, along with anger management training. Any further incident would result in his full suspension from the EMC medical staff. Perhaps not surprisingly, not only did his behavior improve, but so did that of many other physicians who practiced at EMC. Soon after, the quality indicators began to rise.

Case Questions

1. How does the manner in which physicians are treated in a healthcare organization reflect the organization's culture?
2. In this situation, what could Sally do to actively change the culture?
3. How do cultures become dangerous, as in this case?

Chapter Activities

1. Read the Center for Creative Leadership's (2014) GLOBE study at www.ccl.org/leadership/pdf/assessments/globestudy.pdf. Select three countries and write a two- to three-page paper on how their cultural perspectives toward leadership differ.

2. Think of a story you told someone about being tailgated, cut off, or otherwise disrespected while you were driving. Answer the following questions about this event:
   a. When you related the story, what emotions did you feel?
   b. Did you make any facial expressions when telling your story? If so, what emotions did they portray, and how did they affect your story?
   c. How did you start and end your story? What did you want to accomplish by telling the story?
   d. How did the person you told the story to respond? Note any facial expressions, body language, nonverbal cues, or verbal responses of the person.
   e. Would you describe your story as memorable? Would the person you told it to agree?

   After completing this exercise, will you tell stories differently? What will you now pay attention to or emphasize in your stories? Consider assessing some of the key aspects of storytelling, such as voice, body language, descriptions, and timing.

Source: Activity adapted from Leadership Paradigms (2009).

11

DEVELOPING EMPLOYEES THROUGH MENTORING, COACHING, AND DELEGATION

Learning Objectives

After studying this chapter, readers should be able to

- differentiate between coaching and mentoring,
- appraise the value and importance of coaching and mentoring,
- perceive the different types of coaching,
- apply the concept of delegation to improve organizational decision making,
- distinguish between responsibility and authority, and
- conceive the different levels of delegation and the best time to apply them.

Key Terms

- Coaching
- Content coaching
- Delegation
- Feedback coaching
- Gofer delegation
- In-depth development coaching
- Mentoring
- Stewardship delegation

Leadership development remains a significant challenge in today's healthcare environment. Around the world, healthcare systems are changing and requiring new and complex skills to successfully lead. In addition, as healthcare leaders age, the new generation must be prepared to manage in this difficult environment. This chapter deals with two important leadership development mechanisms: (1) mentoring and coaching and (2) delegation.

Mentoring and Coaching

Mentoring and coaching are important means to empower employees and increase the skills and abilities of healthcare managers. Efforts to develop

healthcare leaders increase the caliber and quality of personnel, reduce turnover, and focus the organization on its strategic priorities (McAlearney 2008). Greater complexity and increased stakeholder demands require better leaders prepared in new and creative ways. Development of leadership skills often involves an array of activities, including coaching and mentoring (Berriman 2007). Effective leadership development often engages existing and prospective leaders in programs that integrate training, coaching, and mentoring.

The terms *coaching* and *mentoring* are frequently used synonymously. The concepts are closely related but differ in their temporal dimensions. **Coaching** tends to focus mostly on the transfer or improvement of definite skills over a short period, whereas **mentoring** involves long-term employee growth and nurturing to improve leadership capabilities (Schraeder and Jordan 2011). Coaching primarily aims to help people work out solutions for specific problems and "to think clearly about the . . . actions needed to address specific practical issues, and understand the unconscious processes that may be sabotaging their success"; mentoring, on the other hand, emphasizes sharing experience, advice, and wisdom for "the development of the learner [and thus] is personalized and domain-specific" (Stout-Rostron 2014, 53).

Coaching and mentoring are critical tools for developing leaders, as the importance of leaders' roles in the development process has increased dramatically in recent years (Putre 2013). Coaching and mentoring's great value lies in a person's capacity to take class-based, theoretical training; translate the training directly into actual leadership behaviors; and bridge the gap between training and practice in the workplace (Taie 2011). Coaching and mentoring can fully engage new executives to complete the knowledge transfer that workshops and seminars begin, as described by Stevens and Frazer (2005, 8–9):

> Coaching [and mentoring serve] a mission-critical role for learners—transferring skills from the learning experience to regular workplace practice. The purpose of coaching is to provide higher level direction or fine-tuning that enables the learner to extend the general learning of process and procedure to those idiosyncratic performance settings of the workplace.

Effective coaching and mentoring become a natural complement to training and leadership development programs and are especially critical in new executives' first years (Curran and Totten 2010). Thus, successful coaching and mentoring should be part of an organization's leadership development program. Mentoring strongly facilitates leadership development efforts (Bawany 2014).

The ability of organizations to buck predicted turnover trends in healthcare also necessitates better use of coaching and mentoring. The CEO position in the healthcare industry—especially in hospitals—presently experiences constant, chronic turnover of 14 to 20 percent. The retirement of up to 75 percent of CEOs is predicted in the next ten years (*Managed Care Outlook*

2014). This turnover will require greater vigilance in identifying and developing future leaders.

In addition, with generation Xers' and millennials' tendency to change jobs more frequently than did the baby boomers they are replacing, turnover rates may increase further. Santamour (2011) suggests that the upcoming C-suite generation needs

> coaching . . . preferably a formalized process that uses professional coaches to achieve specific, measurable outcomes, [to hold] both coach and student accountable and [focus] not only on organizational goals, but also on personal development.

A coach's focus is not to provide solutions or address business problems, as might be the aim of a consultant, but to ask penetrating questions to challenge the person being coached, open her up to insights, and shift her awareness and perspective so that she can think differently (Koonce 2010). A coach might be employed by the company, whose employees he coaches, or be independent from an organization. Firms often tap their senior executives to coach and mentor junior, prospective leaders.

Coaching has been identified internationally as a critical way to prepare leaders. Many independent, professional executive coaches are in practice today, and a large number of professional associations represent and certify executive coaches. Some of these organizations are listed in exhibit 11.1.

Executive coaching has become a prevalent strategy in most industries to improve leadership performance (Schraeder and Jordan 2011). However, coaching remains underutilized in healthcare organizations, and much needs to be done to appropriately and effectively use coaching and mentoring programs (Henochowicz and Hetherington 2006; Sloan and Fralicx 2011).

EXHIBIT 11.1
Professional Associations for Coaching

Association for Coaching: www.associationforcoaching.com/home/index.htm

Association for Professional Executive Coaching and Supervision: www.apecs.org

Association of Coach Training Organizations: www.actoonline.org

Association of Corporate Executive Coaches: http://acec-website.org

Christian Coaches Network International: www.christiancoaches.com

International Accreditation Body for Coaching & Mentoring: www.iicandm.org

International Association of Coaching: www.certifiedcoach.org

International Coach Federation: www.coachfederation.org

International Coaching Community: www.internationalcoachingcommunity.com

Worldwide Association of Business Coaches: www.wabccoaches.com

Coaching is typically divided into three main areas (Thach and Heinselman 1999):

1. **Feedback coaching** helps leaders create an individualized development program and generally includes a 360-degree assessment with interpretation and feedback.
2. **In-depth development coaching** extends feedback to include continued consultation and assistance, which is a popular strategy for improving employee performance (Schraeder and Jordan 2011).
3. **Content coaching** narrows the focus to a specific knowledge area and skill set and often involves an assessment of current competencies and the development of activities to improve the competencies to a desired level.

Mentoring, on the other hand, assists in socializing new or junior members in an organization. Studies show that those who receive mentoring are more likely to obtain promotions, higher salaries, and greater job satisfaction than those who do not (Lester et al. 2011). Female healthcare executives are more likely to become CEOs if they received mentoring (Sexton, Lemak, and Wainio 2014). Furthermore, integrating coaching and mentoring with leadership development has assisted the positive transformation of hospitals' cultures by increasing innovation and improving leadership competencies (Hicks and McCracken 2013).

Mentoring should accomplish the following objectives (Osland et al. 2007):

- Prepare and sponsor the candidate for promotions and advancements
- Increase the candidate's visibility and exposure to upper management
- Render advice on how the candidate can accomplish career goals
- Protect the candidate from potentially harmful situations
- Allow the candidate to obtain more challenging, career-developing assignments than he might have encountered thus far

Although mentoring continues to be used in many settings, programs without clear guidelines and direction often fizzle out. Established ground rules greatly assist in the successful application of mentoring functions. First, the involved parties should become acquainted both personally and professionally. Understanding their work styles, personalities, and personal backgrounds can build confidence and trust in each other, which facilitates the value of mentoring. Second, ground rules should determine the following:

- When to meet
- How often to meet

- How to communicate outside the scheduled meetings
- What topics to cover in each meeting

Some participants in the mentoring process have found that even scheduling a year's worth of mentoring meetings is valuable (White 2007).

Both coaching and mentoring provide psychosocial support for junior managers by exposing them to role models whom they can imitate. In addition, positive coaching and mentoring provide mutual support and encouragement that validate efforts and achievements.

Furthermore, counseling for personal and professional problems can be provided that assists in promoting self-esteem and self-image. Finally, long-lasting friendships can develop that span decades and careers (Osland et al. 2007).

Delegation

A critical element in the ability to empower and develop subordinates is **delegation**. Delegation is a tool that, if mastered, can motivate employees and increase the productivity of an organization.

Effective delegation allocates and shares responsibilities to increase productivity and empower employees. Good delegators direct their focus and energy to sharing high-leverage activities that only they can do. In the process, subordinates are provided opportunities to be challenged and to grow, while superiors gain free time to pursue critical activities. "Effective delegation is perhaps the best indicator of effective management simply because it is so basic to both personal and organizational growth" (Covey 2004).

Appropriate delegation imbues jobs with meaning, which is significant because "Americans have consistently identified meaningful work as the most important feature they seek out in a job, ahead of income, job security, promotions, and hours" (Cascio 2003).

If delegation provides so many benefits, why do so many fail to delegate appropriately? Some common reasons include the following (Park Scholarships 2015):

- *I lack the time needed to delegate and monitor work assigned*. Delegating takes too much time.
- *I will lose control*. I will be unable to adequately influence the task.
- *I will not get credit*. If my subordinates do the work, they might get credit for the results.
- *I will lose tasks I enjoy performing*. I find many of the tasks that can be delegated to be enjoyable.

- *I can do the work better*. I am certain I can obtain better results than my subordinate can.
- *I might delegate myself out of a job*. If I delegate, my work might not need me.
- *I have no confidence or trust in subordinates*. I lack faith and trust in my subordinates' abilities and motivation.

A common dictionary definition of delegation notes that it involves "the act of empowering to act for another" (Merriam-Webster 2015b). However, in nursing (for example), parameters must be added for the definition to be descriptive. Delegation in the nursing context is defined as "transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains the accountability for the delegation" (LaCharity, Kumagai, and Bartz 2014). The importance of competence and accountability is highlighted here. For our purposes, delegation is the act of authorizing another to perform a task or duty and, in doing so, allocates and shares responsibilities to increase productivity and empowerment.

Some who have considered delegation believe it entails a loss of control (Shin and Strausz 2014). However, when executed well, delegation establishes better controls. Furthermore, as stated, a key principle of delegation is that, no matter the task delegated, accountability remains with the supervisor.

The four key concepts related to delegation are as follows:

1. Responsibility
2. Authority
3. Accountability
4. Trust

Responsibility always ultimately resides with the supervisor. Jobs and work can be delegated, but responsibility for a task always comes back to the supervisor who delegated it. Therefore, it is imperative to monitor delegated activities to ensure proper outcomes are achieved.

Note that the supervisor's responsibility for the delegated task does not remove the subordinate's accountability for the processes, activities, and results. (Accountability is addressed in detail a bit later.) Furthermore, accountability for results is key: If subordinates feel they are judged on movement and process alone, they might move rapidly and give the appearance of activity but not accomplish what is important.

Authority must be given to the individual entrusted with the task. In fact, having authority is necessary for the delegated task's completion. Delegation does not imply the surrender of overall authority but rather the transfer of the authority needed for task completion.

No Trust, No Delegation

I once served as an executive consultant in a large medical center working with the CEO. The medical center had almost 1,000 beds and employed nearly 9,000 people. The CEO was exhausted. He had been working six to seven days a week for more than two years, often beginning his day at 6:00 a.m. and finishing after 10:00 p.m. He had asked me to help him become more productive.

I was able to quickly diagnose many of the CEO's problems. Although more than 20 employees reported to him, he was reluctant to delegate even the simplest tasks. We reviewed a long list of decisions that he had to approve and sign. These included vacation requests, changes in marital status, expenditures greater than $5,000, pay increases, and many others. Frequently, at 6:00 or 7:00 p.m., when others had gone home, he and his administrative assistant were still in the office signing documents. One evening, he proudly showed me his desk, which had three 6-inch piles of papers awaiting his review.

When I presented my analysis and suggested solutions for his lack of productivity, he demurred to my opinion that he had centralized far too many decisions and needed to delegate some to his subordinates. Rather than review the detailed report I had prepared for him, he stated that he could not see how he could delegate to those reporting to him as he "DID NOT TRUST THEM!" Now, that raised another issue. . . .

Accountability is an essential part of delegation and ties back to responsibility. The person receiving the delegation must understand the outcomes the supervisor seeks and the level of periodic reporting that must occur. Regular feedback is crucial. Delegation still requires supervision, and the ability to offer timely, periodic assessments assists in successful delegation.

Overtime, *trust* becomes the foundation of delegation. If a boss does not trust his subordinates, he will delegate few assignments. Successful delegation builds trust, which then allows greater delegation and growth.

Delegation may take up more of the supervisor's time at the start. Some people use this expectation as an excuse to avoid delegating tasks and often say they could do the job faster than they could explain it. However, as with the CEO in the box above, the boss soon accumulates too many tasks to complete on his own and then has even less time to begin delegating.

Others claim that delegated tasks often do not get done correctly and thus must be redone. Again, delegating does take more time. However, as Covey (1992, 237) stated, supervisors who refuse to delegate

> end up leading harassed lives, putting in fourteen-hour days, neglecting their families and their health, and undermining the vitality of the entire organization. . . . Time spent delegating in the long run, is our greatest time saved.

Levels of Delegation

Delegation has been categorized in different ways. Covey (2004) suggested two basic kinds: gofer delegation and stewardship delegation. **Gofer delegation** is a cute term that signifies the delegation of specific, detailed actions—such as "go for" this and "go for" that—to a person or team who, after completing

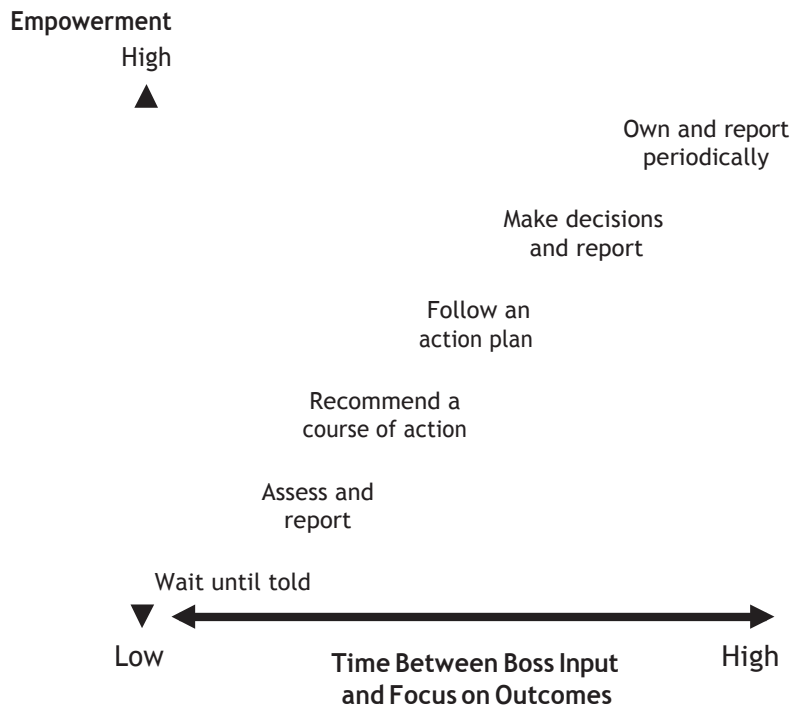
the tasks, must immediately return, report, and then wait for another assignment. As can be imagined, gofer delegation requires a lot of direct, one-on-one supervision and a small span of control.

Stewardship delegation, on the other hand, is focused on outcomes instead of processes. It empowers people or teams to choose how they will complete their assigned activities and be responsible for results.

Gofer and stewardship delegation involve different levels of empowerment, different frequencies (or times) of required reporting back to the boss, and different focuses on outcomes. Even within stewardship delegation, the degree of these factors may vary. As displayed in exhibit 11.2, the levels of delegation—from lowest to highest—include (1) wait until told, (2) assess and report, (3) recommend a course of action, (4) follow an action plan, (5) make decisions and report, and (6) own and report periodically.

1. *Wait until told*. This is the best example of gofer delegation. It involves very little empowerment and no growth potential. The leader simply tells a person or team what to do. The individual or team rushes off, completes the task, and then waits for the next command. This is the lowest level of delegation and, often, the most common in many organizations. The advantage lies in that it is quick, efficient, and

EXHIBIT 11.2
Levels of Delegation by Empowerment, Reporting Time, and Focus on Outcomes



effective in the short term. However, across time it is very ineffective and wastes time, in part because the subordinates learn dependence and lose initiative.

2. *Assess and report*. People are told what to evaluate and to report their findings so that their boss can tell them what to do next. This type of delegation is a form of gofer delegation, but it provides a very small amount of responsibility to the subordinates. Little growth and development is seen with this form of delegation. However, a slight increase in productivity may occur, as the person or team evaluates issues. That said, the leader performs the thinking and takes responsibility for the next steps.
3. *Recommend a course of action*. This is the first level that begins to approach stewardship delegation. Responsibility becomes more shared in that subordinates are expected to evaluate an issue and recommend a course of action, although they must still obtain approval before initiating the solution. The responsibility for determining and suggesting a plan of action has been transferred to the person or team that will carry it out. Both parties can learn and grow at this level of delegation; the leader grows because she needs to take a supporting role to develop the subordinates. This may be an early leadership development activity that allows the leader to learn to trust her thinking and decision making. As her self-trust grows, she can move to higher levels of stewardship delegation, as can her subordinates.
4. *Follow an action plan*. The leader and subordinate agree on an overall plan of action and the subordinate carries it out. At this level, the person or team has limited authority to make decisions and take action across the general action plan. Once the assignment is completed, the subordinate notifies the leader and the action plan is renewed.
5. *Make decisions and report*. This level comes close to full stewardship delegation, as most responsibility has been transferred to the subordinate. The person or team now has an area of responsibility to oversee and provides updates to the leader relatively frequently.
6. *Own and report periodically*. This level represents full stewardship delegation in that responsibility has been transferred in its entirety. The subordinate owns the area, figuratively speaking, and has accountability for the outcomes it produces. These outcomes are reported to the superior at predetermined intervals, such as monthly or quarterly. The leader has trust in the decisions of his subordinate.

Managerial Key Points Regarding Delegation

The ability to delegate depends on the level of trust between the superior and subordinate. In a new relationship, where trust may not exist, it may be best

to start delegation at the "recommend" or "follow an action plan" level. This course allows time for the leader and subordinate to gain experience with each other and to learn to trust in each other. The subordinate can be engaged in the thought process and learn from the leader. As trust builds over time, the leader can transfer increasing levels of delegation to the subordinate.

Beware of Micromanaging

Micromanaging is the worst form of gofer delegation. Micromanagers display a lack of trust, by constantly asking the status of tasks, and an extreme focus on details of the process rather than on outcomes. It also takes an inordinate amount of both the leader's and the subordinate's time, causing inefficiencies for both.

Communicate Clearly When Delegating

One of my earliest bosses consistently counseled me that it is "not good enough to be understood, but to communicate well enough that others could not misunderstand you." This is especially true for communicating when delegating.

The lack of clarity is a main issue in dysfunctional delegation. Often, the objective and level of delegation are muddled (Lipman 2013). Called "dump-and-run" delegation, as described in the box opposite, a boss hurriedly passes off an assignment without clearly defining the expectations, scope, deadlines, or parameters of authority. The subordinate is left solely responsible for completing the assignment, receiving no support or guidelines.

Consider Following the Ten Steps to Effective Delegation

Many of the steps listed here are similar to those for goal setting discussed in chapter 5. Much like for goals, the level and extent of delegation need to be clearly defined and appropriate processes must be established to coordinate efforts between the leader and the subordinate. As noted by Pearce (2006), the delegation steps are as follows:

1. *Decide what to delegate.* Determine what work others should take on to make your time more effective and to help develop the person receiving the work.
2. *Be clear about the details.* Specify what task is being delegated and what steps are involved.
3. *Decide whom to delegate to.* Determine (a) who is ready, with the appropriate skills, competencies, and motivation for the task or (b) who needs the challenge and will develop the required skills. If additional skills or competencies are needed, make certain the means to obtain them is established.
4. *Inform other team members.* Let colleagues know which tasks have been delegated.

5. *Decide how to brief subordinates*. Use either written or verbal detailed descriptions of the delegation, depending on the situation.
6. *Decide how to guide and develop*. Determine the interaction and training necessary for development.
7. *Assign responsibility and authority*. Delegate sufficient authority for the subordinate to accomplish the task. If possible, delegate tasks that can be self-contained and thus are more likely to be successfully completed.
8. *Monitor performance*. Establish appropriate and clear monitoring measures and timing expectations. These metrics may change across the task, with more frequent monitoring initially.
9. *Give feedback*. Provide regular feedback on performance.
10. *Evaluate the experience*. Periodically examine how successful your delegation has been. Decide with your subordinates what went right and what went wrong.

Dump-and-Run Delegation

Your boss calls to tell you, "I need a quick competitor analysis of surgical centers in the United States." You can tell she is at the airport and has only a few minutes before she boards a plane. She swiftly assigns the task to you and Fred, your coworker, but makes it clear that this is a high priority for her boss, the company's CEO. She concludes by expressing her trust that you will complete the task successfully.

You are taken by surprise by the call and assignment, and the urgency and impatience in your boss's voice concern you. What did she really mean? Are you to prepare a one-page summary, a PowerPoint presentation, a 20-page report? And what is the analysis about? Revenue potential? Earnings? Market share? Advertising? You are also not certain who is in charge of the project—Fred or you. In addition, what does "quick" mean? It is required by tomorrow? Next week? In a month?

You remember a previous time when your boss called you at 8:00 a.m. the day after delegating a similar task to you, demanding to know where the analysis was. She was irritated that it wasn't finished because she was going into a meeting with the CEO in 10 minutes. With that experience in mind, you decide to stay late tonight to finish the analysis, just in case. You inform Fred of the assignment but tell him you will handle all of it, even if it takes all night.

Successful delegation comes from practice and experience. Be willing to reflect on your behaviors in terms of what level of delegation you provide and receive. As a boss, seek to build trust concurrent with increasing stewardship delegation. As a subordinate, constantly construct trust by meeting and exceeding expectations, and talk to your boss about taking more stewardship responsibilities.

Chapter Summary

Mentoring, coaching, and delegation provide valuable tools to develop healthcare leaders. The processes assist in training and empowering employees to

cultivate leadership skills and build their confidence. Although the terms *coaching* and *mentoring* are often used synonymously, coaching generally involves short-term support and skill transfer whereas mentoring is characterized by long-term relationships geared toward growing and nurturing leadership capabilities. The wide popularity of executive coaching today is demonstrated by the many professional executive coaching organizations. Three types of coaching are mentioned in this chapter: (1) feedback coaching, (2) in-depth development coaching, and (3) content coaching.

Mentoring can greatly assist in socializing new and junior members of an organization. Research shows that those mentored are more likely to receive promotions and enjoy job satisfaction than staff who are not mentored. Mentoring and coaching can also have a positive impact on transforming a hospital's culture. To be successful, a mentoring program must establish goals and ground rules.

Delegation needs to be appropriately practiced to empower and develop subordinates, as well as to motivate and increase employee productivity. Delegation encompasses (1) responsibility, (2) authority, (3) accountability, and (4) trust. Even though the ultimate responsibility resides with the supervisor, employees should be delegated specific areas of responsibility to achieve results and not just carry out processes and actions. Authority, accountability, and trust are likewise essential for successful delegation. If any of these are lacking, the delegation will be ineffective and both superior and subordinate will become frustrated. Effective delegation may take more time up front to establish, but once functioning, it will free time for the supervisor to execute more important tasks.

The different levels of delegation can be classified into gofer delegation and stewardship delegation. Gofer delegation involves employees carrying out detailed directions and waiting for the next assignment. Stewardship delegation frees employees to think, generate ideas, and implement solutions.

The ability to delegate depends greatly on the level of trust that exists between the supervisor and subordinate. This trusting relationship takes time and effort to develop. Good delegation also requires clear communication and comes from practice and experience.

Chapter Questions

1. What are the major differences between mentoring and coaching?
2. How can coaching be different from having a consultant assist a healthcare leader?
3. Visit the website of one of the professional coaching organizations listed in exhibit 11.1 and describe the services it provides to its members.

4. How might mentoring increase an employee's job satisfaction?
5. What guidelines could be established for mentoring?
6. Are there times when delegation should not occur?
7. How does delegation help establish trust?
8. What is positive and negative about gofer delegation?
9. What is micromanagement, and why is it destructive?

Chapter Cases

Take-Care-of-It Delegation

Early in my career as a 26-year-old assistant administrator at a hospital, I was on administrative call for the weekend. Our hospital provided the only obstetric service for the county, and its three anesthesiologists and five certified registered nurse anesthetists took turns providing call coverage for the hospital. At that time, I was unaware that one of the anesthesiologists was abusing drugs and often would inform his colleagues that he was "sick" when he was scheduled to provide call coverage.

The weekend I was on administrative call, it was the drug-abusing anesthesiologist's turn to provide anesthesia call coverage. However, early that Saturday afternoon, he reported that he was unable to cover the hospital and one of his partners would have to do so instead.

His partners had all left town. Not one was available. The nursing shift supervisor was worried about having no anesthesia coverage for the hospital, which could have serious medical and legal implications. When I received her call, I became alarmed and wondered what to do. I called the hospital CEO, explained the situation, and asked for his advice.

The CEO was a direct and trusting person who believed in delegating and having me take responsibility for my duties. He listened intently, and when I was done talking he said, "Fix it. Let me know Monday what you did." Then he hung up.

Despite feeling stressed by the situation, I did find a solution and was able to arrange for an anesthesiologist from another hospital to cover the weekend. I promised him whatever compensation it took for him to cover the call duty.

On Monday morning, I reported to the CEO what actions I had taken, and he thanked me for my efforts. He complimented what I did and did not criticize the amount I paid the other doctor to cover call.

Looking back, I see this as a significant learning experience in my career that taught me the importance of proper delegation. I never went to the CEO without a solution to a problem and frequently solved issues

(continued)

(continued from previous page)

without his input. I grew more confident, and both of us became much more productive.

Case Questions

1. How did the CEO's actions involve both mentoring and delegation?
2. What did I learn from the way the CEO handled my call?
3. What else could the CEO have done to emphasize stewardship delegation?

When Are We Going to Lunch?

The CEO of a large health system with more than 9,000 employees, 20 of whom reported to her, liked to be involved in decisions, even if they were trivial. In fact, often she put off making a big decision because she was too busy making small ones. Effectively, she was a great "firefighter," resolving crises daily, but was a very poor leader, as she refused to delegate much to her managers.

The effort to get approval for many activities was excessive, as the CEO required a paper trail and expected to sign off on even the most trivial decisions in writing. For example, during a strategic planning effort, the organization had brought in two prominent international consultants. Combined, they were being paid in excess of $10,000 per day. At noon on the first day of their visit, the director of strategy asked if they would like to join him for lunch in the organization's premier dining room. The director, however, had forgotten to obtain the CEO's approval for this expenditure, which was about $15 per person, and he was unable to take the consultants to the dining area without written approval. The director apologized and asked the consultants to sit in his office until he could get the approval. The two consultants sat, wondering whether they were going to eat that day. About 45 minutes later, the approval form was finally signed and the three left for a late lunch.

Case Questions

1. Why do people like this CEO desire to be involved in trivial decisions?
2. What are the consequences when a boss spends most of her time on nonstrategic decisions?
3. What could the director of strategy do to assist his boss in focusing on more strategic issues?

I Thought We Already Made That Decision

By Britt Berrett

It can be said that if the CEO must make all the decisions, then no one makes decisions. At one organization, it had been the previous CEO's custom to analyze and critique every decision. Rather than support important decisions made by his subordinates, the CEO insisted that proposals were to be submitted, reviewed, modified, and authorized only by him.

The benefit of this practice was that the CEO owned each decision. The problem was that members of the executive team refrained from making decisions themselves.

This state of affairs was challenged when a talented vice president (VP) needed to upgrade the Gamma Knife equipment in the imaging department. The department could either upgrade the existing equipment for a nominal expense or replace it at a significant cost. Both options had benefits, including increased capability and improved operational performance. The intricacies of the decision required insights and opinions at the operational level, well outside the expertise of the CEO.

The VP presented the issues and awaited the CEO's decision. His response? "It's your call. I will support your decision."

This unexpected answer called for a new process. Returning to his office, the VP struggled to make the decision—upgrade or replace—because he assumed that eventually the CEO would tell him what to do. Regrettably, he could not accept that he owned the decision.

The VP forwarded several additional reports to the CEO and awaited a written directive. The decision about the Gamma Knife languished for months. Finally, the VP returned to the CEO's office to request that a decision be made. The CEO, attending to other issues, looked up and said, "I thought we already made that decision."

It was a turning point in the dynamic of the executive team. The team finally recognized that the CEO was starting to delegate operational-level decision making with unquestioning support.

Case Questions

1. Why was the VP reluctant to make the final decision, even though he was told to do so?
2. How could the delegation have been more clearly defined?
3. What do you think the CEO and VP should have done to clarify the delegation issue?

Chapter Activity

Take the delegation quiz at www.thefreestyleentrepreneur.com/business-management/do-you-delegate-take-this-self-quiz/ (Ingrisano 2011). How good are your delegation skills?

12

PERFORMANCE MANAGEMENT

Learning Objectives

After studying this chapter, readers should be able to

- appraise the value of performance management;
- recognize tools to chart performance management, including key performance indicators, Gantt charts, and balanced scorecards;
- analyze numerical rating systems, and understand the difficulties with implementing forced distributions and stacked or forced ranking systems;
- evaluate the concept of a 360-degree feedback appraisal system and its challenges; and
- apply a competency-based appraisal system.

Key Terms

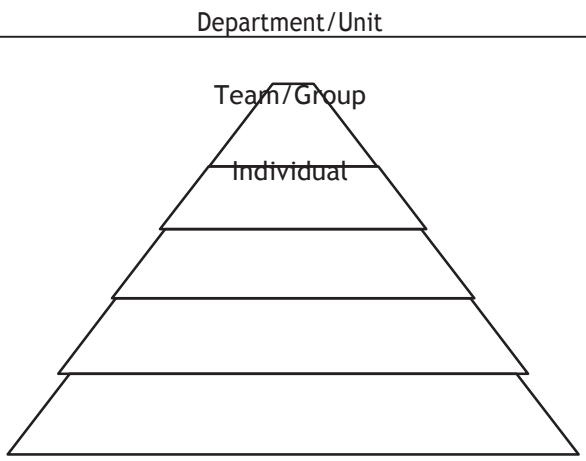
- Balanced scorecard
- Competency-based appraisal systems
- Forced distribution/stacked or forced ranking
- Gantt charts
- Key performance indicators
- Numerical rating systems
- Performance management
- 360-degree feedback appraisal system

erformance management is a critical function for any firm. It has been described as "a process of establishing performance standards and evaluating performance to ensure that goals are being effectively accomplished" (Osland et al. 2007, 573). Performance management encompasses the critical management function of controlling, mentioned in chapter 1.

Performance management occurs at multiple levels in an organization. These levels range from corporate at the top to individual at the bottom (exhibit 12.1). In this chapter, we discuss the mechanisms used to manage performance across these levels.

The ability to provide constructive feedback and monitor performance in organizations is a critical function with which many firms struggle. Most

EXHIBIT 12.1
Levels at Which Performance Management Occurs



large firms establish goals, monitor outcomes, and provide feedback through episodic performance reviews and reports. Performance management systems can be used to support many different company systems, including profitability, efficiency, pay and promotion, employee development, and even staff reductions. Performance management systems vary, and no one type of system is best suited for all objectives. The optimal performance system should be determined by the business needs and culture of the organization.

Successful organizations hold their employees accountable. As illustrated by the box on page 191, this enforcement of accountability might include ending a relationship if the expectations of the job are not being, or cannot be, met. Although assisting employees to gain needed skills and designing mechanisms to motivate are important, at times a leader must have the courage to terminate an employee. The inability to take such action can have negative ramifications for the leader, as she will lose credibility. Enforcing later decisions and correcting future problems will become more and more difficult if the initial issue was not appropriately dealt with.

Performance management requires regular monitoring efforts. Regular monitoring allows management to understand what progress is being made, recognize whether any areas are underperforming, and determine which areas need adaptation and adjustment. Most healthcare organizations establish metrics for gauging progress on their goals. However, as Grenny, Maxfield, and Shimberg (2008, 49) found, monitoring information is not regularly shared:

> We were stunned at how few of the managers in the 40 companies we interviewed during our research had any reliable information about corporate performance at project execution. In spite of the fact that billions of dollars were spent in the form of strategic projects every year, only a handful could tell us what percentage performed to specifications.

However, handled properly, performance management offers an opportunity to

- efficiently achieve goals and objectives,
- evaluate the progress toward mission and vision,
- assess the level of efficiency in using resources,
- encourage ongoing improvement, and
- provide a continued basis for informed decision making and planning.

Sometimes It Is OK to Say Good-Bye

By Britt Berrett

The medical director of the rehabilitative unit was challenged by the new CEO to provide a plan to increase volume and profitability. Unwilling to assume responsibility for growing the business, the medical director claimed that the aged physical appearance of the unit was minimizing its ability to attract new business.

In response to his request for funding, the hospital board committed capital for a new unit, and within six months, a new, modern, and physically appealing unit was completed. Expecting increased volume, the CEO scheduled a meeting with the medical director to review his plan of action. But there was no plan. In fact, the medical director refused to meet with the strategy and planning team. The CEO gave the medical director an ultimatum: Define a plan of action or resign.

In the ensuing weeks, the medical director rallied the political influence of key medical staff leaders to continue supporting him, under threat that his departure would create an organizational and clinical catastrophe.

On the appointed date, the medical director decided not to provide a plan of action and instead threatened to resign. Despite potentially overwhelming political fallout, the CEO accepted the medical director's resignation and swiftly made plans to replace him. The initial reaction from the medical staff was surprise, shock, and anger, but calm eventually ensued.

Subsequent strategy and planning sessions with physician leaders in key critical areas included overwhelming support and involvement by the strategy and planning department, resulting in key alignment and commitment of resources to build volume and improve profitability.

Sometimes it is OK to say good-bye.

Performance Management Tools

Key Performance Indicators

Monitoring requires both the right data and the right processes. Thus, goals and their measures must be carefully established. Metrics used in performance management that are directly tied to strategic organizational goals are often called **key performance indicators** (KPIs). Critical to the success of performance management is the consistent, periodic evaluation of these goals and objectives at weekly, monthly, or quarterly intervals.

Gantt Charts

Gantt charts can be used to quickly determine a project's status. A Gantt chart is a bar chart that shows the schedules of a single or multiple projects. The beginning and ending dates, along with the current percentage of completion, can be graphically presented. Gantt charts can also indicate critical dependencies and key beginning and ending points. A simple example is shown in exhibit 12.2.

EXHIBIT 12.2
Gantt Chart Example

Item	Task	Dependencies	Start Date	Days	% Done	Jul 1-15	Jul 16-31	Aug 1-15	Aug 16-31	Sep 1-15	Sep 16-30	Oct 1-15	Oct 16-31
1	Mission and vision	None	Jul 1	31	0								
2	Environmental analysis	None	Jul 1	62	0								
3	Strategic priorities	1 and 2	Sep 1	15	0								
4	Strategic programs	1, 2, and 3	Sep 16	15	0								
5	Strategic plan	1 and 2	Aug 16	60	0								
6	Board evaluation and approval	1, 2, 3, 4, and 5	Oct 16	15	0								

Source: Walston (2014, 329).

Balanced Scorecards

Many leading healthcare organizations have instituted a performance management system called a **balanced scorecard**—a reporting mechanism that incorporates financial and nonfinancial aspects of performance, such as customer satisfaction and business processes, to allow a comprehensive, balanced perspective of organizational results. All too often, healthcare organizations focus almost exclusively on financial results or, perhaps, finance first and quality second, with each area reviewed separately without regard for one's relationship with the other. With this capability, balanced scorecards have become popular and are implemented across a wide array of healthcare organizations (Zelman, Pink, and Matthias 2003).

A balanced scorecard extends monitoring to generally include the following measures (adapted from Kaplan and Norton 2006):

- *Financial:* Potential measures include profits, revenue growth, return on investment, and expense reductions.
- *Customer/stakeholder:* Potential measures include customer acquisition, retention, and satisfaction.
- *Internal business processes:* Potential measures include production costs and volumes.
- *Learning and growth:* Potential measures include new services, employee satisfaction, and retention.

The balanced scorecard metrics interact with the organizational mission and vision and support each other (exhibit 12.3). Healthcare organizations have modified these dimensions to include healthcare quality, outcomes, and access (Zelman, Pink, and Matthias 2003). Presenting and evaluating performance on multiple criteria provides a more informed and global perspective.

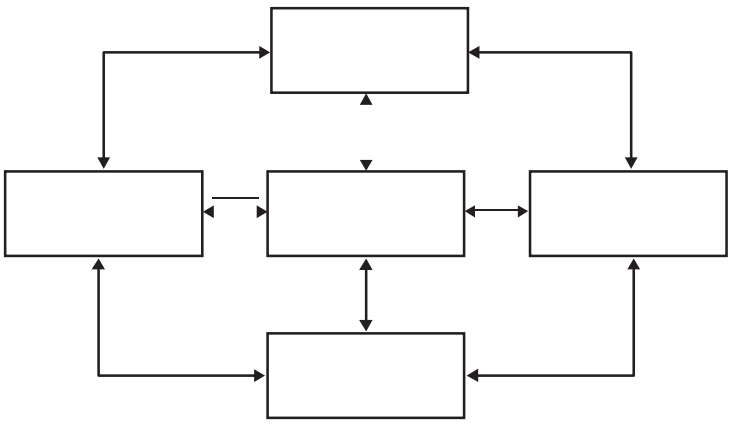


EXHIBIT 12.3 Balanced Scorecard Metrics' Relationship to Mission and Vision

Organizations that seek to implement companywide performance management systems, like the balanced scorecard, often find that aligning goals across the company to expressed strategies can be a challenge. Likewise, ill-defined measures can lead to unintended outcomes.

Individual Performance Management

Individual performance management systems also widely vary. In addition to the purposes of corporate performance management systems, individual performance management systems seek to

- clarify job responsibilities and expectations;
- enhance individual and group productivity;
- develop employee capabilities through effective feedback and coaching;
- drive behavior to align with the organizational values, goals, and strategies;
- provide the metric for performance pay increases;
- improve communication between employees and managers; and
- select employees for promotion, termination, and career development.

However, accomplishing all of these goals simultaneously can challenge the best organization. Performance management systems, which should motivate and improve performance, are considered the Achilles' heel of human resources management. Their flaws cause employees and managers to regularly lament their ineffectiveness. A survey by Watson Wyatt showed that almost 70 percent of workers felt that their company's performance management system did not help improve performance. Less than 40 percent indicated that their personnel evaluation system "established clear performance goals, generated honest feedback or used technology to streamline the process" (Pulakos 2004). Annual performance evaluations "do little to improve the performance of employees," yet nearly 90 percent of firms around the globe continue with annual performance reviews that directly affect compensation decisions (Ewenstein, Hancock, and Komm 2016). The cause of many problems lies not in the poorly developed tools and processes but in the nature of performance management, which is highly personal and can be seen as threatening for both managers and employees.

The implementation of individual performance management usually takes place in the form of performance appraisals, frequently as annual evaluations. Individual performance appraisals are "one of the least favorite activities for managers" (Osland et al. 2007). Employees and managers often complain that performance management systems

- instill a fear of reprisal if candid feedback is given,
- damage relationships,
- require nonexistent skills to be able to appropriately discuss performance, and
- take too much time because of their high complexity.

Some of the problem lies in the dual goals many companies seek to achieve from performance appraisals, if the activity is used for both allocating rewards and identifying developmental needs. For example, some performance systems that focus heavily on numerical outcomes may crowd out their value for employee development. While a performance management system can conceivably address both decision-making and employee development needs, this combination can be difficult to establish in practice. **Numerical rating systems**—mechanisms for rating employee performance on a numeric scale—are used in most performance management systems but may detract from employee development efforts, as employees may be overly concerned about their ratings and rank compared with others and will work to appear excellent in all areas. Therefore, rather than identifying areas for employee development, the discussion centers on performance outcomes and their resultant rewards (Pulakos 2004).

One large firm, Deloitte, has ditched 360-degree reviews and cascading goals that apply to everyone in the organization. Instead of having employees answer numerous questions in their annual self-evaluations, the company has developed four simple questions to be answered at the end of every project (or once a quarter for employees who have long-term assignments). The first two questions are answered according to a five-point scale, while the last two are answered with either a "yes" or a "no." The questions are as follows (McGregor 2015):

1. Given what I know of this person's performance, and if it were my money, I would award this person the highest possible compensation increase and bonus. Scale: 1—STRongly agree to 5—strongly disagree
2. Given what I know of this person's performance, I would always want him or her on my team. Scale: 1—STRongly agree to 5—strongly disagree
3. This person is at risk for low performance. Response options—Yes or No
4. This person is ready for promotion today. Response options—Yes or No

Forced Distribution or Stacked Ranking Appraisals

Potentially compounding the pressures on the numerical scoring are the **forced distribution / stacked or forced ranking** appraisal systems that some companies use. Forced distribution systems require managers to rank their employees across a distribution. Much like "grading on the curve," a certain percentage

of employees must be rated unsatisfactory (often 10 percent) and only a set percentage can be ranked excellent or outstanding (again, often 10 percent). About 30 percent of all major US corporations have used some form of forced distributions, including General Electric and Microsoft (Mathis, Jackson, and Valentine 2014).

Advocates of forced distribution claim that without it, "rater inflation" increases and it is impossible to differentiate and accurately reward performance. It also provides more "disciplined rigor to the management process" and forces managers to address difficult performance-related issues (Lipman 2012). Yet it can create significant employee problems, as objectively ranking employees is fraught with subjectivity. Furthermore, especially for those in the bottom tier, the threat of dismissal can destroy an organization's open culture and damage team cooperation (Lipman 2012).

For its part, the stacked or forced ranking appraisal system has been suggested as a cause of Microsoft's competitive struggles since 2000 (Eichenwald 2012):

> At the center of the cultural problems was a management system called "stack ranking." Every current and former Microsoft employee I interviewed—*every one*—cited stack ranking as the most destructive process inside of Microsoft, something that drove out untold numbers of employees. The system—also referred to as "the performance model," "the bell curve," or just "the employee review"—has, with certain variations over the years, worked like this: every unit was forced to declare a certain percentage of employees as top performers, then good performers, then average, then below average, then poor.
>
> "If you were on a team of 10 people, you walked in the first day knowing that, no matter how good everyone was, two people were going to get a great review, seven were going to get mediocre reviews, and one was going to get a terrible review," said a former software developer. "It leads to employees focusing on competing with each other rather than competing with other companies."

Interestingly, because of the problems it created, Microsoft discontinued stacked or forced ranking in 2013—at the same time that Yahoo adopted it (Brustein 2013).

Finding the correct form for providing appropriate feedback and appraisals to employees continues to be a struggle. In 2015, Accenture—one of the world's largest companies, employing 330,000 people—completely discontinued its annual performance review and moved to more ongoing, timely feedback from managers following assignments (Cunningham 2015). By 2016, approximately 16 percent of surveyed companies had eliminated the rating scale from their annual performance evaluation (McGregor 2016). As noted by Ewenstein, Hancock, and Komm (2016), other companies are experimenting with different approaches, including

- focusing exclusively on only very high or very low performing employees and not seeking to differentiate those in the middle,
- collecting more objective performance information by automated analyses,
- breaking the link for most employees between their performance evaluation and compensation or only linking them for high and low performers, and
- moving more frequent evaluations to an as-needed basis and not scheduled annually.

Guidelines for Providing Performance Feedback Effectively

Although providing constructive performance evaluations can be difficult, some practices can improve their effectiveness. They can be separated into two categories—pre-performance preparation and interview practices (adapted from Pulakos 2004):

Pre-performance preparation

- Set clear, measurable expectations for job performance.
- Provide needed job and skills training.
- Offer feedback and coaching throughout the year.

Interview practices

- Provide immediate, positive, developmental feedback.
- Use a private location for feedback sessions.
- Inform the employee on a timely basis of performance issues; problem performance should not be a surprise to the staff member.
- Ask for the employee's view about what could have been done differently.
- Be specific about what behaviors were effective or ineffective.
- Focus on the employee's actions and behaviors, not personal characteristics.
- Collaboratively plan steps to address development needs.
- Offer help in addressing development needs and providing resources.

For annual performance appraisals to be effective, they must be part of the continuous feedback cycle an employee should be receiving regarding his job. Immediate and proximate feedback for both good and poor performance should be given to employees throughout the year. Research has shown that frequent feedback—at least quarterly and perhaps monthly—generates better results. A study on performance evaluations reported in the *Washington Post* pointed out that the speed of work today frequently exceeds the ability of

human resources policies, such as annual evaluations, and noted that "the idea of an annual performance review or six-month performance review just doesn't make sense any more" (McGregor 2016). Successful performance appraisals summarize the ongoing feedback and set goals to develop the employee. The aim of the annual appraisal system should be to improve performance, not punish employees. Managers should never "store up" employee problems throughout the year and unload them on the employee at the annual evaluation.

The University of Texas in Dallas (UT Dallas) follows this model closely, providing resources to improve performance communication, implement annual performance appraisals, and develop performance improvement plans. The UT Dallas (2015) website notes that the annual appraisal process should be

> a small part of the appraisal process. In its most productive form, performance appraisal is actually a continuous, year-round practice of exchanging information between the supervisor and employee that begins and ends with the formal annual performance appraisal meeting. The most highly motivated, productive employees are those who know what they are supposed to do and how well they are doing it, who participate in planning how their work will be accomplished and who have open, honest rapport with their supervisor. Supervisors are strongly encouraged to make the annual review meetings participative and collaborative.

Performance Rating Scales

Although a numerical scale is not always warranted, organizations often use one to help them compare across employees, units, departments, and divisions. If scales are used, either a 5- or 7-point scale is recommended because it allows sufficient range to differentiate among employees (Pulakos 2004). Exhibit 12.4 shows an example of a performance rating scale that relates the numerical value to behaviors in communication practices and business results. Additional categories should be included to reflect the job responsibilities and organizational values. Job responsibilities might include important behaviors, such as customer interaction, while organizational values should reflect those usually expressed in conjunction with the organizational mission and vision. The values criteria might include categories of teamwork, integrity, innovation, and compassion, among others.

360-Degree Feedback Appraisal Systems

Traditionally, annual employee evaluations have been completed by a superior, with limited input from the employee and based mostly on the superior's experiences and perceptions of the employee. This singular perspective frequently interjects bias into the appraisal process. To provide greater representative feedback to both the rater and the employee, the **360-degree feedback appraisal system** has been introduced in many companies. Some observers estimate that as many as 90 percent of the largest companies use a form of it

EXHIBIT 12.4
Performance Rating Numerical Scale Example

Communication Practices	1	2	3	4	5
Behavioral Assessment	Below Expectations	Sometimes Meets Expectations	Meets Expectations	Sometimes Excels	Consistently Excels
	With guidance, fails to prepare straightforward communications in a timely and accurate manner; products often require corrections. Often fails to adapt style and materials appropriately.	With guidance, sometimes prepares straightforward communications in a timely and accurate manner; products often require minimal corrections. With guidance, adapts style and materials appropriately.	With guidance, prepares straightforward communications in a timely and accurate manner; products may require minimal corrections. With guidance, adapts style and materials appropriately.	Independently prepares communications in a timely, clear, and accurate manner; products require few corrections. Independently adapts style and materials appropriately.	Independently prepares communications in a timely, clear, and accurate manner; products require few corrections. Independently adapts style and materials appropriately.
Business Results	1	2	3	4	5
Results Assessment	Low Impact	Minimal Impact	Moderate Impact	Significant Impact	High Impact
	The efficiency or effectiveness of operations and product quality remained the same or improved only minimally.	The efficiency or effectiveness of operations and product quality improved somewhat.	The efficiency or effectiveness of operations and product quality improved a lot.	The efficiency or effectiveness of operations and product quality improved significantly.	The efficiency or effectiveness of operations and product quality improved tremendously.

Source: Adapted from Pulakos (2004).

(Maylett and Riboldi 2007). In healthcare, organizations are recommending 360-degree appraisals even for physicians (Dubinsky et al. 2010).

The 360-degree system seeks feedback from those stakeholders with whom the employee being appraised has frequent contact. These stakeholders, whose responses are confidential, are asked to evaluate the employee on a broad array of job behaviors, skills, and competencies. At the same time, the employee is asked to complete the same survey. All of the stakeholders' feedback is given to the supervisor performing the appraisal, who is expected to use at least a composite of the responses during the evaluation. The information from others can be compared with the employee self-evaluation, which helps the supervisor or employee quickly identify areas for improvement.

The anonymous nature and multiple sources of the 360-degree system provide more comprehensive and accurate feedback than a traditional evaluation does because they cannot be as easily attributed to bias, thus improving appraisal results (Lepsinger and Lucia 2009). For example, this tool has been used successfully in healthcare to improve physicians' emotional intelligence (Hammerly, Harmon, and Schwaltzberg 2014).

However, some human resources experts caution against using 360-degree appraisals, especially when the outcome affects pay and promotion. This process has been seen as most effective when used as a development tool and not a rating tool. Other potential problems arise when organizations fail to determine which competencies should be reviewed prior to implementing the evaluation and do not maintain the anonymity of reviewers (Taylor 2011). In addition, the amount of time required to perform a 360-degree evaluation is seen as prohibitive by some organizations. Scheduling multiple stakeholders to complete the evaluations, collecting and collating the data, and presenting the review can be a significant time burden. As a result, some organizations perform 360-degree appraisals only every few years, conducting traditional evaluations in between. For example, Texas Health Resources, based in Dallas, has its managers undergo a 360-degree evaluation every three years. In addition, as can be seen in the box on page 201, university medical centers are implementing 360-degree reviews to provide more complete feedback to residents and medical students than can be gathered by traditional student evaluations.

To make 360-degree appraisal systems successful, Jackson (2012) suggested that managers

- seek the involvement and support of the employee's direct supervisor;
- make the questions specific enough to provide actionable information;
- keep the comments and process constructive, not personal;
- set an improvement plan to change behaviors;
- revisit the recommendations with the employee periodically (at least quarterly);

- keep the information and process confidential; and
- focus the evaluation and plan on both strengths and weaknesses.

Competency-Based Performance Systems

Most contemporary appraisal systems are based on competencies, which can be broken down into behaviors to be measured. **Competency-based appraisal systems**—mechanisms for evaluating employee performance on the basis of required competencies established for the employee's position—are intended to facilitate recognition, reward, and correction of behaviors; they are now required for hospitals to be accredited by The Joint Commission (Daniels and Ramey 2005). In addition, this type of evaluation has been recommended for use in appraising boards of trustees (Jarousse 2014).

The key advantages of establishing behavior-related competencies are to (1) set clear employee work expectations and (2) translate them into criteria to assess and develop employees. This process helps establish criteria to appropriately recruit, select, and evaluate employees (Cardy and Selvarajan 2006).

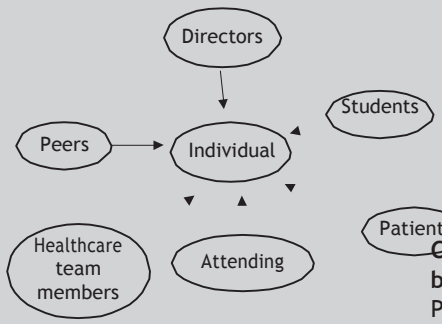
Competency models appraise individuals on the skills, knowledge, and characteristics that are important for attaining positive job outcomes. Generally, five to ten key competencies derived from strategic objectives, organizational values, and key job success factors are used for evaluations. (The number should be limited to ten competencies because too many can overload the raters, who may need to complete many appraisals.)

Although a competency-based evaluation tool can be constructed in many ways, one requirement for any such tool is to have a matching scale for

Competency-based appraisals Performance evaluation systems based on required competencies established for the employee's position.

360-Degree Assessment of Residents and Students

The University of Maryland School of Medicine (UMM) Primary Care Education Initiative is piloting a 360-degree assessment system for residents and students. A 360-degree assessment provides feedback about progress by placing the person to be evaluated at the "hub of the wheel," thus reflecting the center from all sides:



This process provides a full-circle view of the resident's or student's skills and abilities by gathering information from various perspectives: those of the individual, peers, supervisor, patients, and healthcare team members. This profile provides a more balanced overview than self-evaluation or peer-supervisor review does. The completed questionnaires are compiled into a final report for the resident or student. Anonymity for those completing the assessment helps ensure that ratings and comments are fair as well as skill based and behavior based.

Source: Adapted from UMM (2015).

common organizationwide and departmentwide competencies to allow comparison of employees across different units. Once the common competencies have been set, additional competencies should be established for specific job requirements. Competencies should remain unweighted, as weighting can become burdensome and does not provide improved ratings (Pulakos 2004).

As described in the preface, the American College of Healthcare Executives (ACHE 2015) offers the Healthcare Executive Competencies Assessment Tool, which can be used to assess a healthcare leader's expertise. This assessment framework (available as a PDF file at www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf) categorizes competencies into five critical domains:

1. Communication and Relationship Management
2. Leadership
3. Professionalism
4. Knowledge of the Healthcare Environment
5. Business Skills and Knowledge

Healthcare executives are expected to demonstrate competence in all aspects of these domains.

Healthcare organizations that seek to develop a competency-based evaluation for their managers could use this document to establish performance measures centered on these competencies. As shown in the following list, each of the major domains is subdivided into categories, which contain evaluative questions that can be used for appraisals (ACHE 2015):

- Communication and Relationship Management
  - Relationship Management
  - Communication Skills
  - Facilitation and Negotiation
- Leadership
  - Leadership Skills and Behavior
  - Organizational Climate and Culture
  - Communicating Vision
  - Managing Change
- Professionalism
  - Personal and Professional Accountability
  - Professional Development and Lifelong Learning
  - Contributions to the Community and Profession
- Knowledge of the Healthcare Environment
  - Healthcare Systems and Organizations
  - Healthcare Personnel

  - The Patient's Perspective
  - The Community and the Environment
- Business Skills and Knowledge
  - General Management
  - Financial Management
  - Human Resource Management
  - Organizational Dynamics and Governance
  - Strategic Planning and Marketing
  - Information Management
  - Risk Management
  - Quality Improvement

Chapter Summary

Performance management is an important organizational control function that should occur from the corporate tier to the individual level. However, developing and maintaining a constructive feedback and performance appraisal system is a challenge for most companies. Performance management should assist firms in achieving their goals, evaluate progress toward meeting their mission and vision, assess their efficiency, and encourage constant improvement.

Tools used for performance monitors include key performance indicators, Gantt charts, and balanced scorecards. KPIs are the critical metrics used to evaluate the progress of each key goal. Gantt charts provide a visual way to quickly monitor the progress of projects. Balanced scorecards use multiple key metrics to monitor performance.

Individual performance management systems are used in most organizations. They vary widely, but their primary purposes include improving employee skills and aligning employee behaviors with desired organizational outcomes.

Unfortunately, many companies struggle to maintain productive employee evaluation systems, often performed as annual evaluations. Instead of inspiring greater work efforts and motivation, individual evaluations can strain relationships and create excessive stress on both employees and managers. The dual, contrasting nature of the evaluation purpose causes many of these problems. Individual evaluations can support both decision making and employee development.

Numerical rating systems that rank employees allow for differentiated salary increases, promotions, firings, and bonuses. Forced distribution and stacked or forced ranking systems provide an example of a numerical rating system that ranks employees. In this system, managers are required to place a certain percentage of their employees in higher and lower categories for each evaluation. The pressure to score better than peers to achieve the related rewards has caused many firms to discontinue using this system.

Effective performance feedback exists across a time continuum. Prior to the formal evaluation meeting, clear, measureable expectations should be set, along with needed job skills and training. Feedback and coaching should be continuous. Likewise, the evaluation should be conducted in a private location and provide immediate, positive, developmental feedback. The employee should not be surprised by the feedback and should be allowed the opportunity to provide input to identify issues and develop a constructive plan for improvement.

If numerical scales are used for appraisals, they should include a 5- or 7-point scale. Questions and rating scales should be formed for each important employee behavior and area of responsibility.

A 360-degree feedback system can be used to obtain a more comprehensive, representative appraisal from multiple stakeholders, which can be compared with the employee's perception of his work.

Most contemporary appraisal systems use competency-based performance criteria. Appraisal systems based on job-related competencies allow management to set clear job performance expectations and provide constant criteria for evaluations. Such systems appraise individuals on the skills and knowledge required for positive job outcomes. Generally, five to ten competencies should be used for the evaluation.

Chapter Questions

1. Read the article "The Top 50 Problems with Performance Appraisals" at www.eremedia.com/tlnt/the-top-50-problems-with-performance-appraisals/ (Sullivan 2011). According to the chapter, what steps can be taken to address the first five problems mentioned in the article?
2. Why would it be important to have a performance management system linked to and relatively consistent across all levels in an organization?
3. How could one tell whether the metrics used for performance evaluations were KPIs?
4. Describe two ways that a balanced scorecard may be superior to more traditional monitoring systems.
5. Why do companies have so many difficulties with individual performance appraisal systems? Provide four reasons for the difficulties.
6. What are the advantages of a stacked or forced ranking system?
7. Why should employee appraisals be conducted more than once per year?
8. Give two reasons the 360-degree feedback appraisal system improves an employee evaluation. Offer two reasons that 360-degree feedback may make the evaluation more difficult.
9. How do competency-based appraisal systems provide "consistency, transparency, and fairness"?

Chapter Cases

A Surprising Performance Evaluation

Enrique had worked very hard the past four years. He had consistently exceeded the job expectations listed in his employee manual and had received exceptional job evaluations for the first three years. His fourth annual performance appraisal was now scheduled in a few minutes, and he was certain that, although circumstances had changed, he would still receive a good evaluation.

Enrique had been hired as a home health program director four years earlier. He knew that the program was dramatically underfunded, and before he accepted the role, his manager, Rosa, promised to increase the funding and provide more organizational support. Enrique trusted Rosa and accepted the position.

The first two years managing the program went well. Rosa did come up with additional resources, although the need for more was still significant. After two years, however, Rosa quit for a job in another state, and the new manager, Ruben, was brought in from the organization's operation in another city. Ruben liked to threaten employees and bragged in many manager meetings that he would "get those slackers and troublemakers" in his group at their annual evaluations. He stated he would make sure they got less than the usual 3 percent merit increase—that would show them what he thought of them!

During the first year of Ruben's reign, he and Enrique did not get along well. Ruben felt no obligation to honor the commitments that Rosa had made earlier. He cut Enrique's budget back to what it was when Enrique took the position, and he made Enrique move his office—from one close to the physicians with whom he worked into the general offices close to Ruben. He also took away Enrique's expenditure authority for any costs above $50. In addition, he wanted to reduce the pay differentials Enrique had been receiving for two regional duties he had been appointed to. Enrique reminded Ruben that he had been appointed to these regional positions by the regional vice president and offered to resign from them if he were not paid for them. Ruben finally backed off, but he was not happy about it.

Even with this battle, Enrique persevered. The work outcomes and customer satisfaction ratings remained high. However, he began to voice his concerns privately to close friends, and going to work became painful. Finally, in September, Enrique had had enough, and he resigned his responsibilities as program director. In response, Ruben radically lowered Enrique's salary—by not just taking away his director's pay differential

(continued)

(continued from previous page)

but also dropping him three steps in the pay scale. After a lengthy discussion with the human resources department, however, Enrique's original base pay was reinstated. Ruben took over the program director duties.

A month later, the organization sponsored a home health program retreat, which Ruben was not planning to attend. Outside stakeholders were invited, and a facilitator was hired to run the meeting. The ground rules for the meeting called for an open and frank discussion of the program's strengths and problems. Enrique was invited, participated actively, and pointed out the problems, especially those caused by Ruben's poor management decisions. The meeting minutes were dutifully recorded and submitted to both Ruben and the regional vice president. Enrique continued working in the program and received high praise from customers and coworkers.

In December, Ruben was transferred to a different department, and Carlos was appointed in his place. Carlos seemed more fair-minded than Ruben and announced he would begin a search for a new program director in March. However, annual evaluations were due in February. Enrique was anxious but thought Carlos would treat his situation reasonably.

When Carlos and Enrique met to discuss Enrique's annual evaluation, Enrique was shocked to receive a very low overall rating. He demanded an explanation and was told he was a "disloyal" employee whose comments at the program retreat were seen as offensive and inappropriate. No amount of arguing could change the rating. Even though he had performed well in every other category, his rating for the year was "very low," which meant he would receive no merit increase.

The day after his evaluation, Enrique began sending out his resume. Three months later, he left to take another position.

Case Questions

1. According to the chapter, what went wrong with the annual performance evaluation?
2. What should Carlos have done to improve the annual evaluation process?

Mixed Use of Performance Management System Steals Its Effectiveness

Healthrus System had two goals for its annual employee performance evaluations: (1) to motivate employees to work hard and (2) to identify areas in which employees could improve. Healthrus recently made a major change in its approach to reviews by implementing a performance management

system that required managers and their employees to simultaneously complete an evaluation of the employees' activities throughout the year. The evaluation form contained seven separate areas in which the employee could be rated from "1—TOTALLY unsatisfactory" to "7—outstanding." Then each employee and manager were to meet, discuss their individual ratings, and come up with a composite form that would be submitted for significant bonuses. Although the amount of bonus changed each year, the potential bonus this year was a hefty 25 percent of base salary. The problem was, as most employees knew, the hospital had only budgeted an average of 8 percent for the bonus payout.

Peter had joined Healthrus System three years earlier as a maintenance engineer. His wife was recovering from cancer, which had stressed them financially this past year. He had worked hard and felt that his performance this year was exceptional, especially compared to that of the other maintenance engineers. Peter was sure that if anyone deserved the bonus this year, it was him. Last year, he had been told that only those with an average score of 6.6 or higher received the maximum bonus, so when he completed his evaluation, he rated himself with mostly 6s and 7s.

Peter's boss, Henry, liked Peter and appreciated his hard work. However, he wanted Peter to improve in a few areas, especially communication and two technical areas. Scoring Peter lower in these areas would justify recommending him for further training; the hospital had internal classes on communication and could send Peter to the local community college for additional technical training.

Peter and Henry's meeting did not go well. Peter was upset that Henry scored him low in these areas, while Henry became frustrated that Peter was not willing to receive constructive criticism and seek improvement. After an hour of discussion, they both became angry, and Henry decided to end the meeting and reschedule it for a time when each might rethink the other's evaluation.

Case Questions

1. What went wrong with the evaluation meeting?
2. What could be done to motivate employees yet establish training and development needs?

Setting Medical Office Staff Performance Measures

Jill was hired as the manager of a 40-member multispecialty medical practice with 180 support staff. The practice's five clinics were generally

(continued)

(continued from previous page)

prosperous, but a few of them appeared to be poorly staffed. The physician committee that hired her said that only a few of the clinic workers were stars and the rest needed to be motivated or asked to leave. They added that the medical practice's current annual performance system for employees was deplorable and needed to be revised. Annual bonuses had always been tied to these appraisals, which made them important for everyone. Unfortunately, the annual evaluations were due in just six weeks.

Jill was excited, though, and knew she could whip this group into shape. She had just graduated with a master's degree in health administration and had three years of experience working for a smaller clinic. She felt she had the talent, dedication, and energy to succeed. She recognized, however, that if she were to have a functional evaluation tool completed in six weeks, her energy and talent would be tested.

She began by examining the medical practice's values, which included integrity, initiative, respect, communication, quality, and teamwork. She created three questions to identify adherence to these values, basing them on a 5-point scale. To these she added questions about the workers' essential job functions. These questions encompassed their duties and responsibilities, health and safety, professionalism, and efficiency and effectiveness.

Jill also designed a performance improvement plan to allow managers and employees to address and resolve performance issues. The plan required a set time (generally 90 days) for re-review, after which time a written warning would be given to the employee if performance had not improved. If a second period ended without employee improvement, the employee would receive a second and final warning. At the end of the third period without improvement, the employee would be dismissed.

Bonuses had been generously allocated to most of the employees prior to the change. The average rating for employees across the clinic was good to excellent, or 4.1 on a 5-point scale. Considering all of the complaints from the medical staff about the employees' behaviors, Jill was certain the high ratings were the result of lazy clinic managers, and she had to create a mechanism to make the evaluations more reflective of actual performance. She decided that a forced rating system would be the best way to make her managers assess their employees fairly. In her plan, only the excellent employees would receive the full bonus. A graduated, lesser amount would be given to the other employees who still exceeded the average rating. Those below the average rating would

receive no bonus for the year. Finally, those who were ranked in the bottom 20 percent were to have strict performance improvement plans, and they would be terminated if they remained in the bottom 20 percent for two years.

The doctors were enthusiastic about Jill's new appraisal system and encouraged her to implement it immediately. However, when she presented the new system to the clinic managers, she heard a lot of grumbling. A few asked her if she had ever used a forced ranking system. She had to admit that she had not, but almost 30 percent of major companies used one, so it had to be a good method. The managers left, unconvinced, and many complained that their employees were going to be mad if they didn't get their bonuses. A few were heard quietly threatening to resign if they had to rank all of their employees.

The next month flew by, and when the evaluations were completed and the bonues were distributed, 20 staff resigned. The problem was, only one of the staff who left had been ranked in the bottom 20 percent, and five were top performers. Jill was perplexed.

Case Questions

1. What went wrong with Jill's performance appraisal system?
2. What could have been done better?
3. How does forced ranking help improve performance? What changes could Jill implement to make the forced ranking system work?

Chapter Activity

Read the article "Why Incentives Are Irresistible, Effective, and Likely to Backfire" at www.fastcompany.com/1140924/why-incentives-are-irresistible-effective-and-likely-backfire (Heath and Heath 2009). Write a two-page paper explaining why incentives may not produce the actual performance an organization desires.

13

DECISION MAKING

Learning Objectives

After studying this chapter, readers should be able to

- evaluate different decision-making models, including rational decision making, bounded rationality, and garbage can models;
- distinguish the benefits and problems of heuristics;
- identify different forms of bias and what can be done to avoid them;
- appraise methods for improving decision making; and
- describe groupthink and ways to avoid it.

Key Terms

- Anchoring bias
- Bounded rationality
- Confirming-evidence bias
- Framing bias
- Garbage can model
- Groupthink
- Heuristics
- Rational decision making
- Status quo bias
- Sunk cost bias

Decision making ranks as the most important activity managers undertake. Great leaders are also great decision makers (Kase 2010), but making decisions also ranks as the riskiest and most difficult of tasks. Good decisions can further one's career, while poor decisions can derail and damage one's prospects. Decisions include where to allocate resources, whom to hire and fire, and what business and services to offer. Becoming the "decider" brings joy and frustration, blame and honor. Learning to make better decisions is a lifelong process. Determining who makes decisions and how they are made in an organization can fundamentally affect the extent to which a firm succeeds or fails.

Many people seem to make poor decisions on a frequent basis. For example, one survey showed 44 percent of lawyers would not recommend their career to a young person seeking to practice law, implying that almost

half of attorneys made a questionable life decision. Similarly, 40 percent of new, senior-level hires facilitated by executive search firms fail in their role or quit within 18 months of taking the new job (Heath and Heath 2013).

The decision-making process and outcomes can be demonstrated with a decision tree, as illustrated in exhibit 13.1. The exhibit models the sequence of decisions and outcomes, and this is what makes decision trees helpful in understanding the alternative choices and resultant outcomes. It also allows the decision maker to assign probabilities and quantify expected outcomes.

Models of Decision Making

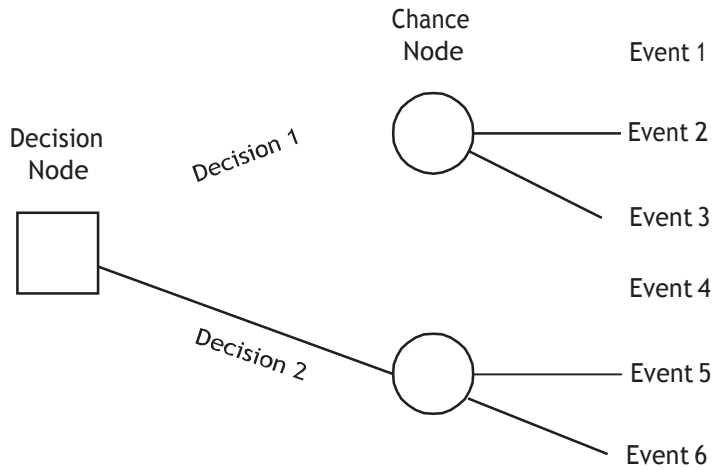
Rational Decision Making

Early management scholars, including Max Weber and Henri Fayol, who are discussed in chapter 1, assumed that individuals and organizations make rational decisions. A contemporary definition of **rational decision making** appears to perpetuate that assumption (WebFinance 2015):

> A method for systematically selecting among possible choices that is based on reason and facts. In a rational decision making process, a business manager will often employ a series of analytical steps to review relevant facts, observations and possible outcomes before choosing a particular course of action.

Rational decision making presupposes that there is a best decision. It involves (1) clearly defining the problem and decision to be made, (2) understanding and ascertaining the important criteria, (3) identifying and

EXHIBIT 13.1
Decision Tree Example



considering all possible solutions, (4) quantifying and determining the outcomes and effects of all solutions, and (5) choosing the best option. Some of these assumptions may not be realistic. Identifying all possible solutions is almost never practical or possible. In addition, knowing and quantifying the outcomes and consequences of one option are impractical. Rational decision making, as defined here, also ignores participants' emotions and cognitive limitations.

However, we know from psychology and sociology that the unpredictable nature of individuals and groups can lead to irrationality in decision making, resulting in undesirable outcomes for individuals and organizations alike (McKinsey & Company 2009). For example, people who gamble often feel that they can beat the odds by using physical and mental tactics that realistically have no influence on the games they play (Greer 2005, 58):

> A craps player must roll an 11 to win his bet. Hoping to do so, he shakes his clasped hands vigorously then fires the two dice at the felt table. Instead, he rolls a four. On his next turn, the magic number is lower—three. He delicately cradles then gingerly tosses the dice. He gets a seven and loses.
>
> The gambler believes he can control the dice by how he throws them—a hard roll for a big number and a soft roll for a low number—even though the result is pure chance . . . a big cause should create a big effect . . . if I roll the die hard I'm more likely to get a big number [S]ometimes we are too eager to find connections, so we create them when none exist. And while using that bias at a craps game is relatively harmless, such thinking causes larger problems—from miscalculating quantity to choosing the wrong person for the job, psychologists say. What's worse, it's a tough bias to overcome.

Bounded Rationality

Recognizing the problems of the rational decision-making model, Herbert Simon (1976) proposed a **bounded rationality** model, which suggested that, given the limitations and costs of identifying all solutions and their corresponding information, people search not for optimal solutions but for a solution that will satisfy their needs. People accept a decision that is good enough, or that "satisfices." Individuals are still intentionally rational in the sense that they remain goal oriented and choose what they perceive is best for themselves, but their rationality is "bounded" by human cognitive limits and emotions as well as the costs of gathering and processing information (Jones 1999). Dating and marriage offer examples of bounded rationality. Instead of searching for the best, optimal partner in the world, we most often date and marry as a result of convenience and social networks. Dating continues until we find someone, who may not be the perfect partner but whose being—including flaws—captures our emotions and clouds our judgment. As evidenced by high divorce rates, many people do not have a good track record in optimizing their marital partners.

The following are critical to making good decisions in an organizational context (McKinsey & Company 2009):

- Ability to accurately understand organizational capabilities and limitations
- Availability of a forum to discuss contrary evidence and critical information
- Alignment of the decision with organizational targets and goals

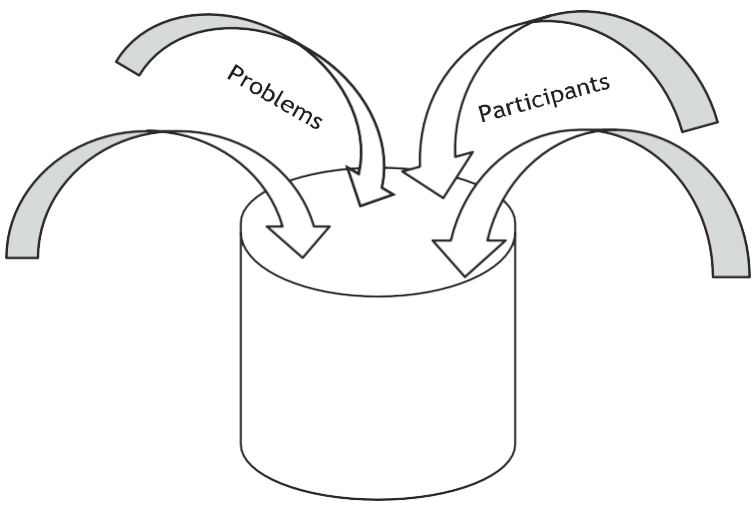
Organizations that chronically make poor decisions allow biases to enter more freely than do firms that have mastered the organizational decision-making process (McKinsey & Company 2009).

Garbage Can Model

This model presents a chaotic form of decision making that is practiced in some organizations. Characterized as existing in "organized anarchies" (firms that exhibit unordered and messy decision making, such as some universities), the **garbage can model** has a messy, unordered format. Rather than have fixed preferences and clear goals, organizations that operate under a garbage can model have problematic, inconsistent, and ill-defined preferences caused by the fluid, frequent entry and exit of decision makers who lack clarity and understanding about how decisions are made (Cohen, March, and Olsen 1972).

The model is analogous to a garbage can because it hosts a haphazard mixture of problems, choices or decisions, participants, and solutions (as shown in exhibit 13.2). How these elements link to produce decisions can be capricious, depending on who the current participants are and what solutions are available. This approach has been described as a "collection of choices looking for problems,

EXHIBIT 13.2
Garbage Can Model



issues and feelings looking for decision situations . . . solutions looking for issues . . . and decision-makers looking for work" (Cohen, March, and Olsen 1972, 2).

The garbage can model can be helpful in understanding decision making in complex and sometimes dysfunctional organizations. In these organizations, a set structure and established participants do not exist to deal with problems and identify solutions that lead to decisions; instead, many potential solutions exist by themselves and are connected to problems only when they arise. As mentioned, universities commonly follow this chaotic style of decision making, but so do medical staffs. If one substitutes medical staff for university, as Cohen, March, and Olsen (1972, 11) stated,

> decision making frequently does not resolve problems. Choices are often made by flight or oversight. .... Problems, choices and decision makers arrange and rearrange themselves. In the course of these arrangements the meaning of a choice can change several times. .... Problems are often solved, but rarely by the choice to which they are first attached. A choice that might, under some circumstances, be made with little effort becomes an arena for many problems.

As anyone who has worked in a dysfunctional organization can attest, such decision making (or lack thereof) is exceptionally frustrating. In these circumstances, efforts should be made to frame the structures, goals, and processes in a rational and consistent manner.

Biases in Decision Making

Even in rational organizations, poor decisions are made frequently. For example, flawed decisions have been linked to leaders with an increased sense of power that causes a failure to listen to advice. A perception of self-importance and power diminishes the receptiveness to suggestions, which has been tied to poor decision outcomes (See et al. 2011).

In addition, we—often unknowingly—interject individual, group, and organizational biases into our decision making. Biases creep into our judgments in several ways, including the use of **heuristics**. Heuristics are mental shortcuts or rules of thumb generated from personal experiences and used during problem solving. We often generalize personal experiences and apply them to a wide variety of situations that require decision making. At times, these rules are extremely helpful in making fast, efficient decisions. However, if attention is not given, their application can result in cognitive biases. Individuals and organizations rely on a small number of heuristics to make judgments. They are useful most of the time, but they also can "lead to severe and systematic errors" (Tversky and Kahneman 1974, 1124). For example, meeting a number of people from China who were much shorter than I initially led me to assume that all people from China were short. Of course, this assumption does not

hold when we consider individuals such as Yao Ming, the famous 7-foot-6-inch Chinese basketball player.

All of us would like to think that we make rational, objective decisions. However, we all have biases tied to our heuristics that can influence the choices we make. These biases can cloud our judgment (sometimes subconsciously) and cause us to make unwise or suboptimal decisions. Some biases that impede our decision making include the following:

- **Anchoring bias**—bias toward the first information received. Our early impressions and data become references for future decisions (Biswas 2009). Thus, in making decisions, we begin from an initial point but reach a final decision by making judgments that are biased toward that point. For example, suppose you are asked two questions in succession: "Is the population of Nigeria greater than 25 million?" and "What do you think the population of Nigeria is?" You would likely answer the second question with a number close to 25 million. (Nigeria is, in fact, home to about 174 million people.) The first question "anchors" and influences the response and decision. Anchoring is one bargaining tactic used by some salespersons. For example, the initial price at which a home is listed in a real estate sales agreement often becomes the anchor for subsequent negotiations.
- **Status quo bias**—bias toward choices that perpetuate the status quo and the current situation. Leaving the status quo means taking action and assuming responsibility, which can subject one to criticism and regret. Not surprisingly, people look for reasons to maintain the status quo and do nothing because that course causes less psychological risk (Hammond, Keeney, and Raiffa 2006). This bias reflects the old saying, "Better the devil you know than the devil you don't."
- **Sunk cost bias**—bias toward investments that cannot be recovered. In decision making, only costs and benefits that vary with the consequences of decisions should be included as factors. Sunk costs should not be considered because they are fixed and nonrecoverable. However, individuals often include sunk costs as major factors in their decisions. For example, say you paid a premium price for excellent seats at a professional football game. Early in the third quarter, your home team is behind 45–0, and much of the crowd is beginning to leave. You opt to stay because you paid too much to leave the game early. In reality, the ticket price is a sunk cost and cannot be recovered. Thus, your decision to leave should be made without consideration of the price you paid for admission.
- **Confirming-evidence bias**—bias toward information that supports or reinforces a position or belief. This bias affects where the evidence is obtained and how it is interpreted. For example, your political leaning

may influence your decision to watch a news channel that delivers information and views in a way that matches your preference. As a result, you may discount the contrary information provided by other channels. Loaded with information that justifies and reinforces their existing beliefs, people may make uncompromising and potentially damaging decisions.

- **Framing bias**—bias toward a choice framed positively. The way a question is framed can strongly influence the choices made in response to it. People tend to be risk averse when making decisions and reject options that present even the possibility of a small loss and even if paired with a large potential gain. People are also much more likely to accept a decision presented in a positive format than in a negative one. For example, in a study by Tversky and Kahneman (1981) individuals were asked to choose between two different treatments that were to be given to 600 people who suffered from a deadly disease. Treatment A was projected to result in 400 deaths, and Treatment B was predicted to lead to a 33 percent chance of survival but a 66 percent chance of death. When a positive frame was used (i.e., "Treatment A will save 200 lives"), 72 percent of participants chose Treatment A. However, when a negative frame was presented (i.e., "400 people will die with Treatment A"), only 22 percent of participants chose Treatment A.

Groupthink

Another detriment to good decision making is **groupthink**. Today's employees work extensively in groups, and leaders need to understand how group dynamics can affect decision making. Although not explicitly considered a bias, groupthink can seriously affect important decisions. Groupthink is "the tendency for members of a highly cohesive group to seek consensus so strongly that they fail to do a realistic appraisal of other alternatives, which may be more correct" (Osland et al. 2007, 471).

When groupthink occurs, group members avoid raising controversial issues and stifle dissent as a result of their group cohesion, often arising from a lack of diversity among group members. Loyalty to perceived or actual group norms has priority over independent judgment.

The consequences of groupthink may include an incomplete survey of alternatives, failure to seriously recognize risks, a poorly applied search for supporting information and a biased analysis of it, and a lack of contingency plans. Examples from US history include decisions leading up to President John Kennedy's Bay of Pigs invasion in Cuba; the federal government's failure to anticipate that Japan would attack Pearl Harbor, Hawaii, triggering the United States's entry into World War II; and President George W. Bush's decision to invade Iraq following the September 11, 2001 terrorist attacks (Redd and Mintz 2013).

Decision Making in Healthcare

The ability to make rational, effective, and efficient decisions is extremely important in healthcare. However, the challenges that leaders face in doing so continue to grow. Healthcare decision making has become highly complex. In the beginning of the twentieth century, physicians had only to choose between a few simple tests to diagnose patients. When it was first published in 1899, the *Merck Manual*—one of the most famous comprehensive medical texts—had only 192 pages; its nineteenth edition, published in 2011, comprised 3,754 pages (Porter and Kaplan 2011). The critical nature of decisions in healthcare also highlights the importance of decision making. Clinical healthcare decisions result in substantial consequences, important trade-offs, and significant uncertainties (Hunink and Glasziou 2001).

A major issue today that most countries grapple with is the wide disparity in health and healthcare among population groups. Decision-making biases are said to contribute to health disparities among racial and ethnic groups (Dovidio and Fiske 2012).

To help offset these issues, the Affordable Care Act encourages greater shared decision making between patients and providers. Patients historically have not been adequately involved in their care. One survey showed that less than 10 percent of clinical decisions made in medical offices meet the government's minimum standards for informed decision making. Providers are encouraged to offer written materials, videos, or interactive electronic presentations to inform patients and families regarding care options, outcomes, skills needed to perform procedures, and costs (Lee and Emanuel 2013).

Information technology has also become an important component in both clinical and administrative decisions in healthcare (Walston, Bennett, and Al-Harbi 2014). A 2012 report from the US government's Agency for Healthcare Research and Quality found that clinical decision support and knowledge management systems may improve healthcare process results across diverse settings, but significant efforts are needed to ensure that these systems reach their potential (Lobach et al. 2012).

Improving Decision Making

Learning to make good decisions is a lifelong challenge. Good leaders constantly seek to improve their ability to make informed, well-thought-out decisions. However, they recognize that errors will be made, and these become learning experiences.

Good leaders also seek to understand their own and their employees' biases and create processes to guard against the influence of such biases.

Ways to minimize the chance of making a bad decision include the following (adapted from Myatt 2012b):

- *Perform a situation analysis*. Determine which factors motivate the decision, what happens without a decision, and who will be affected with each potential solution, and then use appropriate data analytics and research to inform the decision.
- *Subject the decision to public scrutiny*. Allow appropriate stakeholders to review the potential decision and the information and data on which it is based. Listen to their feedback, and adjust the decision, if needed, on the basis of new information from their input.
- *Conduct a cost–benefit analysis*. Ascertain whether the potential benefits from the decision outweigh the potential costs.
- *Perform a risk/reward ratio*. Determine whether the possible rewards exceed the risks. Assess the odds of success as either favorable or unfavorable.
- *Determine the right thing to do*. Ensure that your decision is ethical and appropriate on the basis of your and your organization's values.
- *Make a decision*. Have a preference for action. Understand that bounded rationality will never allow all knowledge and options to be known. Do not get bogged down with "analysis paralysis."
- *Have a backup plan*. Good leaders know a decision can go astray, so they have contingency plans ready in case the initial decision fails.
- *Include diverse viewpoints*. Better decisions are made when a diversity of opinions can be heard. Involving people with different backgrounds, cultures, genders, and races encourages greater idea sharing and leads to more informed decisions.

Leaders need to both make quality decisions and obtain their employees' acceptance and buy-in of their decisions. As discussed in chapter 19, organizational structure and information flows are critical for good decision making.

Not only is decision making a complicated and difficult task in most organizations, but it is also the key managerial duty that ultimately makes the difference between success and failure. Good leaders make—rather than avoid—the tough decisions. The box on page 220 describes a real situation in which the CEO, at great personal risk, decided to increase nursing salaries when it became clear that doing so was the best decision for the organization.

Decision Making in Meetings

Decision making often occurs in meetings. For those working in a health-care organization, sitting through the tenth poorly organized and seemingly

Sometimes It Takes Courage

By Britt Berrett

A new CEO arrived to lead a hospital that was experiencing a 35 percent vacancy rate and 38 percent turnover in nursing services. A recent employee engagement survey determined that 45 percent of the staff were "actively disengaged." An analysis by the hospital's human resources executive found that much of this dissatisfaction was due to the fact that nursing salaries were significantly under market standards and had been for almost two years.

In response, the executive team created a plan to be submitted to the division office for approval. Unfortunately, the division office's past behavior was to reexamine, reanalyze, reconsider, and effectively delay any salary grade adjustments.

Sometimes it takes courage to effect positive change. The members of the executive team understood that if they proceeded without corporate approval, their jobs would be in jeopardy. But they also recognized a dysfunctional decision-making process that was creating a toxic and unsafe work environment.

Under the explicit direction of the CEO, the salary adjustments were implemented. The division office reacted by threatening to terminate the CEO. Other members of the executive team were shielded from corrective action, but the CEO was immediately put on disciplinary status and denied both a merit increase and an annual bonus.

Were the actions of the executive team painful? Unwise? Even stupid? Yes, yes, and yes. But they were courageous.

The implications were quickly communicated throughout the organization. The fairness of the executive staff was confirmed, and the organizational response was the first step in creating a world-class organization nationally recognized for its financial performance.

pointless meeting of the week is both frustrating and fruitless. To improve the likelihood that decisions will be made in the meeting setting, meetings need to be appropriately coordinated to allow healthy conflict to be generated.

Effective meeting coordination includes careful preparation, organization, process, and follow-up. Agendas should be distributed beforehand, along with sufficient background materials, to inform participants of the upcoming topics. Meetings should start and end on time. Items that involve decisions should be noted. Minutes should be kept, assignments given, and responsibilities fulfilled. Meeting management should be seen as a cycle, as shown in exhibit 13.3. For subsequent meetings, agendas should be published, meetings properly managed, minutes taken and published, assignments completed, and topics prepared for new discussions.

To make timely and informed decisions, each of these meeting guidelines requires effort and thought. An agenda should be considered a framework and means of focus to guide and support the meeting. As such, it should reflect the critical topics that are relevant to the purpose of the meeting or committee. At a minimum, agenda items should be designated as requiring a decision and be accompanied by a note as to who will lead the discussion. Everyone with a stake in the given topic should be invited to the meeting. One person—generally the one in charge of the meeting—should be assigned to manage the agenda, schedule the meeting, and send out (at least 24 hours prior to the meeting) the agenda and any supporting materials. Generally, agendas contain the following elements:

EXHIBIT 13.3
Meeting Cycle

- List of invited attendees
- Review of minutes from the previous meeting
- Follow-up on previous assignments
- New business (discussion of new topics, listing the name of presenter, time allotted, and desired outcomes)
- Date and time of next meeting

Successfully managing a meeting requires the work and cooperation of many. At least two roles should be established for each gathering: a meeting leader and a recorder of minutes. Prior to meetings, the means by which decisions will be made (whether for the whole meeting or for specific items) must be decided. Some groups use majority vote, others a super majority, and others consensus. Either the meeting leader or a designated participant should keep people on track, involve everyone, and make certain that decisions are made. At the conclusion of the meeting, the recorder should summarize the actions to be taken.

Just because a meeting concludes does not mean that assignments will be completed. The meeting leader needs to follow up with those who have been assigned tasks to ensure timely completion. Some leaders take this action at the next step—while preparing the next meeting agenda. Requests for additional items and reminders of assigned activities can be given concurrently.

In short, running effective meetings facilitates decision making, but meetings require structure and order to be effective (exhibit 13.3). Using an organized agenda, involving all participants, and managing the meetings well help with making and implementing decisions.

Chapter Summary

Leaders are hired to make decisions, and good leaders tend to make good decisions. Learning to make good decisions and improving decision processes are a lifelong pursuit for most. Understanding the basic principles of decision making and biases can directly affect the quality of decisions.

Three models of decision making are presented in the chapter. The rational decision making model was popular prior to the 1950s and assumed problems could be clearly defined, all options and their effects could be known, and a best solution could be chosen. Although ideal, this model has been found to be unreasonable in practice.

Offering an approach more reflective of reality, the bounded rationality model incorporates many of the constraints people experience in decision making, including human cognitive limits and emotions and the costs of gathering and processing information. People do not seek the optimal solution but continue their search until they find a good-enough or satisfactory solution. Thus, decisions are "bounded" by human limitations.

The third decision model is the garbage can model, a chaotic form of decision making that occurs in organized anarchies, or organizations that exhibit unordered and messy decision making. This model involves the mixing of choices or decisions, participants, and solutions in a somewhat haphazard manner. The solutions selected can appear capricious, as they may depend on the current participants and available solutions.

Decisions can also be influenced by biases that exist at an individual, group, or organizational level. Often, these biases unknowingly affect our thoughts and decisions. Heuristics is one way biases creep into our decisions. Heuristics are mental shortcuts or rules of thumb that help us make quick decisions yet can lead us terribly astray.

Many types of biases can influence our decision making, including (1) anchoring bias, (2) status quo bias, (3) sunk cost bias, (4) confirming-evidence bias, and (5) framing bias. Each can cloud our judgment, and we need to understand and compensate for biases that may lead us to a poor decision.

Another detriment to good decision making is the concept of groupthink. Groupthink occurs when members of a group seeking harmony or conformity make irrational or dysfunctional decisions. Groupthink often happens in homogeneous groups with limited diversity and when loyalty to group norms takes priority over independent judgment.

Learning excellent decision-making skills is extremely important in healthcare, as the level of complexity and challenges grows. Providers need to involve patients in decision making; evolving information technology offers the ability to improve both clinical and administrative decisions.

Having effective meetings improves decision making. Well-organized and -facilitated meetings allow topics to be appropriately discussed and timely decisions made.

Overall, decision making is a challenging task for leaders and managers. Good leaders constantly seek to improve their decision-making abilities and guard against the influence of biases.

Chapter Resources

Following are a number of tools that can be used for creative problem solving, along with a brief explanation and online information:

- *How–how diagram*—identifies ways to accomplish a goal or solve a problem by graphically displaying a range of solutions:
  - www.agric.wa.gov.au/improvement-tools-how-how-diagrams
  - http://creatingminds.org/tools/how_how.htm
- *Why–why diagram*—helps to creatively explore and consider multiple causes of a problem:
  - http://sustainableimprovement.weebly.com/why-why-diagram.html
  - http://cct.wikispaces.umb.edu/Why-WhyandHow-HowDiagrams
- *Fishbone (Ishikawa)diagram*—identifies many possible causes for an effect or a problem:
  - http://asq.org/learn-about-quality/cause-analysis-tools/overview/fishbone.html
  - http://moodle.cce.cornell.edu/pluginfile.php/2509/mod_page/content/3/Documents/fishboning.pdf
- *Kepner Tregoe decision making*—aids in gathering and prioritizing information in a structured way:
  - www.decision-making-confidence.com/kepner-tregoe-decision-making.html
  - www.toolshero.com/problem-solving/kepner-tregoe-method/
- *Synectics*—encourages the use of the conscious and unconscious creative faculties:
  - www.ideaconnection.com/thinking-methods/synectics-00013.html
  - http://digitalcommons.buffalostate.edu/cgi/viewcontent.cgi?article=1035&context=creativeprojects

Chapter Questions

1. What are the major differences between rational decision making and bounded rationality?

2. What characteristics does a university have that might be conducive to the garbage can model of decision making?
3. What is the difference between a bias and a heuristic?
4. Why should one ignore sunk costs in decision making?
5. I choose only to watch one news channel that matches my political persuasion. This is an example of which bias? Why?
6. Which of the biases discussed in this chapter could seriously affect a survey response? Why?
7. What could a leader do to reduce the possibility of groupthink?
8. How can healthcare decisions be improved?

Chapter Cases

Allocating Salary Increases and Effort

Pat and Chris were hired by Central O. District Hospital (CODH) as part of a three-year management contract with HCA Management Company. The hospital had been poorly run during the past decade, and numerous problems were evident. Pat and Chris were both young and energetic, but Pat's role as CEO meant greater visibility to the hospital board and community. Chris, the chief financial officer, was more operationally oriented and helped Pat make the tough decisions needed at the facility. They had learned to trust and depend on each other.

After the first year, they had made great progress. Instead of producing losses, CODH began to generate reasonable positive margins of 3 to 5 percent each month. New, badly needed equipment was purchased. The hospital seemed to be having one of its best years in decades. Pat, the CEO, received very positive news coverage in the local newspaper, which touted the "youthful turnaround" at CODH. A picture of Pat was prominently placed on the front page. Chris was exceptional with numbers but sometimes did not relate as well to others. However, the two were close friends, sometimes socializing after work, and had an extremely good working relationship.

The CODH board consisted of county residents, who were elected for four-year terms. Most were successful businesspeople with whom Pat could easily relate. The board had been displeased with the previous two CEOs it had hired. Both had financial backgrounds (one was a certified public accountant), had a hard time communicating with the board members, and were shy in approaching the public and media.

The time for Pat's and Chris's first-year evaluations came, and Rory, the regional vice president for the management company, visited the hospital to meet with the board. At the beginning of the board meeting, Pat presented a summary of the hospital's accomplishments during the past year. Afterward, Pat and Chris left the room, and the board, with Rory present, met in an executive session. Rory offered a positive evaluation of the hospital's performance and rated both executives' overall work as exceptional. In light of their superior performance, Rory recommended to the board that both receive 6 percent increases in their base salaries.

After an extended debate, the hospital board decided, against Rory's advice, to divide the salary increase differently. Instead of giving a 6 percent raise to both, the board, believing Pat was more responsible for the success of the hospital than Chris was, gave the former a 9 percent increase and the latter only 3 percent. When this information was shared, Pat was mortified and wondered how the board could have made such a decision.

Case Questions

1. Which biases may have entered into the board's decision making?
2. What might the board have done to minimize the effect of potential biases?

Seeing What We Want to See

Graham ruled with an iron will. He felt that the only way to motivate his employees was by giving them clear direction and having them keep him informed of their progress. He had full confidence in his abilities and believed that his employees respected and liked his management style. This belief was validated in almost every meeting: He would present his agenda and state what needed to be done, and everyone would happily agree with him. Well, almost always. One time, during a department head meeting, the new director of maintenance publicly disagreed with him. That discord was short lived, as Graham made it clear that his opinion on a topic would stand.

Recently, Graham and his sister were discussing a *Harvard Business Review* article titled "Three Tips for Overcoming Your Blind Spots" (Dame and Gedmin 2013). His sister, who was studying leadership, suggested that all leaders have blind spots, which cause them to believe something other than reality. The article noted that blind spots may occur because of confirmation (or confirming-evidence) bias, selective memory,

(continued)

(continued from previous page)

and groupthink. Graham thought the article was interesting but told his sister that biases weren't present in his organization, that he could tell what his managers and employees felt about his suggestions, and that he could read in their faces and body language that they agreed. Graham boasted that he had built a cohesive, well-oiled management team he knew like the back of his hand.

Case Questions

1. How is Graham's situation a possible example of confirming-evidence bias?
2. How could decisions made by Graham's management team be subject to groupthink?
3. What could you suggest to Graham to improve the decision-making process in his organization?

14 CREATIVITY AND INNOVATION

Learning Objectives

After studying this chapter, readers should be able to

- recognize the value of creativity and innovation for an organization,
- appraise the methods to foster creativity and innovation,
- distinguish among different types of innovation,
- describe the diffusion of innovations throughout an industry and market, and
- interpret the difference between disruptive innovation and sustaining innovation.

Key Terms

- Creativity
- Diffusion
- Disruptive innovation
- Innovation
- Sustaining innovation

Although creativity and innovation have traditionally targeted the development of groundbreaking products and processes—new therapies, medical devices, and drugs in the healthcare industry, for example—they encompass much more than development. Healthcare leaders who encourage creativity and innovation in their organization must address a wide array of questions and seek to solve a multitude of problems, which Drew Gilpin Faust, past president of Harvard University, laid out (Chin et al. 2015):

> Healthcare, of course, has more than its share of very complex questions. How can we reduce costs and increase value, improve patients' experiences and outcomes, speed the translation of research into therapies and cures, make healthcare something that people can have access to here in the United States and, ultimately, around the world?

The global healthcare system has a great need to innovate and develop the creativity needed to address these issues, especially access to the "right" type of care. As enumerated by the Institute of Medicine (2001), care must be

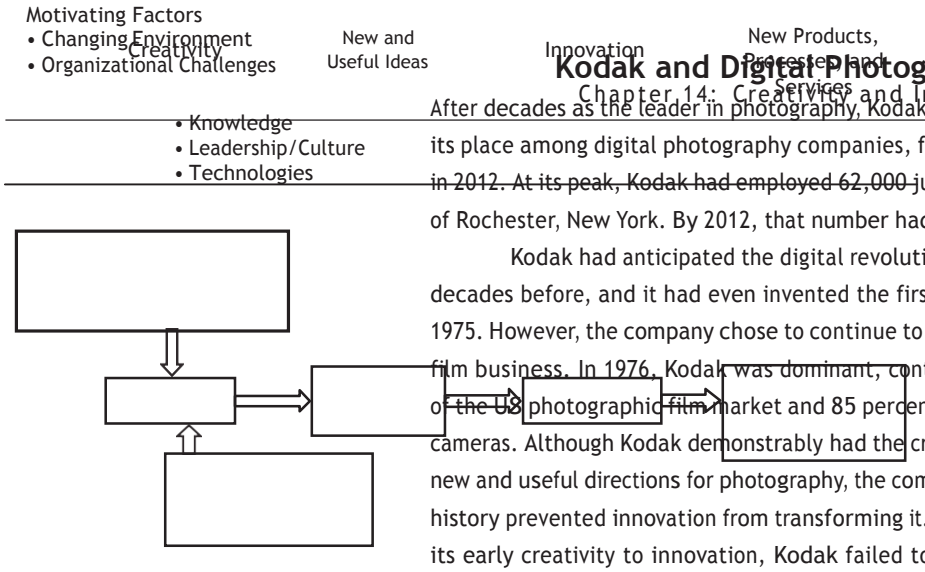
1. *safe*—avoiding injuries to patients from the care that is intended to help them;
2. *effective*—providing services on the basis of scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively);
3. *patient centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
4. *timely*—reducing wait times and harmful delays for those who receive and those who give care;
5. *efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy; and
6. *equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status.

The Link Between Creativity and Innovation

Frequently, business leaders erroneously equate innovation with creativity. However, innovation is not creativity. According to Osland and colleagues (2007, 319), **creativity** is "the development of new ideas" and the "precursor to **innovation** [which is] the implementation of new ideas." Anderson, Potočnik, and Zhou (2014, 1298) offered a more elaborate definition of both terms:

> Creativity and innovation at work are the process, outcomes, and products of attempts to develop and introduce new and improved ways of doing things. The creativity stage of this process refers to idea generation, and innovation refers to the subsequent stage of implementing ideas toward better procedures, practices, or products. Creativity and innovation can occur at the level of the individual, work team, organization, or at more than one of these levels combined but will invariably result in identifiable benefits at one or more of these levels of analysis.

As shown in exhibit 14.1, creativity is often sparked by a changing environment and organizational challenges. Knowledge, leadership and culture, and technologies also spark creativity, which in turn generates new and useful ideas that stimulate innovation that then produces new products, processes, and services. Effective creative environments require strong knowledge bases from which



Source: Adapted from Dawson and Andriopoulos (2014).

EXHIBIT 14.1
From Creativity to Innovation

employees can draw, leaders and a culture that promote investigation and imaginative exploration, and cutting-edge technologies (Dawson and Andriopoulos 2014).

Creative companies need to attract, reward, and retain employees who are risk takers. These are people who are willing to fail and operate in a culture that allows failures to be seen as a learning process. In addition, such employees should possess creativity-related cognitive skills and domain-specific knowledge, coupled with the intrinsic motivation to drive them forward. Because of the importance of employee characteristics, many creative organizations screen applicants for creative traits (Osland et al. 2007).

Creativity by itself is not sufficient, however. Creative organizations may generate many novel ideas, but unless the ideas are transformed into usable, valuable products and services, a firm's creativity may ultimately be of little worth. As shown in the adjacent box, even large, successful companies such as Kodak can fail to convert their creativity into innovation. Although Kodak was the dominant firm in its industry for decades, its inability to take its staff's creative ideas to market significantly contributed to its failure. Turning creative ideas into valuable, functional products, processes, and services requires innovative action.

Kodak and Digital Photography

After decades as the leader in photography, Kodak, struggling to find its place among digital photography companies, filed for bankruptcy in 2012. At its peak, Kodak had employed 62,000 just in its hometown of Rochester, New York. By 2012, that number had fallen to 7,000.

Kodak had anticipated the digital revolution in photography decades before, and it had even invented the first digital camera in 1975. However, the company chose to continue to focus on its legacy film business. In 1976, Kodak was dominant, controlling 90 percent of the US photographic film market and 85 percent of the market for cameras. Although Kodak demonstrably had the creativity to develop new and useful directions for photography, the company's culture and history prevented innovation from transforming it. Instead of moving its early creativity to innovation, Kodak failed to capitalize on the opportunity and now is only a shadow of its former self.

Source: Information from Gustin (2012).

Organizations that are creative and innovative do not copy other firms but instead develop unique products, processes, and services. Because healthcare systems across the globe require unique changes to address their many problems, successful healthcare innovation comes in the form of viable solutions to make patient treatments and care more accessible, better, and cheaper. As Lazarus and Fell (2011, 363) noted:

> True innovation is a powerful concept with an inherently unique capacity to align people, foster creativity, and bring significant improvement to existing processes or transformational change to whole systems and industries.

Types of Healthcare Innovations

Healthcare innovations are segmented into three types:

1. *Consumer-focused innovations:* The way consumers buy and use healthcare is covered in this segment. Health plans may become more user-friendly and empower healthcare customers.
2. *Technology innovations:* Technological innovations in healthcare have long been known to be "directly related to the diagnosis and treatment of disease" (Kimberly and Evanisko 1981). Today, these innovations include pharmaceutical breakthroughs; sophisticated drug-delivery systems; advanced information technology, such as artificial intelligence; and diagnostic devices that can be less costly to operate, allow less-invasive testing, and offer a less-painful patient experience.
3. *Business model innovations:* Hospital and health system business models continue to evolve through the reorganization and improved integration of the healthcare activities of physicians, hospitals and nursing homes, and other providers (Herzlinger 2006).

Changes to all or any of these three types of innovation may alter the future of healthcare. Consumer-focused innovation parallels the efforts of many healthcare organizations to become patient focused or provide patient-centered care. However, in the United States, the patient has long been outside the chief focus of healthcare providers. For example, although the following statement refers to pharmaceutical concerns, it is just as applicable to all other healthcare providers (Coleiro 2013):

> In healthcare, patients are often thought of as the passive recipients of what is manufactured by pharma companies, prescribed by their HCP [healthcare provider] and paid for by the insurance company or state funded system: not as decision-makers.

This focus is beginning to change. For example, Philips, one of the largest healthcare firms in the world, has designated its strategy to be "people-focused, healthcare simplified. Philips integrates technologies and design into people-centric solutions" (Parameswaran and Raijmakers 2010).

In addition, changes in the US insurance market are giving consumers more options in choosing their health insurance, which has driven insurers to begin designing their products for consumers. Emphasizing this trend, the head of Aetna, one of the largest US insurance companies, stated that the company is committed to people and products focused on consumers (Rosenthal 2012).

Technology innovation is probably the best-known type of implemented creativity in healthcare. Examples include the discovery of penicillin and the development of MRI (magnetic resonance imaging) scanners, to name just a couple. Throughout the twentieth century, technological innovations led to dramatic improvements in the quality of life and longevity of people across the globe. The continued advances in digital technology allow the development of more, and increasingly user-friendly, portable devices that empower patients and provide continuous monitoring and treatment.

Business model innovation is another type of innovation that can transform healthcare. A business model is "the core elements of an organization and how it is structured to deliver value to its customers and generate revenues" (Walston 2014, 44). It incorporates all parts of an organization and the way it operates, is funded, and relates to other organizational segments. Organizations with innovative business models may succeed, while others with better ideas and technology but a poor business model may fail.

Renowned Harvard professor Clayton Christensen (1997) suggested that innovation in healthcare can be a "game changer" and can drastically improve care and reduce costs. Glabman (2009) listed seven specific healthcare innovations believed to fulfill Christensen's promise of game-changing creativity implementation. Although portions of the three types of innovation may be present in the following seven innovations, the first three primarily involve the creation and implementation of new technology while the last four reflect a combination of customer-focused care and new business models (adapted from Glabman 2009):

1. *Technology to transfer care from specialists to generalists:* A groundbreaking system of transfer is emerging from physician to physician, from generalist physician to nurse, from nurse to allied health professional, and from allied health professional to patient. For example, the skills of a board-certified family practitioner may not be needed to determine whether a sore throat must be treated with antibiotics if a rapid strep test is available and can be used by other healthcare professionals. In addition, just as people with diabetes and

those with clotting disorders now test and inject themselves routinely, people with other chronic conditions could use innovative technology to monitor and control their diseases.

2. *Surgical robots:* Equipment such as LASIK machines is commonplace. Medical procedure devices that operate themselves will continue to be developed.
3. *Telemedicine:* Designed to deliver care conveniently to patients, even at their homes, telemedicine provides "virtual consults" to improve access and enables early screening and diagnosis. For example, in Norfolk, Nebraska, a rural location with no medical facilities, an obstetrician installed kiosks in remote pharmacies to allow walk-in patients to connect with his clinic, located about two hours away.
4. *Personalized medicine:* Through pharmacogenomics, personalized medicine helps determine how genetic differences affect an individual's response to a drug, and genetic tests identify those who will likely benefit from which drug. This innovation can be important, as almost 50 percent of people receive no benefit from drugs they now take.
5. *Medical tourism:* Providing the opportunity for patients from high-medical-cost countries to receive equivalent care in lower-medical-cost countries, medical tourism allows a US-based patient to save at least 30 percent on her cost of care. For example, a hip replacement may cost $43,000 to $50,000 in the United States but only $9,000 to $12,000 in Singapore.
6. *Single-organ-focused hospitals:* These hospitals specialize in a narrow range of surgeries and treatments, allowing economies of scale and improved quality. For example, the Shouldice Hernia Centre in Ontario, Canada, can perform a hernia repair for about $2,300, whereas the same procedure costs about $7,000 at a US hospital.
7. *Retail clinics:* Coupled with electronic health records, physician order entry systems, and e-prescribing applications, retail clinics bring less expensive, high-quality primary care services to more patients at a convenient location.

Strategies for Increasing Creativity and Innovation

Companies vary dramatically in their creative and innovative abilities. Those that are creative frequently take proactive measures to boost that trait in their organization. At the same time, they minimize behaviors and actions that discourage it. As displayed in exhibit 14.2, the level of creativity and innovation found in a firm is related to the types of employees, culture, jobs, leaders, and rewards. To have high levels, employers should screen new job candidates for

EXHIBIT 14.2
Activities That Encourage and Discourage Creativity and Innovation

Employees and Culture	Screen job applicants for innovative characteristics Employ staff with diverse backgrounds and skills Continually train and "retool"	Limit turnover Retain a negative legacy culture
Jobs	Provide time to be creative Design complex jobs with significance, identity, variety, autonomy, and feedback Allow extensive contact with customers	Encourage a high degree of competition Place tight controls on information and decision making Do not alleviate time pressures Emphasize status quo
Leaders and Rewards	Offer a clear vision and goals Recognize and reward creativity Encourage risk taking Practice participative leadership	Focus excessively on financial/extrinsic rewards Set tight limits on staff Micromanage Allow political problems to perpetuate

Source: Adapted from Osland et al. (2007).

specific innovative characteristics, which the leadership can establish on the basis of organizational needs and vision. In addition, they should diversify the backgrounds and skills of their employees and continually train them. Before embarking on a new hiring system, however, companies must be aware that limited turnover and a negative legacy culture that discourages change will cause problems for the new employees who would like to create and innovate.

Part of this problem can be avoided by better job design. Time should be built into the workday for employees to think creatively and implement creative concepts. Jobs should be relatively complex but (as reviewed in chapter 5) significant and meaningful nonetheless, lending identity, variety, autonomy, and feedback to employees. Jobs that foment high degrees of competition, require tight controls on information and decision making, involve excessive time pressures, and emphasize the status quo discourage new thought and innovation.

Last, leaders who articulate clear visions and goals, recognize and reward creativity, encourage risk taking, and engage their employees in participative leadership promote creativity and innovation. Conversely, leaders who place

Innovation at Massachusetts General Hospital

Innovation occurs when problems are specifically addressed and people are organized to improve processes. One such successful innovation effort took place at Massachusetts General Hospital (MGH) with its development of a "smart" drug-infusion pump. At the MGH complex, as across the United States, drug-dosing calculation errors that involve drug-infusion pumps were very common. To solve the problem, MGH organized a team to identify ways to prevent intravenous (IV) medication errors. The team found that providers did not receive timely guidance on IV drug delivery practices and no foolproof method was in place to prevent serious errors caused by IV pump dosing.

Working with the healthcare device companies, the MGH team helped create a smart infusion pump. The new pump interfaces with a "hospital-specific, electronic library of hundreds of IV drugs and infusion protocols." Providers are notified and the dosing is halted if the pump is programmed with doses outside the prescribed protocols. The smart pump is now being used in hospitals nationwide.

Source: Information from Blakeney et al. (2009).

excessive focus on financial or other extrinsic rewards, set tight limits and micromanage, and foment political situations in their organization discourage creativity and innovation.

To promote innovation, many US health systems and even government bodies have created dedicated innovation centers. Three examples include the Mayo Clinic Center for Innovation, founded to "transform the experience and delivery of health care" (www.mayo.edu/center-for-innovation/); Massachusetts General Hospital's Center for Innovations in Care Delivery, established to bring teams together to innovate (www.mghpcs.org/Innovation/); and the Center for Medicare & Medicaid Innovation, part of the Centers for Medicare & Medicaid Services, created to test "innovative payment and service delivery models to reduce expenditures . . . while preserving or enhancing the quality of care" (http://innovation.cms.gov/About/index.html). The initiatives launched by these centers address a wide range of innovations, including retail medicine, mobile monitoring, products for rural practices, and advancing best practices (Lazarus and Feil 2011).

As described in the box below, if innovative efforts are organized and directed, they can have important, lasting effects on the improvement of patient care and organizational success.

Diffusion of Healthcare Creativity and Innovation

Not only are creativity and innovation important to every healthcare organization, but their widespread diffusion—both nationally and internationally—is also critical for improving overall patient outcomes. Most of the progress in health improvement in the second half of the twentieth century can be traced to the diffusion of new innovations through public health and medical channels (Rust et al. 2010). However, much of the innovative medical technology adopted over the years has also been a major

driver in increasing medical costs (Hashimoto et al. 2006). Therefore, new technology alone will not suffice to improve healthcare; a new wave of all types of innovations—and their diffusion—is required to open access to high-quality, low-cost care.

While we define diffusion and explain its process in detail later in this section, some background is helpful at this point in the discussion. When we talk about diffusion, we mean that these innovative solutions must be not only locally discovered but also disseminated nationally or globally. Necessary changes defy simple solutions, and innovative designs are critical.

Although many astonishing advances have occurred, concerns have been raised that the time required to diffuse new innovations across healthcare systems is far too long (Darzi and Parston 2013). To promote diffusion, organizations such as the World Innovation Summit for Health (WISH 2015a) have sponsored forums, including an annual meeting; research; and reports, some of which help identify and document global innovations. The box below describes one of the many innovations WISH has been cataloging since 2014.

Diffusion of healthcare innovation is complicated and facilitated by many issues. Two important factors that encourage adoption of new technology are (1) the perceived ease of use of the technology and (2) its perceived usefulness by its stakeholders (Thakur, Hsu, and Fontenot 2012). Stakeholders in healthcare may be the providers, managers, regulators, or patients. They first need to be exposed to and learn about new technology, as its perceived ease and benefit of use is related to their knowledge of and experience with the technology (Walston, Bennett, and Al-Harbi 2014). Assuming a positive interaction, the more stakeholders are exposed to an innovation, the more likely it is to be adopted.

In addition to WISH, other organizations have founded exchanges and mechanisms to share innovation resources and ideas with healthcare stakeholders. These include the following:

- *Agency for Healthcare Research and Quality's Health Care Innovations Exchange*: The exchange expands efforts to spread innovations by sponsoring "learning communities" that collaboratively adapt and implement innovations that improve healthcare quality (https://innovations.ahrq.gov).

The 7 Day Mother Baby mCheck Tool

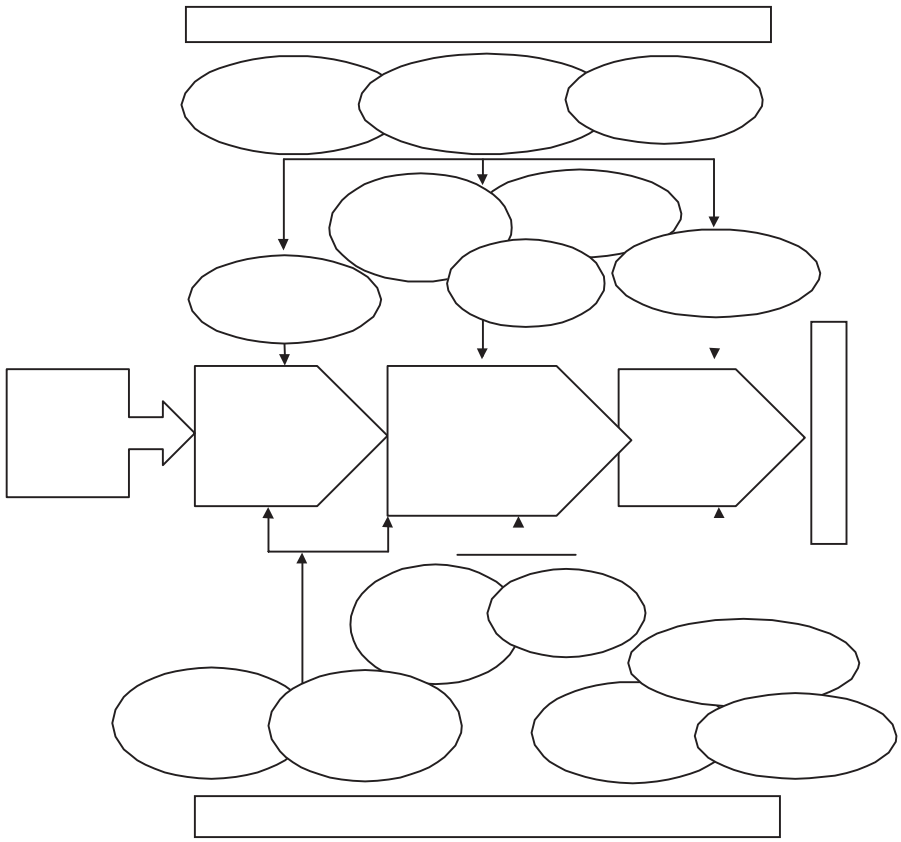
The World Health Organization (WHO) created the 7 Day Mother Baby mCheck Tool to increase safety and reduce mortality and morbidity during high-risk postnatal periods for mothers and their babies. This tool is the first patient-held, mobile checklist and focuses on common causes of maternal and child illness and disease in the first seven days following birth. It provides questions for clinicians to ask mothers to identify the presence of danger signs in the mother or her baby and to assess the severity and urgency of the problem. The tool uses mobile phone technology to help guide the evaluation if medical care is required.

Sources: WHO (2015); WISH (2015b).

- *TEDMED:* TEDMED offers conferences that promote innovation and idea sharing across a wide scope of health-related topics (www.tedmed.com/home).
- *Fund for Innovation in Healthcare Leadership:* Sponsored by the American College of Healthcare Executives, the fund seeks to "bring innovation to the forefront of healthcare leadership" (www.ache.org/abt_ache/Fund_4_Innovation.cfm).

Diffusion is the act of spreading and embedding innovation to transform an organization, an industry, or a system. Exhibit 14.3 illustrates how creative ideas for innovation become transformational in three phases: creating a climate for change, engaging and enabling an organization to implement change, and embedding and sustaining the change. If these phases are completed, the innovation can become transformational and significantly affect the healthcare system.

EXHIBIT 14.3 Enablers That Promote the Phases of Healthcare Innovation Diffusion



Source: Adapted from WISH (2015A).

Note: ICT = information and communication technology.

The factors that enable the different phases are listed in exhibit 14.3. Across the full process, the presence of the following is crucial:

- Alignment of vision, strategy, and leadership to promote innovation and creativity
- Transparency of research and data that can be easily used for experimentation
- Communication channels to facilitate the transmittal of information

To create a climate for change in Phase 1, an organization should have the following:

- Specific agent to promote and shepherd the change
- Process to engage patients and the public
- Mechanism with which to address the concerns of healthcare professionals about the change

To complete Phase 2, an organization must engage and enable implementation of the innovation. This phase is facilitated and enabled by the following components:

- Specific funding for diffusion of the innovation
- Incentives and rewards to encourage the implementation and dissemination of the innovation
- Appropriate information and communication technology (ICT)
- Adequate time and space for learning new concepts
- Champions who can promote and encourage innovation

Phase 3 consists of embedding and sustaining the change. It can be promoted by the following enablers:

- Presence of standards and protocols
- Efforts to "delayer" or eliminate old practices
- Adapting the innovation to the local context
- Improvement as a result of the initial innovation and preparation for the next change

Disruptive Innovation and Sustaining Innovation

The concept of **disruptive innovation**, as championed by Harvard University professor Clayton Christensen, has become well known. Disruptive innovation

differs from **sustaining innovation** in that disruptive innovation creates radical change and destroys existing organizational competencies, whereas sustaining innovation builds on past successes and organizational competencies and provides incremental improvements (Christensen 1997; Clayton and Martha 2009). The vast majority of innovations are sustaining, which helps existing organizations thrive. However, when disruptive innovation arises, firms frequently fail and are replaced by new companies (Paetz 2014).

Technological breakthroughs often engender disruptive innovation. Examples include the microprocessor, which created personal computers and doomed mainframes; the Internet, which has largely supplanted traditional print news; and digital photography, which has overwhelmed photo film companies. Disruptive technologies often drive exiting companies out of business. Companies that previously dominated markets—such as Polaroid and Kodak in photography; Blockbuster with movie rentals; and many prominent newspaper organizations, such as the Tribune Company (now the Tribune Media Company) and the *Minneapolis Star Tribune*—have filed for bankruptcy as a result of the influence of disruptive technologies (Frezza 2012; Liedtke 2009; Sherman 2010).

Few dominant businesses survive disruptive innovation, as the value of much of their key competency is destroyed. For example, over the course of several decades, Kodak dominated the photography film market with expertise and competencies in chemical engineering. However, digital imaging destroyed the value of this competence, and thousands of chemical engineers employed by Kodak were eventually laid off. Electrical engineering skills were the competency needed for digital imaging, and Kodak, absent this platform, failed to survive (Walston 2014).

Healthcare may now be experiencing disruptive innovation with the use of new categories of mid-level providers (e.g., dental therapists) or retail clinics as alternatives for physician care (Edelstein 2011; Pauly 2011). Advances in genomics and gene therapy may have great potential for disruptive innovation in the diagnoses, treatment, and prevention of disease (Centers for Disease Control and Prevention 2012).

However, information technology remains a key facilitator for innovation in healthcare. The ability to transmit healthcare images and data globally offers an opportunity to radically transform the healthcare industry around the world (Omachonu and Einspruch 2010). As discussed in chapter 9, leaders must provide a vision and exhibit transformational traits to achieve this transformation.

Chapter Summary

Creativity and innovation are critically important for healthcare to address the many challenges that exist today. Creativity may be seen as the precursor

to innovation and involves idea generation, whereas innovation refers to the implementation of ideas. Creativity can be motivated by changes in the business environment and organizational challenges. It can also be facilitated by increased knowledge, proper leadership and culture, and cutting-edge technologies.

Creativity is necessary for an agile business, but it is not sufficient. Creative ideas must be converted through innovation into usable, valuable products, processes, and services to be of worth. In healthcare, innovation is needed to create viable solutions to improve the treatment of patients and make care more accessible and cheaper than it is currently. Healthcare innovation can be segmented into three types: (1) consumer-focused innovations, (2) technology innovations, and (3) business model innovations.

Companies that are creative and innovative consistently take measures to increase these competencies. The types of employees, culture, jobs, leaders, and rewards directly affect the levels of creativity and innovation in a firm. Too great a focus on financial and extrinsic rewards, managers who micromanage, and adverse political situations discourage creativity and innovation. To promote innovation, many healthcare organizations have established dedicated innovation centers.

The diffusion of that innovation is also important, especially in healthcare. Most of the progress in health improvement in the latter part of the twentieth century resulted from the diffusion of public health innovations. However, many of the recent medical innovations have also greatly increased healthcare costs. Diffusion is facilitated by the perceived usefulness of the innovation. To dramatically improve worldwide healthcare, more rapid diffusion of healthcare advances needs to occur. To this end, organizations have been established to promote diffusion of healthcare innovations.

Several enablers of innovation have been identified, which differentially affect the three phases of moving an innovation toward a transformative outcome. Critical to the process are the alignment of vision, strategy, and leadership; transparency of research and data; and open communication channels.

Disruptive innovation—innovation that creates radical change and destroys existing organizational competencies—is facilitated by technological breakthroughs and frequently places incumbent, dominant firms out of business. Mid-level providers, retail clinics, genomics, and information technology have the potential to develop into disruptive innovations.

Chapter Questions

1. Can an organization have innovation without creativity?
2. The creation and operation of a single-organ-focused hospital is what form of healthcare innovation?
3. What can organizations do to discourage the ability to be creative and to innovate?

4. Examine two of the innovation centers listed in the chapter. How are they similar? Different? Do they focus on any different aspects of healthcare innovation?
5. What two factors encourage the diffusion of an innovation? Why? What can be done to encourage these two factors?
6. What organizational enablers will best assist in creating a climate for change in a company?
7. What is the difference between disruptive innovation and sustaining innovation?
8. Name some potential disruptive innovations in healthcare. Why might they be disruptive?

Chapter Cases

UCLA Health's Introduction to Innovation

UCLA Health, the healthcare system of the University of California at Los Angeles, had appointed a chief innovation officer, Molly Coye, MD, to reinvigorate its innovation efforts. Past initiatives seemed to have flagged, and a new focus and energy were needed. Although the system had many past successes, it recognized that it had to overcome many current and future challenges if it was to fulfill its mission to educate future healthcare providers, effectively and efficiently treat patients, and promote research.

During her first week in the position, Coye met with the department chairs. Over the course of the two-hour discussion, she was asked, "Isn't innovation mostly about technology, and doesn't it fit with the research part of our mission?"

To this, she replied that almost all innovations were enabled by technology, but having a culture that promoted innovation and implementing change were even more important than technological invention.

This answer confused some of the chairs, one of whom said that he thought invention and innovation were the same concept. Coye then pointed out that the scientists at UCLA invented new things almost daily, but few of those inventions were actually used to affect patients' care. Innovation was the piece that provided value creation, she added.

Then one of the doctors asked what she meant by changing the culture. She explained that healthcare must move to more evidence-based and personalized medicine, along with a culture that supported both. This shift involved more predictive systems; greater preventive efforts; increased participation by all stakeholders, especially patients; and more personalized care.

The chairs were interested in how innovations would be implemented. Coyle stated that the institute she would be heading would scan innovations and select those that had the best chance of advancing the system's transformation. She explained that when candidate innovations were selected, they would be brought to an innovation leadership council and ultimately to the executive group to charter. A pilot project would then be initiated. If successful, commitments would be made to deploy the innovation across the system.

Coye was then asked which areas of innovation the system would be seeking to develop. She stated that the innovation portfolio would be broad and include drug discovery, neuromodulation, primary care–integrated care coordination, and patient relations. In addition, to remain fresh and cutting edge, UCLA had joined other national organizations focused on innovation, including the Institute for Healthcare Improvement, the Innovation Learning Network, and the Los Angeles Health Innovators Forum.

The chairs were impressed, but many withheld judgment until they could see the results.

Source: Adapted from Gamble (2013).

Case Questions

1. According to this chapter, creativity and innovation are different concepts. How does this case address creativity? Innovation?
2. What other factors discussed in the chapter could Coye implement to enable greater creativity and innovation?

The Future of Biotechnology, Gene Therapy, and Computer-Assisted Diagnostics

Biotechnology, gene therapy, and computer-assisted diagnostics continue to advance, but what will this progress mean to the healthcare industry? Recent events show that yesterday's science fiction is today's reality when it comes to gene therapy and biotechnology. Advanced human trials are now being conducted, and governments will begin approving gene therapy treatments for diseases such as prostate cancer, metastatic melanoma, artery failure in limbs, neurodegenerative diseases, early-onset blindness, and metabolic syndromes.

Gene therapy may present disruptive innovation to many medical fields. This revolution could affect every level of society—doctors

(continued)

(continued from previous page)

especially. The new drugs, treatments, and technologies will mean a new model of medicine that will destroy past competencies.

As genetic therapies advance, a genetic revolution is predicted. Tools now widely used in animals provide tomorrow's scientists with the power to alter every aspect of life on earth, even the potential of redesigning the human race. Although such knowledge raises serious ethical issues, it also promises wonderful results.

Gene therapy is not a single entity, however. It may be divided into three areas:

1. Replacing a defective or maladaptive gene that is responsible for some monogenic disease (e.g., cystic fibrosis, sickle cell anemia)
2. Altering or killing an aberrant cell (e.g., infected by HIV, cancerous)
3. Inducing production of a therapeutic protein (e.g., treating hepatitis C by promoting secretion of interferon by other cells)

In addition, some experts predict that combining computerization and gene therapy will produce many bionic enhancements. Advances have been made that link computer chips to human cells and nerves to help those who are paralyzed to move or walk. Soon, providers will be able to implant biochips that control blood sugar levels, benefiting people with diabetes. Biochips may also be implanted directly on the brain to potentially restore sight, hearing, and movement and even enhance memory and heighten intelligence. Preliminary work has already been completed in animals that fused living nerve tissue with the surface of a chip, allowing nerve impulses to activate a computer pathway and, in turn, a computer to activate brain cells directly.

Computer-aided diagnostics and genetic therapies are two promising technologies for twenty-first-century medicine. Both may be used to create healthier, stronger people, with enhanced characteristics. Processes may include cloning for needed body parts; cures for cancers; new drugs from microbes; viruses that correct genetic defects; genetically modified foods that contain vaccines; and continuous biomonitoring of functions, such as blood sugar levels, by means of implanted electrical devices that last a lifetime.

Instead of having the freedom to diagnose and treat by themselves, doctors will need to consult computers for advice before prescribing important treatments. These diagnostic computers will offer expert opinions, with malpractice consequences if ignored. Medical training will also shift

from emphasizing what individuals know to teaching how accurate data can be obtained from computer-based information sources.

Some specialties, such as surgery, will remain in demand, as accidents and aging will provide many opportunities for surgery. However, surgeons will add remote surgery to their routine, along with teleconferencing to advise surgical teams. Disease-related specialties that have a relation to genetics—such as cancers, blood disorders, allergies, and cardiac problems—will radically decrease in number, diminishing the need for physician specialists in their areas.

Will biotechnology, computer-assisted diagnostics, and gene therapy become disruptive innovations in healthcare? Will medical competencies established over centuries be destroyed? Time will tell.

Sources: Adapted from McCain (2005); additional information from Dixon (2016).

Case Questions

1. Which medical specialties may experience the most disruption—biotechnology, gene therapy, or computer-assisted diagnostics? How would this occur?
2. What can medical professionals do to adapt to the new technologies?

Chapter Activities

1. Read "At 3M, a Struggle Between Efficiency and Creativity" at www.bloomberg.com/news/articles/2007-06-10/at-3m-a-struggle-between-efficiency-and-creativity (Hindo 2007). Write a two-page paper on the challenges of balancing efficiency and innovation in an organization.
2. Visit the World Innovation Summit for Health website at www.wish-qatar.org/research/innovation-catalogue (WISH 2016). Select and read one of the innovations listed, and explain why this is an innovation, what its potential impact on healthcare could be, and which factors might prevent its diffusion and practical use.

15

GROUP AND TEAM DYNAMICS

Learning Objectives

After studying this chapter, readers should be able to

- evaluate the importance and use of groups in today's workforce,
- distinguish among different types of groups,
- compare and contrast the types of interdependence and the environments in which they exist,
- discuss the types of teams, and
- differentiate among the stages of team building.

Key Terms

- Command groups
- Formal groups
- Forming
- Groups
- Informal groups
- Interdisciplinary teams
- Multidisciplinary teams
- Norming
- Performing
- Pooled interdependence
- Reciprocal interdependence
- Storming
- Task groups
- Teams

Working in groups and teams has become the norm in today's workplace. Groups and teams exist in almost every facet of work. **Groups** are a collection of individuals who interact with each other and share common interests or characteristics. People come together in both informal and formal groups. **Informal groups** are self-formed and may evolve from work and social interactions. They are not prearranged by an organization and can include people who meet after work to exercise, golf, serve at a soup kitchen, or take part in some other activity.

Formal groups involve both command and task entities. **Command groups**, such as an executive team, are units that can give directions and orders within their organization. **Task groups** are organized for a specific job

or undertaking and may be structured on the basis of individual expertise and not hierarchical position.

In healthcare, task groups include patient care teams and project groups. Such groups are often organized into either task forces or standing committees. Task forces are formed for a limited time, usually until the completion of a project or an objective; a standing committee continues indefinitely (Lussier 2012).

Healthcare systems generally have a handful of standing committees as part of their governance structures. For example, the board of directors of the Cook County Health & Hospitals System (2015) in Chicago has five standing committees: (1) audit and compliance, (2) finance, (3) human resources, (4) quality and patient safety, and (5) managed care.

Group identity is an important aspect of human existence. Personal security, companionship, and behavior relate to group identity. Individuals are acculturated into groups through interactions, stories, and rituals. The core of group commitment is strengthened by the greater emotional intensity of group experience and collective rituals, which encompass religious ceremonies, festivals, rallies, commemorations, weddings, sporting events, and even holidays (Thye and Lawler 2010). The stronger the initiation, the stronger the group commitment.

Groups also form through professional organizations. Professional organizations allow individuals with similar backgrounds and interests to interact and develop their skills. They impart group norms that establish acceptable and unacceptable behaviors. Their numbers have grown tremendously—to almost 100,000 in the United States—and about 70 percent of US residents belong to one or more (Walston and Khaliq 2012). A few of the more prominent in healthcare include the following:

- AcademyHealth (www.academyhealth.org)
- American Cancer Society (www.cancer.org)
- American College of Healthcare Executives (www.ache.org)
- American Heart Association (www.heart.org)
- American Hospital Association (www.aha.org)
- American Medical Association (www.ama-assn.org)
- American Public Health Association (www.apha.org)
- America's Essential Hospitals (https://essentialhospitals.org)
- Association of State and Territorial Health Officials (www.astho.org)
- Healthcare Financial Management Association (www.hfma.org)
- Mental Health America (www.mentalhealthamerica.net)
- National Association of County and City Health Officials (www.naccho.org)
- National Association of State Mental Health Program Directors (www.nasmhpd.org)
- National Environmental Health Association (www.neha.org)

As discussed in chapter 4 with regard to the American College of Healthcare Executives, members of a professional group agree to the ethical codes espoused by the organization. These groups establish behavioral expectations, and their educational activities provide socialization opportunities.

Groups Versus Teams

Often the terms *group* and *team* are used interchangeably. However, **teams** are evolved groups that have great task orientation, purpose, interdependence, structure, and social familiarity. Teams work together to accomplish shared goals and mutually bear the responsibility for their own success. As exhibit 15.1 shows, teams coordinate tasks and activities; focus on producing outcomes; and, as a result, are more interdependent than groups are. Teams are also generally smaller than groups; the membership of groups can range into the millions (e.g., Hindus, females). The optimal team size depends on many factors and continues to be debated. In general business, "teams of between 5 to 10 people" may be more successful than larger or smaller teams (Beagrie 2005); in healthcare, the optimal team size seems to fall between 12 and 15 individuals (Richter, Peiro, and Schaufeli 2007).

Healthcare uses interprofessional teams extensively. Properly functioning interprofessional teams are essential to providing safe and high-quality care to patients. The Institute of Medicine defines an interdisciplinary (interprofessional) team as "composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods" (Greiner and Knebel 2003, 54).

Interprofessional team members work together as colleagues to deliver quality, individualized care for patients. These teams can consist of

Focused leadership	Shared leadership
Individual accountabiity	Individual and team accountability
Individual work outcomes	Team work outcomes
Desire for efficient meetings	Desire for open discussion and problem solving
Effectiveness measured by indirect influence	Effectiveness measured by collective work output
Discussion, decision, and delegation	Discussion, decision, and working together on output

EXHIBIT 15.1 Differences Between Groups and Teams

Source: Adapted from Katzenbach and Smith (2005).

interdisciplinary groups of nurses, physical therapists, occupational therapists, and patient care assistants who work together to reduce the incidence of immobility-associated complications (Markey and Brown 2002), or they can be composed of physical, occupational, speech and language, and exercise physiology therapists providing wellness and prevention interventions to the homeless and the chronically ill senior population (Hamel 2001). A number of healthcare educational institutions have begun to recognize the need to jointly train different professionals and have changed their curriculum to better create interdisciplinary teams (Barr et al. 2005). Interdisciplinary education is now promoted for schools of public health by their professional association and accreditation body (Petersen, Finnegan, and Spencer 2015) and practiced among medical schools such as the University of Minnesota to train collaborative and coordinated care (Robeznieks 2014).

The difference between groups and teams can also be seen in sports. Well-functioning teams are essential for successful football, basketball, and soccer clubs. Often in these sports, the winning team is not the one with the best player but the team that plays best together. Players have positions and roles with distinct contributions and require great interdependence; they need to execute their tasks effectively and act and react simultaneously to their team members' actions. Sports organizations that have exceptional individual players but fail to work as a team frequently lose. As the coach of a perennially successful soccer team, Manchester United, stated regarding one of its 2014 losses, "We never played as a team I think . . . and also we don't reach the required level and maybe because of that we haven't played like a team" (*Irish Times* 2014).

On the other hand, individual sports—such as track, wrestling, and golf—require little teamwork. The interdependence among "team" members is often minimal, and these teams consist more of groups of players than of teams in the true sense.

Interdependence

The type of interdependence that exists in a work setting strongly dictates the need for group or team characteristics. Thompson (1967) proposed three types of interdependence:

1. Pooled
2. Sequential
3. Reciprocal

Here, we discuss pooled and reciprocal interdependence in more depth.

EXHIBIT 15.2
Type of Interdependence and Need for Relationship

	Type of Interdependence		
	Pooled	**Sequential**	**Reciprocal**
Description	Members make separate, independent contributions	Tasks completed in a sequence and handed off to other team members	Work moves back and forth among members
Sports Examples	Golf, wrestling	Relay race/track	Soccer, football
Healthcare Examples	System-owned hospitals dispersed across the country, multidisciplinary teams	Hospital admission process	Intensive care or trauma care unit, interdisciplinary teams
Spectrum	Group ◄——————————►		Team
	Multidisciplinary team		Interdisciplinary team

As suggested in exhibit 15.2, the need for a team relationship increases as the type of interdependence moves from pooled (least interdependent) to reciprocal (most interdependent). Groups function better with limited interdependence. **Pooled interdependence** requires that members make only discrete, independent contributions, such as exists with a group of hospitals owned by a healthcare system and dispersed across the United States. Each hospital may be operated independently, and its finances and capital resources may be "pooled" in the system headquarters.

Reciprocal interdependence requires members to have a team relationship because their work is highly interactive and necessitates immediate responses. Reciprocal work settings in healthcare that do not display team characteristics can negatively affect the quality and efficiency of care, with serious consequences (Baker, Day, and Salas 2006).

Multidisciplinary and Interdisciplinary Teams

In addition to highly interdependent teams, healthcare operations function best with multidisciplinary and interdisciplinary teams, which also can be arrayed across the interdependence spectrum.

Multidisciplinary teams are composed of professionals from multiple disciplines—such as medicine, nursing, nutrition, physical therapy, respiratory therapy, and pharmacy—who work to provide a great breadth of services to

patients. Traditionally, most healthcare has been organized this way. Even though a multidisciplinary team's members work with representatives of other disciplines, they tend to perform independently and interact formally. Multidisciplinary teams allow members to act as they deem best with little or no awareness of services or efforts outside their disciplines, as experts from different professions may treat components of a patient's case relatively independently. Rather than reflect an integration of care, patients' ailments are segmented and treated simultaneously by distinct providers.

On the other hand, an **interdisciplinary team** is defined as (Jessup 2007)

> [a] group of persons who are trained in the use of different tools and concepts, among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of limitations provided by the work of the other members and often with group responsibilities for the final product.

This team is composed of professionals who work interdependently in the same setting. Separate assessments may still be performed, but patient information is shared and issues are resolved systemically, involving other team members. Interdisciplinary teams require greater interdependence and integration of the involved medical disciplines, as indicated at the bottom of exhibit 15.2.

The interdisciplinary nature of healthcare makes the ability to successfully work in teams even more critical. However, the many professional groups required to provide high-quality patient care often express mistrust and difficulty relating to each other. These groups—including dietitians, laboratory technologists, respiratory therapists, occupational therapists, pharmacists, nurses, and physicians—develop their own social identity, as individuals are socialized into their professional communities of practice. The mixing of professionals with diverse backgrounds and perspectives frequently causes intragroup conflict, which may negatively affect the quality of care and constrain the spread of valuable innovations (Bartunek 2011).

Team Building

High-functioning teams are the result of a healthy organizational culture and periodic training in team building (see exhibit 15.3). Building excellent, effective teams requires effort and management attention. Whenever a team is formed—whatever its nature—the following guidelines are helpful:

- *Define a clear purpose, goals, and priorities.* Teams need to understand clearly what they are trying to accomplish and for what purpose. The

EXHIBIT 15.3
Successful Team Characteristics

A study at the Massachusetts Institute of Technology examined the group dynamics that high-performing teams exhibit. The results revealed that successful teams share several distinct characteristics:

- Everyone on the team talks and listens in roughly equal measure, keeping contributions short and sweet.
- Members face one another, and their conversations and gestures are energetic.
- Members connect directly with one another—not just with the team leader.
- Members carry on back-channel or side conversations within the team.
- Members periodically break to go exploring outside the team and then bring information back.

Source: Adapted from Pentland (2012, 65).

goals and priorities should be linked to the larger organizational goals or mission and be seen as adding value to patients, staff, and the organization as a whole.

- *Set appropriate time frames.* Establish schedules for important team deliverables to achieve the goals and priorities. Attach dates to the important milestones.
- *Select members who offer the best contributions.* When forming a new team or replacing team members, choose individuals who have the knowledge and ability to contribute. Having equal representation by discipline or hierarchical level is not necessary. Although people directly involved with the issue or problem should be selected, sometimes inviting someone from outside may provide a fresh and unique perspective.
- *Define the roles for team members.* Unless previously established by job descriptions or other means, set forth the roles for the team. Team roles may relate to decision making and process facilitation (e.g., team leader, coach, facilitator) or to functional duties (e.g., scribe, interteam liaison, task worker).
- *Have a sponsor or champion within the organization.* Successful teams require organizational support and a "go to" sponsor or champion. This individual may be the leader to whom a work team reports or a champion positioned to facilitate the implementation of a team's recommendations.
- *Establish ground rules.* Agree on how team members should treat and interact with each other. Set rules for how decisions are made, what level of participation is acceptable, and what degree of formality is followed. Creating ground rules helps establish a nonthreatening

environment that encourages open communication and avoids personal attacks, greatly facilitating team building.

Breaking down barriers and team building among professional groups are critical in healthcare to ensure the delivery of high-quality care. As mentioned, groups of healthcare professionals are consistently placed together; but if left alone, many professionals will remain in groups and not develop into cohesive teams. Bereft of guidance, groups may also become dysfunctional and produce workers full of anger, mistrust, and cynicism. Team building can allow teams to produce results quickly and achieve high levels of openness, participation, and creativity. Team building can be important for temporary teams, such as task forces, and for permanent work units, such as patient treatment teams.

Team building is an ongoing process that seeks to build the skills and trust of team members (Stoner and Hartman 1993). Although most organizations have a clear understanding that team-building efforts are vital, many continue to assume that placing a group of individuals together will automatically produce a well-functioning team. Of course, not all new teams will need intensive team-building efforts. However, more team building should be available than is generally in place and should cover a greater diversity of team participants, organizational culture problems, complexity of tasks, and higher importance of outcomes.

Team building is often designed around improving team problem solving and processes. Efforts to build teams should include the following components (adapted from Buller 1986):

- Planned intervention with known objectives or desired accomplishments
- Facilitation by a third party, if potential emotional and personality barriers are present
- Necessary team members; do not begin the team-building process if key members are absent
- Identification of barriers and skill needs to improve problem solving

Because many teams bring together members from diverse departmental and educational backgrounds, some of the team members may lack knowledge of key areas to accomplish the team goals. Training may be needed to educate members regarding the operational processes, technology, and the organizational interface of the problem or issue under evaluation. For example, if a team has been formed to evaluate the pharmacy distribution system, some of its members—such as representatives from materials management, information technology, or administration—may not understand the operation and

function of the pharmacy. Education for this team might cover the hospital's formulary, purchase contracts, and existing distribution system, among other aspects of pharmacy distribution. This shared common knowledge is essential to evaluating and improving the existing system.

For critical teams, a formal team-building process may be needed for as long as one to two years and may require consultants—either external or internal organizational development personnel—to regularly intervene and facilitate team development (Stoner and Hartman 1993).

When individuals form teams, undercurrents of conflicting emotions and loyalties often seem to get in the way of efficient progress. If left unattended, these undercurrents can impede effective team performance. Addressing team dynamics and group processes can dramatically improve team performance.

Teams often underestimate the need for their own development. Frequently, they do not recognize that teams do not automatically function at high levels of performance. They must spend time working on both their processes and the feelings among members, which frequently are only indirectly related to their team's outcomes.

Team building should also focus on strengthening relationships. High-performing teams most often develop strong bonds to the team, among team members, and to their organization. These relationships can be categorized as personal identity with the team, identity with other team members, and identity with the organization:

- *Identity with the team:* Team members relate to and feel part of the team.
- *Identity with other team members:* Proper, congenial interactions, which are critical to performance, exist among team members.
- *Identity with the organization:* Effective team members usually identify strongly with their own department and organization.

Teams that gain a strong sense of team identity are effective, and their members feel that the team is distinctive, valued, and important. Team identity can be strengthened in many ways, especially by distinguishing and highlighting the team's importance. Five approaches toward this end are the following (Butterfield 2011):

1. *Create a team name*. A name distinguishes the group and creates a sense of identity.
2. *Develop a team logo*. A logo can help establish a brand for the team, increase team visibility, and foster morale.
3. *Adopt slogans, songs, or cheers*. In some work cultures, these elements are effective in promoting team pride.

4. *Develop visual signs and reminders.* Create images to reinforce the purpose and processes of the team.
5. *Create branded apparel.* Such items can be used both as incentives and as methods for highlighting the importance of the team.

Ultimately, effective team members learn to trust and respect each other. They interact both formally and informally and generate synergies that allow them to accomplish much more than when working as a group or as individuals.

Stages of Team Building

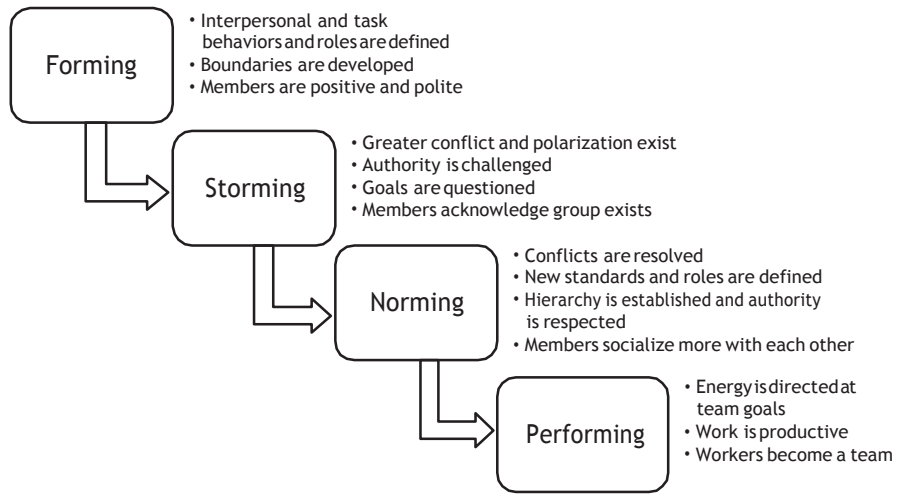
Teams progress through four predictable stages (as seen in exhibit 15.4):

1. Forming
2. Storming
3. Norming
4. Performing

Effective results occur in the fourth stage, highlighting the importance of moving efficiently through the first three stages.

Forming occurs when a team comes together. Members are usually excited, and this becomes a stage of transition from individual to member status. **Storming** may be the most difficult stage for any team. Members may determine that the task is more difficult than they had realized and begin to resist collaboration with other team members, perhaps becoming defensive and arguing over noncritical issues. Team building is especially critical in this stage.

EXHIBIT 15.4
Four Stages of Team Building



Source: Adapted from Tuckman (1965).

Next comes **norming**, which involves establishing group rules for the team. Harmony begins to replace conflict, and a sense of team cohesion and common goals develop. Finally, at the **performing** stage, relationships and expectations are settled. Team members have accepted each other's strengths and weaknesses and learned their roles. Members can prevent or work through group problems and begin to function as a cohesive, efficient team.

Early-Stage Team-Building Exercises

Teams in the forming stage can benefit from team-building exercises. For example, activities that introduce team members to each other can open lines of communication and create team bonding. Many types of activities can be used for team bonding, including the following exercises:

- *Two truths and a lie:* Team members tell three stories about themselves, of which two are true and one is a lie. After each member tells her three stories, the other members vote on which story they believe is the lie.
- *First jobs:* Each member tells the others about his first job. The team member then answers the following three questions:
  - What parts of the job did you find most difficult?
  - What impression did you have of the bosses? What did you learn from them?
  - What did you learn most about that job?
- *Superlatives:* Each team member writes answers to a list of questions. Once the individuals complete their answers, the team comes together to compare and determine who the extreme member in each category is. Here are sample questions:
  - How old are you?
  - How many children do you have?
  - How many homes have you lived in?
  - How many years have you attended school?
  - How old was your father when you were born?
  - How many brothers and sisters do you have?
- *Conversation starters:* Prior to the meeting, a list of incomplete sentences is created and posted so that the team members can review them. At the meeting, each member around the table is asked to start a conversation on one topic, focusing on his experience. Then the whole team discusses the idea. When that conversation is over, the next person selects a new topic. Following are some examples of incomplete sentences to introduce:
  - Anybody will work hard if . . . .
  - People who run things should be . . . .
  - I would like to be . . . .

  - One thing I like about myself is . . . .
  - Nothing is as frustrating as . . . .
  - The teacher I liked best was a person who . . . .
  - Ten years from now, I . . . .
  - Every winning team needs . . . .
  - I take pride in . . . .
  - If you want to see me get mad . . . .
  - A rewarding job is one that . . . .
- *If I were at my job right now:* Team members share what they would be doing if they were not in the meeting. They should go into detail, or they can be probed for more detail. Once everyone has spoken, members are asked to forget about their usual job responsibilities until the meeting ends.

Signs of an Effective Team

How can you tell if your team is effective? An effective team involves its members and has a leader who is approachable and listens. When an effective team meets, shared discussion takes place—not a monologue or faction-dominated conversation. In addition, team members communicate freely and openly among themselves. They are unafraid to provide difficult feedback, and they use appropriate problem-solving tools as needed.

Members of effective teams willingly volunteer and complete tasks. They are task focused yet innovative, and they do not allow personal differences to interfere with task achievement. Members also take responsibility for team decisions and positively communicate their team's efforts to outside stakeholders.

An assessment for team effectiveness is provided in exhibit 15.5. Think of a team with which you have worked. Score each category and then add up the points, for a total of 75 possible points. Teams that score more than 60 points can be considered well-functioning teams.

Conflict

Conflict can be positive or negative for teams. Conflict is natural and occurs when people work together. Many people perceive conflict negatively and associate it with tension and anger, but it can be valuable to a team's functioning as well. Conflict, if appropriately managed, can increase a team's vitality and creativity and lead to effective solutions. Managed conflict also minimizes the potential for groupthink, as discussed in chapter 13. Conflict can be positive if a team uses it to perform team building and the tension is appropriately resolved. However, team leaders need to be aware of group dynamics and

60 points are likely well functioning.

Team Criteria

Goals	Unknown		Unclear		Clear
	1	2	3	4	5
Commitment to goals	None		Marginal		Great
	1	2	3	4	5
Meetings	Unproductive		Somewhat productive		Very productive
	1	2	3	4	5
Implementation of decisions	None		Periodic		Consistent
	1	2	3	4	5
Trust among team	None		Some		High
	1	2	3	4	5
Work distribution	Unfair		Mixed		Fair
	1	2	3	4	5
Communication	Poor		Adequate		Excellent
	1	2	3	4	5
Respect among team	None		Adequate		Excellent
	1	2	3	4	5
Innovation	None		Adequate		Excellent
	1	2	3	4	5
Involvement of members	Little		Adequate		High
	1	2	3	4	5
Progress checks	None		Some		Consistent
	1	2	3	4	5
Attendance	Poor		Adequate		Excellent
	1	2	3	4	5
Harmful conflict	Always		Sometimes		Never
	1	2	3	4	5
Task assignments	Unclear		Known		Clear
	1	2	3	4	5
Collaboration	None		Adequate		Excellent
	1	2	3	4	5

EXHIBIT 15.5 Team Assessment Tool

Source: Adapted from Dyer (1987, 42–43).

respond to unresolved conflict. Following are some guidelines (Scholtes, Joiner, and Streibel 2000):

- *Do not overreact or underreact.* React to behaviors that may be disruptive and hurt the team's progress toward its goals. Ignore minor disruptions, but confront chronic or serious disruptions directly.

Doctors Behaving Badly

By Britt Berrett

The newly arrived Dr. Lira found tremendous professional satisfaction in belittling the clinical staff. He created a difficult and dysfunctional work environment as he leveled his wrath at clinicians who did not meet his expectations or did not agree with his clinical direction. He cornered such staff members in private moments, when they would be the sole recipient of his anger.

Having long endured similar antics, nursing staff in general are uniquely aware of bad physician behavior. Initially, a nursing supervisor addressed Dr. Lira's behavior, but he failed to respond to this early interdiction. The issues escalated as more individual nurses and therapists became the target of his tirades.

The nurse manager and director called a meeting with Dr. Lira to discuss his behavior. Insulted by the efforts of leadership to intervene, he continued his attacks—now even more carefully and deviously delivered. Months passed, and additional incidents involving the doctor created an almost untenable environment. The CEO inserted himself into the corrective plan of action, summoning Dr. Lira to his office to discuss employee complaints about him and to provide specific direction on the doctor's future behavior. The poor behavior improved for a time, but eventually the caustic interactions reemerged.

The final and most effective strategy was deployed by several imaginative nurses. Aware of Dr. Lira's propensities, the nursing team was on high alert for clues of potential escalating behavior. Once his rage was detected, the nurses would call a "code white," upon which all nurses on the unit would gather as quickly as possible to encircle the doctor during a tirade. No words would be exchanged; the nurses would stand in solidarity with their colleagues and simply stare at Dr. Lira.

This ingenious strategy became known throughout the hospital and was a source of tremendous embarrassment for not only Dr. Lira but also other physicians on staff. Culturally, the nurses had succeeded in redefining appropriate and acceptable behavior. Despite policies and procedures and committees and interventions, group dynamics effectively dictated organizational norms and expectations.

- *Praise in public, and criticize in private.* Leaders should address serious conflicts and problems in private. Public admonitions and criticism tend to only create more problems.
- *Use appropriate humor to diffuse tense situations.* Humor can have a positive effect on a group. Tension can be resolved and energy redirected toward the task at hand.
- *Focus on group progress and not individual problems.* Negative conflict often occurs when an individual feels he is being personally attacked. People need to feel secure, safe, and not personally blamed.

Highly functioning teams can also help resolve conflict. As illustrated by the adjacent box, teams—especially those within a professional group—can form a united front to discipline even a person with higher authority. In this situation, the nurses created an announced "code white" to summon others to witness and, ultimately, shame a physician into behaving appropriately.

Chapter Summary

Today, people work primarily in groups and teams, which can be formal or informal, permanent or temporary, committees, work groups, or task forces.

Healthcare organizations manage extensively through committees and teams. Professional groups also exert significant influence in healthcare and establish behavioral expectations and socialization opportunities. Although the terms *group* and *team* are often used interchangeably, teams are a subset of groups and have greater task orientation, purpose, interdependence, structure, and social familiarity. Groups with reciprocal interdependence need to evolve into teams to be effective.

Multidisciplinary teams have been the traditional model used extensively in healthcare and are composed of members from diverse professions who work independently, segment patients' ailments, and treat the conditions distinctly. Interdisciplinary teams share information, work integratively, and collaborate on the treatment of patients.

Effective, high-functioning teams have clear goals and purposes; they understand what needs to be achieved and by when. Such teams include members who take needed roles and have the knowledge and ability to contribute and treat each other with respect.

Team-building efforts can be effective in moving groups to become well-functioning teams. This process may involve only singular interventions or a consistent, multiyear process. Unified team members identify with the team, other team members, and their organization.

Team building follows four stages: forming, storming, norming, and performing. Forming begins when a team comes together, which then transitions into storming. Storming often is the most difficult stage, and team-building efforts are critical during this time. Norming allows teams to set rules and goals, which then enables performing to be achieved.

Effective teams can be identified by how they interact and handle difficult problems. They generally have leaders who are approachable and listen and members who communicate openly. Members volunteer willingly and complete tasks.

Conflict can be positive or negative for teams. If handled appropriately, conflict can engender team vitality and creativity. Leaders should not overreact or underreact to conflict and should deal with chronic and serious disruptions directly.

Chapter Questions

1. How does a team differ from a group?
2. How do professional organizations emphasize group identity for healthcare professionals?
3. Why can groups function better in situations of pooled interdependence than in reciprocal interdependence?
4. Why might interdisciplinary teams, as defined in this chapter, be more efficient than multidisciplinary teams?

5. Why is establishing team ground rules a good initial step? In which stage of team building might this be helpful?
6. What are ways to increase team identity?
7. Use exhibit 15.5 to assess a team of which you are a member. What areas are positive about the team? Negative? What could be done to improve the team's performance?
8. Although conflict is normal, often people see it as negative. Why is this the case?

Chapter Cases

Dr. Handly and the Multidisciplinary Team

Sue Handly, MD, was recently recruited into a multispecialty group of 40 physicians. The clinic offered a wide scope of services, including a relatively sophisticated radiology department, physical therapy, and a same-day surgery unit. The clinic had been growing and employed highly trained healthcare providers.

In addition to her medical degree, Sue had completed a master's degree in health administration while she was practicing in South Carolina. She had always wanted to return home to Texas and, after an extensive search, found this group in a suburb of Austin, which was relatively close to her hometown. During her management training, she thoroughly enjoyed the time she spent with the health system's organizational development team, which performed team building with different system groups and committees to improve their performance.

During her first week in the new practice, Sue noticed that the staff and physicians worked like a multidisciplinary team. Each practiced reasonably good medicine but did not interact or communicate well with one another; the staff and physicians worked together but did not feel like team members. Sue wanted to change this, so she obtained the permission of the clinic's executive group to lead a team-building effort. A team-building steering committee was created, and over the course of several meetings, the following mission statement and goals were established:

1. Overall organizational mission statement: Improvement of patients' health
2. Goals:
   a. Reduction in barriers to access to care
   b. Improvement in practice's financial performance
   c. Enhancement of physician and staff satisfaction

The committee then set specific, measurable operational objectives (adapted from Bodenheimer 2007):

- At least 80 percent of patients with diabetes in the practice will have hemoglobin A1c lower than 8.
- At least 90 percent of nonurgent requests will receive an appointment within one week.
- The practice will achieve $1.2 million in revenue per month.
- Each team member will establish an explicitly identified goal for personal professional development.
- Physicians' and staff members' roles will be reevaluated and reconfigured in the next six months.
- Eighty percent of staff will be cross-trained to substitute for other roles.

Sue knew that this was just a start, but she felt happy to have established these goals. Now for the next steps.

Case Questions

1. How would you evaluate what Sue has done so far? What is positive? Negative?
2. What would you recommend for her next steps?

A Brief History of Primary Care Teams

Teams are especially needed in primary care. Primary care offices offer many different services, and patients, especially the elderly, can present with multiple diagnoses and be prescribed handfuls of medications. To simplify the delivery of care, some primary care offices have decreased their number of staff and have the physician perform most of the care. However, this approach is not efficient.

The primary care / general practitioner in the early twentieth century was a solo operator. Carrying his equipment in a black bag, he often treated patients in their homes. Gradually, more patients were treated in an office setting, often by a husband-and-wife team, with the wife serving as receptionist, nurse, billing clerk, and bookkeeper. Later, seeking more efficiencies, nonphysician tasks were segmented into separate positions for nurses, receptionists, medical assistants, billing clerks, radiology

(continued)

(continued from previous page)

technologists, and so on—a pattern found in myriad small practices dotting the United States.

Concurrently, many groups sought to introduce and develop primary care teams. In 1915, teams of physicians, health educators, and social workers were developed at outpatient areas of Massachusetts General Hospital. Efforts to create functional primary care team models continued at New York's Montefiore Hospital in 1948 and at Yale in 1951. Then, in the 1960s, neighborhood health center programs sought to establish primary care teams in area clinics.

However, the use of primary care teams did not become dominant because of several barriers. One barrier was the tension between physicians and nurses regarding their respective responsibility, authority, and knowledge. Another obstacle resulted from payment systems that primarily paid only for physician-related services and failed to reimburse nonphysician work. In addition, team relationships during the 1960s and 1970s were vaguely defined and not based on training or clear divisions of labor. Team meetings became drawn-out, unproductive affairs.

Large teams were difficult to manage in primary care. Some experts assert that optimal primary care teams should include between 6 and 12 people. Even in teams this size, however, decision making can be problematic.

The activity of building new teams involves creating alternative systems of care delivery. Processes must be changed and decision making must be transformed. These efforts do not occur overnight and may take years to accomplish fully. But ultimately, the rewards of improved quality and patient satisfaction will be worth the effort.

Source: Information from Bodenheimer (2007).

Case Questions

1. What were the barriers to forming primary care teams?
2. Why might the forming of teams be more difficult in primary care settings than in single-specialty physician offices or other businesses?
3. What could have been done to strengthen teams over the history of healthcare delivery?

Chapter Activities

1. Read "Six Common Misconceptions About Teamwork" at https://hbr.org/2011/06/six-common-misperceptions-abou/ (Hackman 2011). Write a two-page paper with your thoughts on the article.

2. Take the quiz "Are You a Team Player?" at www.eatyourcareer.com/2012/08/quiz-are-you-a-team-player (Scivicque 2012). Identify those areas in which you are better and worse at working in a team.

16

COMMUNICATION

By Stephen L. Walston and Benjamin Whisenant

Learning Objectives

After studying this chapter, readers should be able to

- recognize the importance and components of organizational communication,
- identify problems and barriers that can occur in communication,
- distinguish and apply the differences between information richness and message complexity and importance,
- appreciate the value of nonverbal communication, and
- learn and apply methods to improve communication and dialogue.

Key Terms

- Communication
- Communication channel
- Decoding
- Dialogue
- Encoding
- Feedback
- Information richness
- Noise
- Nonverbal communication

Good communication skills are paramount for any manager in business today. The ability to conceptualize an idea and have others understand it is a core function of leaders. In Myatt's (2012c) assessment, "it is impossible to become a great leader without being a great communicator" and "effective communication is an essential component of professional success whether it is at the interpersonal, inter-group, intra-group, organizational, or external level." Economy (2015) indicated that leaders spend as much as 75 percent of their day communicating, speaking, listening, reading, and writing to interact with others, solve problems, and plan strategies; Remland (1981) suggested this figure could be as high as 90 percent. Yet, miscommunication

occurs far too often, and, sadly, many organizational problems occur because of the poor communication skills of a firm's leaders.

The general population also recognizes that good communication skills are essential to succeed. The Pew Charitable Trusts surveyed Americans in 2014 about what skills were most important for children to succeed in the world today. At the top of the list was communication (see exhibit 16.1). Furthermore, two of the top five most important skills were reading and writing—components of communication skills.

Skill	Percentage of Survey Respondents
Communication	90%
Reading	86%
Math	79%
Teamwork	77%
Writing	75%
Logic	74%
Science	58%
Athletic	25%
Music	24%
Art	23%

Source: Data from Goo (2015).

EXHIBIT 16.1
Skills Needed by Children to Succeed in Life

Communication Process

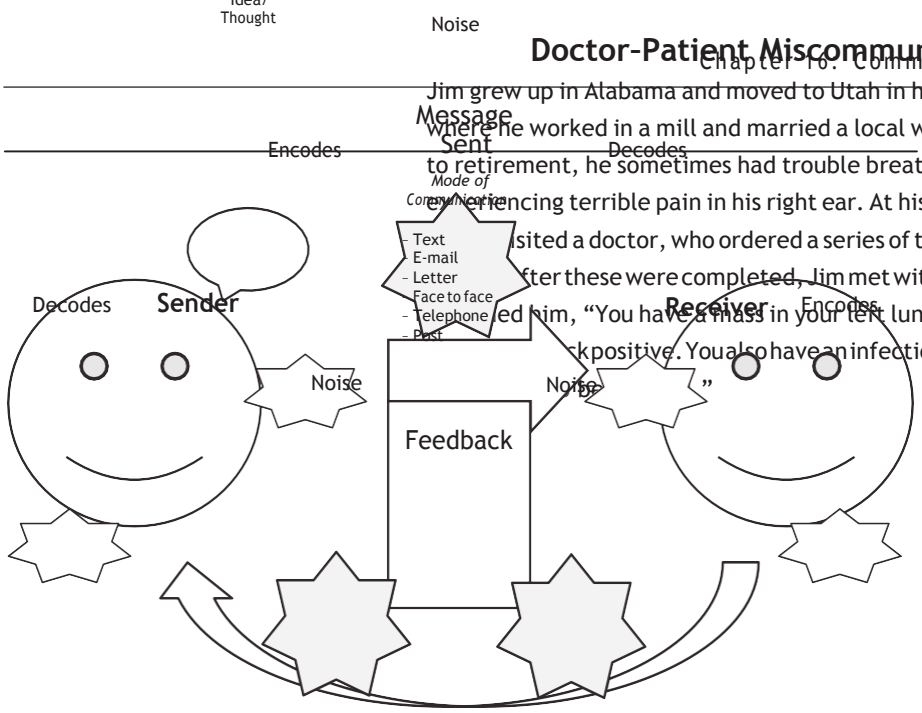
Communication is the two-way process of transmitting information and meaning from one individual or group (the sender) to another (the receiver) (Guffey and Loewy 2011). As exhibit 16.2 shows, this process starts with the sender or encoder having a thought or an idea, which is encoded and then transmitted through some mode of communication to the receiver. The receiver decodes the message; gives it meaning; encodes a response; and provides feedback to the sender, who decodes the response. All the while, the communication is surrounded by noise that can impede the accurate exchange of information.

The communication process may appear simple, but clearly communicating an idea or a thought is often difficult. A problem with any portion of the transmission can reduce communication effectiveness. The first step is **encoding**—or transforming a message into signs or symbols—and it can misfire. How the message is encoded depends on the sender's evaluation of the

Jim grew up in Alabama and moved to Utah in his early twenties, where he worked in a mill and married a local woman. Now close to retirement, he sometimes had trouble breathing and also was experiencing terrible pain in his right ear. At his wife's urging, he visited a doctor, who ordered a series of tests and X-rays. After these were completed, Jim met with the doctor, who told him, "You have a mass in your left lung, and the cancer is positive. You also have an infection in your right ear."

(continued)

EXHIBIT 16.2 The Communication Process



receiver's capability. However, people who formulate messages often encode their thoughts into words, gestures, and symbols that cannot be interpreted by or may mean something different to the receiver (Quester et al. 2007).

As the box below describes, erroneous encoding of a message can easily occur with both verbal and written communication. Almost half of US adults report having trouble understanding what their doctor tells them (Chesanow 2013). Doctors often encode their thoughts into words that many patients do not understand. For example, many patients do not comprehend what *bowel*, *colon*, *screening test*, or *blood in the stool* mean (Davis et al. 2001), and 95 percent of patients with advanced cancer reportedly had difficulty understanding their diagnosis (Cabral-Isabedra 2016). Proper encoding requires the sender to know the receiver's background and abilities.

Furthermore, hospital executives suggest that the lack of communication skills among healthcare service providers results in increased errors. At times, doctors do not communicate well with hospital personnel or patients, with miscommunication resulting in almost 2,000 patient deaths and factoring in about 30 percent of medical malpractice cases (Bailey 2016). About 80 percent of serious medical errors in US hospitals are attributed

Doctor-Patient Miscommunication

(continued from previous page)

The doctor asked Jim if he understood. Jim said, "Yow," which was his way of saying yes. The doctor then wrote a prescription for the ear infection that Jim was to take to the nurse to administer. The prescription stated, "This patient may be S.O.B. Take care, but please place the medication in the R.ear."

Jim called his wife immediately, relieved that although he had something big in his lung, the test was positive so he must be good to go. He was upset that the doctor had called him an SOB and planned to tell off the doctor at his next visit. However, Jim was so glad about the "positive" cancer test that he must not have heard the doctor say the nurse would be making him lie down and putting the medication in his rear. Needless to say, his ear infection did not improve, and he was surprised when, the following week, he was called to come in to start chemotherapy.

to preventable communication errors (*Joint Commission Perspectives* 2012).

In addition, cultural differences and translations from one language to another can dramatically increase encoding errors. The following examples are from actual signs:

- On an office door in a large tertiary hospital in Saudi Arabia: "Head Transplant Surgery"
- Over a kiosk in the immigration area of an airport in Korea: "Declaration for Livestock-Related Persons"
- At a Korean buffet over chopped celery: "Salary Mix"
- On an Air China sign in the airport: "Cuss Baggage Drop Off"
- On a sign in New Zealand: "If caught you will be trespassed!"

Each of these signs involves an inexact translation and encoding into English. The signs may be humorous, but they also illustrate the difficulties in conveying meaning.

Beyond ensuring that the communication itself is understandable, a communicator must select a workable *channel* of communication. Among the many possible modes are face to face, videoconferences, phone calls, voice mails, texts, e-mails, letters, policy statements, newspapers, and formal written reports. And these do not even begin to cover the nonverbal channels such as "gestures, facial expressions, body position, and even clothing" (Lunenburg 2010).

The selection of a **communication channel**—the medium through which a message is sent and received—should relate to the complexity and importance of the message, which dictates the degree of **information richness** required. As displayed in exhibit 16.3, channels of communication vary in their capacity to relay information-rich content and messages in their full complexity and importance. High degrees of information richness convey more nonverbal information, which allows for improved understanding and feedback regarding the message. Effective communication occurs when the right degree of information richness is used, given the complexity and importance of the message.

Highly important and complex messages, for example, should be transmitted through face-to-face conversations. However, face-to-face conversations

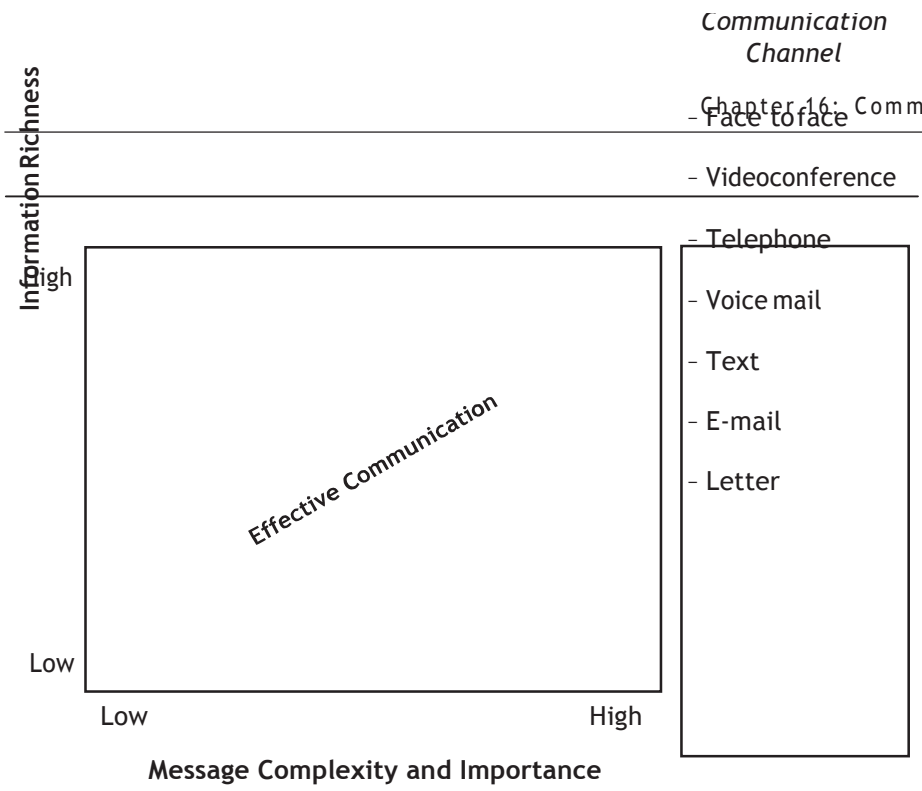


EXHIBIT 16.3 Information Richness and Complexity

Source: Adapted from Daft and Lengel (1984).

for trivial and noncomplex messages may result in an ineffective meeting because the communication is too intense. On the other hand, using a communication channel with a low degree of information richness for a complex, important message may result in an ineffective and too simplified interaction. Most have experienced this ineffective messaging upon sending a misunderstood e-mail only to realize a richer channel should have been selected.

Choosing the correct channel of communication can be challenging. Low-richness channels—such as letters, e-mails, and texts—should be used for only routine and low-urgency matters, whereas high-richness channels are recommended for situations of complexity. High-richness channels, which allow opportunities for feedback, are also recommended for first meetings, where each party places high value on a clear impression of the other.

The next step in communication is **decoding**, the process by which the receiver assigns meaning to the message that is, with luck, consistent with the sender's original intent. Decoding creates meaning from language and nonverbal behavior, but it still fails frequently. As with encoding, decoding is highly influenced by the receiver's self-identity, background, mood, culture, and behavior. In addition, the receiver may lack knowledge about or misinterpret the meaning of the symbols (verbal and nonverbal) used by the sender. As illustrated by the box on pages 267–68, improper decoding can create serious problems.

Each of the aforementioned components of communication—the sender, the receiver, and communication channels—is subject to noise. **Noise** consists of distractions that diminish the effectiveness of the communication process. Distress, self-consciousness, environmental conditions, personal status, and

Noise in Hospital Communication

Employees in hospital settings are subject to a great deal of noise that impedes good communication. Staff members face competing tasks, fatigue, and cultures that can discourage questioning and increase the risk of decoding errors. "For instance, the physician may ask a resident to pull a chest tube, but perhaps the patient has two tubes and the resident translates this message to mean the right-sided one, without confirming this interpretation with the attending."

Source: Salas and Frush (2013, 59).

feelings, among other factors, can act as noise and impede communication (Quester et al. 2007). As demonstrated in the adjacent box, noise is ever present in healthcare settings and, if care is not taken, can result in care delivery errors.

Cell phones and other personal communication devices add another dimension of noise to our lives. Each of us has attempted to speak with someone who was checking e-mail or reading social media posts or texts during the conversation. Such noise distracts from and hinders good communication.

Another crucial aspect of communication, which is often overlooked in real life, is **feedback.** Feedback refers to the "acknowledgement and reaction of the receiver to the sender after receiving the message. Feedback enables the sender to ensure that the message is being properly communicated to the receiver" (Kumar 2010, 472).

In other words, feedback is the process in which the sender and receiver engage to validate the message sent and received. It allows the receiver to reverse roles with the sender to verify whether she has interpreted a message accurately. In this way, information is shared, recycled, and fine-tuned to achieve mutual understanding by creating a circular mechanism to clarify the meaning of a message. Feedback tells the sender how the receiver interpreted the message, thus accommodating adjustments to perceptions and interpretations.

Communication without feedback can lead to erroneous results. One-way, single-directional conversation can leave the sender thinking that he has adequately communicated his message when, in reality, the receiver may be very confused and frustrated. An example of one-way communication is an intercom announcement, which can come across garbled in speech and meaning. One-way communications also frequently occur between individuals who reside in different authority levels of an organization. Bosses often tell (send) and fail to listen (receive) for feedback.

In healthcare, two-way communication involving feedback is critical. If one-way communication is employed, feedback is lacking and the interpretation of the intended message can be radically different, with potentially tragic consequences. Patient safety processes among healthcare professionals are entwined thoroughly with feedback—from double-checking patient identities, surgical sites, and medications to encouraging and framing clear questions. Physicians also need feedback from nurses, pharmacists, and others to ensure proper communication so that the correct service, medication, and treatment

Surgical Time-Outs

Most hospital surgical departments have adopted surgical time-outs to improve communication and thereby eliminate errors. In 2003, The Joint Commission instituted a universal three-step protocol to eliminate wrong-site surgery. Performed prior to surgery, the protocol consists of a time-out, or pre-procedure verification process, involving all members of the procedure team to validate the correct procedure for the correct patient at the correct site. The process requires communication among all members of the surgical or procedure team and should be initiated by a designated team member. No procedure should begin if any member of the team has concerns.

Sources: Feldman (2008); Joint Commission (2016).

are provided. Clearly, feedback is highly important in healthcare (Salas and Frush 2013).

Verification is a process to increase feedback and ensure that the information has been received accurately. Verification can be achieved by asking the receiver to repeat what she has been told. Joint Commission International (JCI), the prominent accreditation body for healthcare organizations worldwide, encourages providers to include verification in their healthcare processes. In a joint publication with The Joint Commission and the World Health Organization, JCI requires "the use of at least two identifiers (e.g. name and date of birth) to verify a patient's identity . . ." (WHO Collaborating Centre for Patient Safety Solutions 2007). This accreditation requirement mandates verification and time-outs (explained in the box above) to direct open communication and ensure consensus of surgical team members before invasive procedures begin.

Nonverbal Communication

As mentioned earlier, much is communicated nonverbally, without words. Nonverbal cues add significant information for the receiver to interpret what is really being said, and these cues are present in all communications. In fact, **nonverbal communication** may more accurately represent the actual message than the words used. In many cases, at the very least, the nonverbal information can overshadow the verbal message and comprise more than half of the meaning conveyed (Arnold and Boggs 2016). As the box on page 272 shows, nonverbal communication can even unknowingly, yet severely, hamper the promotion of a staff member.

Nonverbal communication can be provided in many different ways, which can be categorized under the following seven forms (adapted from Pedersen, Miloch, and Laucella 2007):

1. *Physical touching:* Touch can convey a set of meanings. Shaking hands in Western culture communicates hospitality and openness. Likewise, embraces, touching someone's arm, or patting another person's hand contribute meaning to a message.

Nonverbal Communication Dooms Promotion of General

In 2003, US Defense Secretary Donald Rumsfeld, in the process of replacing the Army's chief of staff, disqualified one general, who many thought would be given the position, because of "bad body language." Rumsfeld's office reportedly viewed a film of the Defense Secretary delivering a major speech in Baghdad in which Lt. Gen. David McKiernan was seen standing with his arms crossed and failing to intone the traditional "hoo-ah" at the secretary's applause lines. The conclusion reached by Rumsfeld's office was that McKiernan's behavior was not indicative of "someone who's on our team."

Source: Adapted from Daily News Wire Services (2003).

2. *Gestures:* Movement of the hands, eyes, and body can aid in communication. Gestures express meaning, such as an index finger over one's mouth or a wink. Facial expressions tend to reveal emotional states.
3. *Space:* Proximity may indicate the relationship between parties, through designated personal space, private territory, and seating arrangements. Greater personal space and private territory may signify greater power differentiation. In addition, the distance between individuals suggests the degree of interpersonal relationship.
4. *Physical characteristics:* Body size and shape and the type of clothing worn may provide significant nonverbal cues. Assumptions are made regarding people, their occupation, and their status on the basis of their physical characteristics.
5. *Environmental factors:* Physical settings may communicate status, authority, position, and even personality characteristics. Office, work, and home environments influence communication.
6. *Tone:* The tone of speech carries particular messages through speed, volume, intonation, rhythm, rate, and fillers (e.g., *er*, *um*). Each tends to relay information about the speaker and the message beyond the content of the speech. For instance, impressions of age, personality, occupation, emotional state, and temperament can be conveyed through tone.
7. *Time perception:* How time is perceived and used by people provides added meaning. Who shows up on time, who tends to be late, and how much time people spend with each other reveal priorities and meaning.

Barriers to Effective Communication

Most of us want to be good communicators, but too often our efforts to truly communicate go astray. Effective communication and mutual understanding can be stymied repeatedly along the way. Following are some major barriers (Osland et al. 2007):

- *Poor relationships:* Damaged relationships and poor communication go hand in hand. If we do not feel safe with another person, our conversation will be guarded and we will not provide open, understandable feedback.
- *Lack of clarity:* The encoded message may not accurately reflect the intended message. The encoder may fail to consider how the audience will perceive the message and may load the message with ambiguous language and jargon. Never assume your meaning is obvious to others.
- *Individual differences in encoding and decoding:* An individual's experiences, personality traits, and abilities strongly influence how he encodes and decodes messages. Ignoring these factors creates barriers to mutual understanding.
- *Gender:* Overall, women focus on connecting with others and relationship building, while men tend to emphasize status and dominance in conversations. If these tendencies are not adjusted for, communication across genders can be compromised.
- *Perceptions:* Individuals give selective attention to messages and interpret them subjectively, often according to their own preconceived understandings.
- *Culture:* As described later in the chapter, differences in cultural backgrounds inhibit the ability to effectively communicate. Some environments (e.g., in Germany, Switzerland, and the United States) have low-context cultures that rely on clear verbal communication to transfer intent and meaning, whereas high-context cultures (e.g., in Asia and Latin America) transmit more meaning through physical and relational contexts, social norms, and historical context beyond the verbal message.
- *Silence:* The meaning of silence differs according to culture, but its frequent use as a means to punish and leverage conversations is unconstructive. A communicator who readily moves to silence, and a party's inability to break that silence, can be a significant barrier to effective communication.
- *Misinterpretation of nonverbal communication:* As discussed earlier, nonverbal communication produces significant meaning, often overshadowing transmitted words. For instance, a message sender may interpret a pursing of lips by the receiver to mean anger rather than deep thought.
- *Defensiveness:* People who feel defensive stop listening and frequently misinterpret messages. Defensive people spend most of their time protecting themselves and justifying their positions rather than achieving understanding.
- *Lack of feedback and clarification:* Assumptions that the message's meaning is obvious and clear often lead to little or no feedback.

Absence of consistent feedback methods, such as asking for clarification or paraphrasing the sender's words, can create serious barriers to communication.

- *Seeking to place blame:* If people seek to place blame and determine who is at fault when poor communication occurs, the communication will inevitably break down further.

Impact of Culture on Communication

The relationship between communication and culture has long been established. In 1959, Edward Hall (1959, 169) asserted that "culture is communication and communication is culture." One person taking part in a message cannot hope to enjoy effective communication without understanding the other's culture. Ignoring cultural differences seriously hinders communication.

Nonverbal communication, in particular, can be easily misunderstood and impede the accurate flow of meaning. For example, a gesture as common as smiling or making eye contact can carry far different meanings in different cultures. In Western cultures, smiling signifies happiness, but some Chinese smile when they are discussing a sad or an uncomfortable topic. Likewise, people from Western cultures tend to feel that a person does not show respect unless she looks into the eyes of the individual she is speaking with. Yet American Indians and Asians may deem eye contact—especially with an authority figure—disrespectful (Acello and Hegner 2015). In the Maori culture of New Zealand, too much eye contact is a sign of confrontation and disrespect (Amitabha Hospice Service 2012).

Managers often have a hard time discerning the source of communication problems because they are not aware of others' cultures. In addition, cultural contrasts vary widely. For example, cultural differences between the United States and many European countries exist but are minimal in comparison to the dissimilarities between US and Asian cultures. "An American . . . described how understanding how to interact with Japanese was something that took a lot of work and specialized attention. We use[d] our own cultural norms to try to influence behavior and these [were] offensive to the Japanese" (Oertig and Buergi 2006, 28).

Clearly, communication requires mutual understanding. Somewhat counterintuitively, the increasing cultural diversity and globalization of our communities may make achieving this understanding more difficult. However, to successfully communicate, we must not only learn about but also appreciate and respect our differences. Recognizing that people are different and being open minded and accepting of our differences are paramount. In ambiguous settings where you do not know what the cultural norms are, be tentative and follow cues from those with whom you are interacting.

Virtual Communication

Across the globe today, more and more work is being accomplished by virtual work groups. Virtual work groups have greater communication challenges because of the physical distance and reduced frequency of interactions among workers. Communication among virtual work groups can suffer as group members have limited nonwork interactions, speak less frequently with each other, and are less attuned to the nonverbal cues of colleagues. Although videoconferencing, as shown in exhibit 16.3, has high information richness, research suggests that video calls do not facilitate good communication within virtual teams. Instead, according to Levi (2011, 271), virtual teams need to build team identity through personal interactions:

> The use of more informal social communication technologies may help to deal with this problem. Instant messaging, chat rooms, and other informal communications technologies can allow team members to share their work experience. Facebook and other social networking technologies can help to create a social identity for the team. The simple act of sharing photos by team members can help to develop social connections within virtual teams.

Successful Communication

Good communicators possess a heightened awareness of their situation and context. They are highly skilled listeners and observers. They can sense the moods, attitudes, and concerns of their audience. In addition, they adapt their messaging to their environment. They know that the ability to communicate successfully is not about the messenger but about the needs and expectations of those with whom they are communicating (Myatt 2012c).

Moreover, because people can practice ways to improve their communication, good leaders constantly seek to develop their communication skills. Some of these approaches include the following (Myatt 2012c):

- Increase the level of trust between you and others. Trust can be earned by always being honest in your communication and following through on your commitments.
- Make your conversations personal and engaging. Demonstrate your concern about your subordinates by addressing their needs.
- Be specific and clear by using simple and concise language. Communicate well so that people not only understand but also cannot misunderstand the message.
- Focus on transferring your key ideas, aligning mutual expectations, and inspiring action.

- Be open minded. Update your assumptions as you obtain more information.
- Listen extensively, especially to different opinions.
- Show empathy for others, be authentic, and demonstrate transparency.
- Seek to understand the underlying message that may not be communicated with words.
- Be a technical expert on the subject being communicated.
- Speak to groups as individuals.
- Be willing and prepared to change the message if necessary.

Successful communication moves a conversation to **dialogue**—the free flow of meaning between two or more people. The more people share their ideas, feelings, thoughts, and opinions, the greater is their understanding and shared meaning. Greater meaning can be shared when trust and a sense of safety exist. When people feel unsafe and at risk, they are not secure enough to deal with difficult conversations. To make others feel safe, establish mutual purpose, trust, and respect (Patterson et al. 2012).

Chapter Summary

Communication—the transmission of information and meaning from one individual or group to another—is a critical skill for any manager or leader and is a primary function of the position. The communication process involves a two-way method whereby a sender encodes and transmits information to a receiver, who decodes the message, gives it meaning, and provides feedback to the sender. Although the process appears simple, communicating with others is a challenge for all of us. Poor communication engenders stress in relationships and can lead to errors in process or outcomes. Healthcare professionals frequently use terms that patients fail to understand. This and other communication shortcomings often lead to the errors that occur in hospitals and other healthcare settings.

The communication channel should match the complexity and importance of the message and the information richness required. High degrees of information richness convey more nonverbal information. Highly important and complex messages should be transmitted through information-rich channels, such as face-to-face meetings.

Decoding takes place when the receiver assigns meaning to a message. As with encoding, decoding is highly influenced by the receiver's personal characteristics and traits, which may lead to misinterpreting the sender's true meaning. Noise surrounds the entire communication process and distracts and diminishes the effectiveness of communication.

Feedback is essential for successful communication. Conveyed through a two-way process, feedback allows the sender and receiver to acknowledge that the message was properly transmitted. It informs the sender about how the receiver interpreted the message and permits timely adjustments to clarify and validate the message's intended meaning. Communication without feedback leads to a one-way, single-directional conversation that may cause serious problems. Patient safety processes require two-way communication to ensure that proper, high-quality services, medications, and treatments are provided.

Nonverbal messages comprise much of any interpersonal communication. Some experts suggest that almost two-thirds of perceived meaning comes from nonverbal communication. The seven forms of nonverbal communication are physical touching, gestures, space, physical characteristics, environmental factors, tone, and time perception.

Many barriers can impede good communication. Some of the major barriers include poor relationships, lack of clarity, individual differences in encoding and decoding, gender, perceptions, culture, silence, misinterpretation of nonverbal communication, defensiveness, lack of feedback and clarification, and seeking to place blame. Any or all of these can prevent successful communication.

Differing cultures between senders and receivers can create significant challenges to communication. Ignoring cultural differences often seriously hinders communication. Cultures can differ in many ways, especially in regard to nonverbal communication. Facial expressions, eye contact, and many other behaviors have a variety of meanings depending on the communicator's culture. Successful communicators recognize such differences and act accordingly.

More and more work is being accomplished through virtual work groups. Virtual work groups may increase communication challenges, as distance between members leads to less formal and practically no informal contact. Virtual work groups must make efforts to increase their interpersonal interactions to create a team identity. This sense of affiliation may be accomplished, in part, with available social media.

Successful communicators possess a heightened awareness of their situation and context. They listen and observe. They sense their audience's moods, attitudes, and concerns and adapt their messages accordingly. Good leaders should constantly strive to improve their communication skills. They should seek to improve trust, engage people in their conversations, work to deliver specific and clear messages, and focus on transferring key ideas. They should also be open minded, listen, and show empathy for others' points of view. In addition, good leaders speak to groups as individuals and, more than any other characteristic, are willing and prepared to change their message as needed.

Successful communication moves a conversation to dialogue, which brings people to a mutual understanding and shared meaning. Mutual understanding and shared meaning can only exist when trust and safety are present.

Chapter Cases

The Case of the Busy Regional Vice President

Leo was a busy man. He had been given the task of supervising 21 hospitals located in eight different US states. He had run a large hospital earlier in his career, so he felt comfortable giving his CEOs advice about how their operations should run. This was a difficult time for his company, as it had just been created through an employee stock ownership plan, and cash flows had become extremely important for the company. Leo's charge was to increase the profitability of each of his hospitals and generate greater cash flows.

Leo was so busy that often he did not have time to speak directly to his CEOs. Consequently, most of his interactions with them took the form of memos, e-mails, and reports that he required his CEOs to produce. These reports allowed him to understand the operations of the hospitals, from the current state of accounts payable to staffing ratios. If he did not understand a report or had an underlying question, he would

Unsafe communication environments place people at risk, which diminishes their ability to operate effectively. Mutual purpose, trust, and respect should be established to create a safe environment in which communication and dialogue can reside.

Chapter Questions

1. What is the difference between two-way communication and one-way communication?
2. What problems are associated with one-way communication?
3. How does the selection of a communication channel relate to information richness?
4. How is the speed to convey a message related to information richness?
5. How has today's environment increased the amount of noise that can impede communication?
6. How has feedback been incorporated in patient safety processes?
7. Why is nonverbal communication misinterpreted?
8. How can the lack of trust destroy communication?
9. How can communication problems within virtual work groups be addressed?
10. In what ways can you improve your communication skills?

immediately call the CEO who produced the report. Because Leo was so busy, he frequently reviewed the reports late at night or on the weekend. He had the home and cell phone numbers of all of the CEOs, and when he called, he expected them to answer and provide the needed explanations to his questions. Although he sometimes felt overwhelmed, he also felt compelled to stay heavily involved in the day-to-day decision making, lest the organization's profit goals not be met. To this end, he sent out the following e-mail to the hospital CEOs:

> All—In order to improve our financial situation, I would like each of you to begin weekly monitoring of your employees' man-hours by unit. We have already established "man-hour/statistic" goals for each of your major units that will be met by the end of the year. However, I want you to review the man-hour/statistic by unit each week and compare it to the existing goals. Deviations should be reported on Form 135, e-mailed earlier by the regional financial officer. If any of your units is 10 percent or more above the set goal, then I want you to call and explain the reasons for this variation.
>
> Also, starting next week, any adjustments in salary, vacation leaves of more than two weeks, capital expenditures over $10,000, and nonbudgeted staff expenses must be approved by me. I would prefer speaking with you about these before I approve them.
>
> If there are any general questions about these requests, I will address them at our monthly conference call with all of you.
>
> Thank you—Leo

This e-mail caused some confusion among the CEOs. Although man-hour/statistic goals had been established for most units, many specialized units did not have set goals. Also, several of the hospitals experienced wide seasonal variation in their activity levels. Hospitals in the Southwest and Southern California were almost always busier in the winter, and conversely, those in the Northern Intermountain Area were slower. Because most hospital units had base, minimal staffing levels, the low number of patients always made them go over the annual set goals. Would they need to explain all of this each week?

Furthermore, what information would be needed for vacation requests? Currently, the CEOs did not get reports of requested vacations. How could they easily obtain this information? And then, they really didn't understand what "nonbudgeted staff expenditures" meant. A number of CEOs raised these questions in e-mails to Leo, but they did not hear back from him until the regional conference call.

(continued)

(continued from previous page)

During the conference call with all 21 CEOs, Leo lectured them about the importance of meeting budget and warned that those coming in under budget would be rewarded whereas those over budget would be "dealt with." This last statement was pretty clear, especially considering three CEOs in the region had been fired in the past six months. After his 25-MINUTE monologue, Leo asked if there were any questions. One brave CEO asked what specific matters Leo would like to be called about. Leo retorted that he expected good CEOs to recognize important variations and know when to confer with him. That was the last question asked, and the conference call ended.

Leo was busy, but soon he became busier. CEOs began calling him immediately about variations in their budget. Queries related to an employee requiring a bone marrow transplant (the company was self-insured), an unbudgeted physician recruitment fee, unexpected repair costs for broken radiology equipment, and many others flooded his office. Now he was so busy that he was unable to receive the CEOs' calls. In addition, he wanted to review each hospital's information before taking its CEO's call. Therefore, his secretary would not connect the calls but gathered information first so that he could call back later. He refused to set up a time for the return calls, because his schedule was too hectic.

Return calls seemed to be made randomly. Sometimes he returned the call promptly, but frequently he called back four to six hours after the CEO's initial call—and occasionally as much as two days later. This structure may have benefited Leo, but it was problematic for the CEOs because often the return calls caught them in inconvenient locations, and sometimes they did not have the details needed to respond adequately. Still, the CEOs felt obligated to take the calls because if they told his secretary they were busy, she would inform them that he would call them back, returning them to the randomized calling queue. Consequently, they often appeared unprepared, so some fell out of Leo's favor.

The end of the year was approaching, and only about half of the hospitals were achieving their budgeted profits. At this same time, Leo was to perform annual evaluations of the CEOs. He set up a time for all of them to fly to his location at the regional headquarters. This would be the first time in five or six months that the CEOs would see him in person and, some CEOs thought, the only time they could fully clarify his directives, offer suggestions, and share concerns. However, the annual performance evaluations were not the best time for them to communicate with Leo. On top of his curt disposition, minimal time was set aside for

the evaluations. Each evaluation was scheduled for one hour, and seven evaluations were scheduled each day for three days. For the fourth day, Leo had scheduled a regional meeting. Many wondered if they would still be employed by the fourth day.

Case Questions

1. From a communication perspective, what are the basic problems in this case?
2. What communication problems emanate from the CEOs? From Leo?
3. How is feedback lacking, and what could be done to improve it?
4. How does trust, or lack thereof, affect the CEOs' ability to communicate?

Unsafe Patient Care—the Result of Poor Communication

Healthcare organizations have invested in many tools to promote patient safety, but are they effective without good communication skills? Checklists, handoff protocols, warning systems, severity indexes, and other tools alone may not address the patient safety issues that face our healthcare system. Nurses, especially in critical care areas, are confronted by these challenges daily. Often, because of the political and emotional stress that occurs when nurses raise issues with physicians, the resulting silence "undermines the effectiveness of current safety tools." The choice to avoid a conversation can create organizational silence that leads to unfavorable results.

A 2010 survey conducted by VitalSmarts, the American Association of Critical-Care Nurses, and the Association of periOperative Registered Nurses showed that more than half of nurses had experienced situations in which they felt unsafe to speak up or unable to have others listen to them, with almost 20 percent encountering this situation multiple times per month. The incidents coincided with three general scenarios: (1) dangerous shortcuts, (2) displays of incompetence, and (3) demonstrations of disrespect.

Dangerous shortcuts, displays of incompetence, and demonstrations of disrespect were reported by more than 80 percent of nurses. Although dangerous shortcuts and incompetence clearly may harm patients, disrespect is also important because it prevents nurses from presenting their opinion and communicating their concerns and problems. Only a small number of nurses (fewer than 15 percent) reported speaking up. Stories of problems included the following:

(continued)

(continued from previous page)

During the surgical safety checklist, we realized the permit and the scheduled surgery did not match (wrong side). We tried to stop the doctor (plastic surgeon) and he said the permit was wrong. The patient was already asleep and he proceeded to do the wrong side against what the patient had verified, which had matched the permit. We could not get any support from the supervisor or anesthesiologist. The surgeon completed the case. Nothing was ever done.

We felt awful because there was no support from management to stop this doctor. What is the point of having a checklist when it is not consistently followed? We felt absolutely powerless to being an advocate for the patient.

Breaking the silence that surrounds these incidents is critical for improving patient care. Specific recommendations were made to create a culture of safety that invites communication and allows people to express their concerns. These recommendations included the following:

1. Identify Crucial Moments that put safety protocols at risk.
2. Define Vital Behaviors that keep patients safe.
3. Develop a Playbook as a strategy to implement vital behaviors.

The ability to improve quality of patient care and ensure patient safety goes beyond the presence of safety tools and hinges primarily on the organizational culture that permits communication regarding difficult issues. Nurses, in particular, face these challenges in our healthcare system, and efforts need to be made to address these needs.

Source: Adapted from Maxfield et al. (2015).

Case Questions

1. How does poor communication result in silence? How does this happen in healthcare?
2. How do patient safety tools become ineffective when employees do not feel free to fully communicate?
3. What should an organization do to improve its culture of open communication?

Chapter Activity

Take the communication quiz at www.mindtools.com/pages/article/newCS_99.htm (Mind Tools 2016). Write a one-page paper describing your communication strengths and weaknesses.

17

MANAGING DIVERSITY

Learning Objectives

After studying this chapter, readers should be able to

- analyze the concept of diversity and its importance to organizations,
- recognize the problems with ethnocentrism and how to address them,
- differentiate among the generations and their cultures and values,
- summarize affirmative action and why an organization may engage in affirmative action, and
- discuss diversity management and its application to healthcare organizations.

Key Terms

- Affirmative action
- Baby boom generation
- Collective cultures
- Diversity
- Diversity management
- Ethnocentrism
- Generation X
- Individualistic cultures
- Millennial generation
- Postmillennial generation, iGen, or generation Z

iversity is a word that has become popular and important across all industries today. When the word was used initially in the twelfth century, it conveyed a negative meaning of being odd, wicked, and perverse (Digh 1998). Today, people perceive diversity differently, and many understand the value and benefits it can bring to an organization. **Diversity** in the workplace means an employee population characterized by a wide array of differences and similarities in areas such as (Osland et al. 2007, 366)

> ethnicity, race, culture, gender, age, functional and educational backgrounds, lifestyle preferences, tenure with the organization, personality traits, and ways of thinking.

Coca-Cola Company's Global Diversity Statement

The Coca-Cola Company's global diversity mission is to mirror the rich diversity of the marketplace we serve and be recognized for our leadership in Diversity, Inclusion and Fairness in all aspects of our business, including Workplace, Marketplace, Supplier and Community, enhancing the Company's social license to operate.

Source: Reprinted from Coca-Cola Company (2014).

Diversity is about having and valuing differences. Everyone, however, is a unique individual with a distinct culture, background, and identity. Diversity, therefore, is relative according to the degree of similarity and differences among people. Similarities group people into common cultures and identities. Cultural and ethnic diversity influence how people see themselves and how they interact with others in work settings (Patrick and Kumar 2012). As can be seen in the box above, companies with successful diverse employee populations (such as Coca-Cola) have open, accepting cultures that welcome all groups and their distinctive contributions.

Attention to diversity has increased as a result of changes in the racial and ethnic makeup of nations across the globe. Because of globalization, most large organizations have a diverse workforce. These changes, taking place in many countries' populations, are directly reflected in the healthcare organizations that operate in these countries. The diversity results from an increase in expatriate workers as well as immigrants. For example, in the Middle East, more than three-quarters of healthcare professionals are non-nationals (expatriates) and large healthcare organizations often employ staff from as many as 50 countries (Whitman 2015). Likewise, the United States has become a more diverse nation. In 2014, about 38 percent of the US population belonged to a minority group; by 2060, the proportion of minorities is projected to grow to more than 55 percent (US Census Bureau 2015).

Cultural, Racial, and Ethnic Diversity

As stated, culture and race are aspects of diversity, but they are not necessarily the same as ethnicity. An ethnic group identifies itself through a common language and a similar behavioral norm, view of the world, background, and ancestry, all of which encompass a cultural group. People may seek to equate ethnic groups with nationality, but nations contain many, vastly different ethnic groups. For example, the Philippines is home to more than 40 identifiably different ethnic groups that have distinct cultures and languages (Utrecht Faculty of Education 2015).

People frequently try to distill race and ethnicity into smaller categories. For example, the US government has established the following five

categories for its collection of data on race and ethnicity (adapted from Humes, Jones, and Ramirez 2011):

- *American Indian or Alaska Native*—a person with origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment
- *Asian*—a person with origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent
- *Black or African American*—a person with origins in any of the black racial groups of Africa
- *Hispanic or Latino*—a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race
- *Native Hawaiian or Pacific Islander*—a person with origins in any of the original peoples of Hawaii, Guam, or other Pacific Islands
- *White*—a person with origins in any of the original peoples of Europe, the Middle East, or North Africa

These categories are very general and point to the problem of classifying individuals in a work setting. People who fall within one of these groups may have cultures, backgrounds, and perspectives that are dramatically different from those of other members in the group. Lumping individuals into such categories allows stereotyping, which, as described in chapter 7, can lead to serious misconceptions and even prejudice. Organizations need to understand diverse cultural orientations within singular-appearing categories and welcome the differences.

Ethnocentrism

People commonly cluster into groups and distinguish between their "in" groups and outsiders. Interestingly, many tribes across the globe have names that translate as "the human beings" or "the people," which implies that individuals who are not part of their tribe are not considered humans (Dana 2000). Although more cohesive cultures exist with "in" and "out" populations, the danger of ethnocentrism results. **Ethnocentrism** is the "exaggerated tendency to think the characteristics of one's own group or race are superior to those of other groups or races" (Hofstede 1984, 25). If not addressed appropriately, ethnocentrism can lead to implicit or explicit segregation, racism, and discrimination.

Individualistic and Collective Cultures

Exhibit 17.1 shows the major cultural differences among the three most populous countries in the world. One major difference stems from the relative value placed on individualism versus collectivism. **Individualistic cultures**

EXHIBIT 17.1
Major Cultural Values of Select Countries

China:	Respect, obedience, humility, group loyalty, importance of personal connections, and ordered hierarchy
India:	Collectivism, fatalism, hierarchy, and duty
USA:	Individualism, freedom and equality, pragmatism, and achievement and material gain

Source: Osland et al. (2007).

value loose social relationships that encourage individuals to take responsibility for themselves and their relatives. **Collective cultures** emphasize group responsibility to protect and care for their communities. The United States has a relatively individualistic culture, whereas countries in Asia and the Middle East have highly collective cultures. Individualism in the United States can be seen in workers who promote their self-interests and organizations through active office politics. In contrast, collectivism encourages workers to seek the good of the group and self-sacrifice.

Misperceptions can occur when a person from an individualistic culture encounters someone from a collectivist culture. For example, some Asians may be perceived as quiet, passive, and nonconfrontational when they express that they value their culture of harmony, the opinions of others, and what is best for the group. Rather than not being engaged, their behavior may reflect their backgrounds and be very appropriate from their perspective.

Gender and Age Diversity

Diversity is also often expressed in terms of gender and age (Osland et al. 2007). A fundamental and pervasive workplace diversity issue involves gender. Although women participate in most professions and workplace settings, significant barriers in corporate cultures remain, impeding women from entering management positions. These barriers have been static for decades as a result of men's failure to recognize these impediments. In a McKinsey & Company (2014) survey, three-fourths of men thought diverse leadership teams with significant female participation improved company outcomes, but a strong majority of males failed to recognize the challenges women face.

Globally, even in traditionally conservative countries, increasing gender diversity is seen as positive and desired. Overall, according to Sperling, Marcati, and Rennie (2014), authors of a separate McKinsey study, having female representation in leadership has been seen as

- desirable by a strong majority of organizational members in the Arab Gulf countries;

- positive, as women bring diverse perspectives, transformational leadership, and new problem-solving skills;
- important to improving meeting dynamics by making women more professional and results oriented; and
- critical to increasing the pool of talent for organizations.

Age differences are also important to address in today's multigenerational workforce. Demographic factors in most of the industrialized world are encouraging older employees to remain in the workforce longer and, as a result, will increase the number of generations working together. A generation is attributed as roughly the first two decades of a person's life, when core values and attitudes are formed (Delcampo et al. 2011). Generational values influence how employees are motivated. Without an understanding of those values, these motivations can create conflict between workers from different generations.

Generational Differences

Several generations at a time dominate the current and future US workforce. Delcampo and colleagues (2011) and Howe and Strauss (2007) described the first three, and Horovitz (2012) and Sterbenz (2015) characterized the fourth:

- **Baby boom generation**: Born between 1943 and 1960, members of this generation are products of post–World War II optimism and are known for challenging traditions and conventions. Boomers tend to remain employed or pursue new careers late in life. Its members appear as highly eccentric and incompetent to younger generations.
  - Positive attributes: accountability, adaptability, clear communication, initiative, organizational management, problem solving, service orientation, collaborative skills
  - Weaknesses: desire for instant gratification, ignorance of new technology, lack of appreciation for diversity
- **Generation X**: Born between 1961 and 1981, members of this population lived their adolescence during a time of failing schools and marriages. They learned to distrust institutions, prefer entrepreneurship, and lack corporate loyalty. Gen Xers seek job security, but their risky behaviors clash with younger people. They also push for efficiency and innovation through negotiating their own deals. They tend to switch employers frequently.
  - Positive attributes: adaptability, initiative, resource management, problem solving, knowledge of technology, valuing diversity
  - Weaknesses: lack of organizational management, service orientation, collaborative skills, loyalty

- **Millennial generation**: Born between 1982 and 2005, members of this generation are more aligned with teamwork and less risk seeking than are gen Xers, and they value work–life balance. Many have become more traditional than the preceding generations. Millennials adhere to community norms, favor rituals, demonstrate loyalty, and seek community building. They tend to be confident, trusting, and teachable at work. Conversely, they may be seen as pampered, risk averse, and dependent and thus may require more consistent feedback and direction.
  - Positive attributes: accountability, organizational management, service orientation, knowledge of technology, valuing diversity, collaborative skills
  - Weaknesses: lack of communication skills, problem solving ability, and loyalty; too great a dependency on technology
- **Postmillennial generation, iGen, or generation Z**: Although the name has not been thoroughly established, members of this generation, born after 2005, will enter the workforce in the next decade. Of significance for this generation is its early introduction to and widespread use of the Internet, making the group comfortable with technology. Postmillennial households are significantly nontraditional, with many members coming from multiracial and single-parent families. Most postmillennials place a strong value on education.

Understanding backgrounds that are different from ours allows us to interpret others' behavior on the basis of their—instead of our—cultural norms. This perspective permits us to comprehend actual motives and rationale while avoiding stereotyping, misperceptions, and false attributions of behavior.

Racial and Ethnic Disparities in Healthcare

One reason for the importance of addressing diversity in healthcare is the underlying racial and ethnic disparities that exist in the provision and outcomes of healthcare. For example, the Agency for Healthcare Research and Quality (2014) reports that minorities consistently receive worse quality and access to healthcare than whites do. Barriers to proper healthcare arise when physicians and other health professionals lack cultural awareness, as patients' cultural values may conflict with traditional Western medicine and damage communication. Also, even when subtle racism exists among healthcare providers, the healthcare of minorities is marginalized (Marrone 2007). As reported by the Institute of Medicine (2002, 5):

> Patients' and providers' behavior and attitudes may therefore influence each other reciprocally, but reflect the attitudes, expectations, and perceptions that each has developed in a context where race and ethnicity are often more salient than these participants are even aware of Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. Prejudice may stem from conscious bias, while stereotyping and biases may be conscious or unconscious, even among the well intentioned.

Affirmative Action and Diversity Management

Many of the legal guidelines and laws regarding diversity evolved from legislation addressing equal employment and affirmative action. In the 1960s and 1970s, the US government created laws to help minorities gain "equal pay for equal work" and avert race and gender discrimination. In the 1980s, affirmative action programs made discrimination illegal and set up quotas for employing members of disadvantaged groups (Woodward and Saini 2006). Affirmative action is not diversity management, however. **Affirmative action** is legally driven, quantitative, problem focused, and reactive. It is a policy or action that actively seeks to improve the employment and educational opportunities of members of minority groups and women. In contrast, **diversity management** is voluntary, opportunity and benefit focused, and proactive (Digh 1998). Diversity management promotes the unique differences of people and highlights the economic benefits organizations can gain from a diverse workforce. In other words, it seeks to form a culture that acknowledges employees' differences and allows employees to use these traits to achieve organizational goals (Woodward and Saini 2006).

Fulfilling the promise of diversity requires overcoming many obstacles. Organizations simultaneously must recognize differences, address the difficulties of working together, and perhaps change long-standing practices to promote equity and inclusiveness. Once achieved, however, diversity's benefits can be immense and include the following (Clapp 2010):

- Stronger ethical foundation for the organization
- Improved organizational decision making
- Reduced conflict and improved employee communication
- Improved performance by employees, who feel connected and relevant
- More solid relationship between the institution and its community
- Increased likelihood of recruiting and retaining an even more diverse workforce

Diversity problems in organizations will not be eliminated by legal and regulatory initiatives but by the active participation of healthcare leaders (Institute of Medicine 2002). The likelihood of instituting a well-functioning, diverse workforce dramatically increases with the involvement and commitment of the organization's top management. If the leaders can model behaviors and create processes that promote diversity, the rest of the organization will generally follow. CEOs should become their organization's chief cultural officers. In this role, they personally should seek out disparities and inequities in their company's culture and eliminate barriers that limit both employee and patient satisfaction (Hobby 2006).

To fulfill this role, The Joint Commission recommends that leaders adopt the following practices (Wilson-Stronks et al. 2008):

1. Create policies and procedures that build cultural competence to meet the needs of diverse populations.
2. Collect and use data to identify and monitor health disparities in an effort to provide quality healthcare to culturally and linguistically diverse patients.
3. Develop services and activities tailored to meet the needs of diverse populations.
4. Establish collaborative practices that bring together multiple departments, organizations, providers, and individuals to devise initiatives that meet diverse patient needs.

In addition, the US Department of Health and Human Services has issued guidelines in three areas—(1) governance, leadership, and workforce; (2) communication and language assistance; and (3) engagement, continuous improvement, and accountability—to "advance health equity, improve quality, and help eliminate health care disparities" (Office of Minority Health 2016). (See exhibit 17.2.)

EXHIBIT 17.2
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that

(continued)

EXHIBIT 17.2 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care *(Continued)*

(continued from previous page)

promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: Reprinted from Office of Minority Health (2016).

One way to stress the importance of diversity is to create an organizational diversity statement. These statements often fall within or appear near a company's values statement and express how diverse employee characteristics

benefit the organization. For example, Johnson & Johnson, one of the largest healthcare companies in the world, states its commitment to diversity and ties that commitment to its values and dedication to the communities it serves (see exhibit 17.3). Successful diversity statements define what diversity means to a company and what diversity's business value is (Digh 1998).

Organizations also need to align their human resources (HR) systems to promote diversity. Often, HR systems are structured to promote conformity and similarities, which help the organization apply common evaluations. As discussed in chapter 7, managers can unknowingly introduce bias into their hiring and promotion processes, as they are more likely to give positive evaluations to employees who resemble them. Such processes can seemingly benefit the organization by employing similar workers—those who "fit" the firm's culture, are expected to cause minimal conflict, and relate well to its managers. As Barnard (1938, 224) long ago noted,

> the general method of maintaining an informal executive organization is so to operate and to select and promote executives that a general condition of compatibility of personnel is maintained. [M]en cannot be promoted or selected, or even must be relieved . . . because they "do not fit." This question of "fitness" involves such matters as education, experience, age, sex, personal distinctions, prestige, race, nationality, faith, politics, sectional antecedents, and very specific personal traits as manners, speech, personal appearance, etc.

Thus, unintentionally, many organizations have created barriers to diversity. The result of many HR processes is to ensure employees fit the organization, which can create a highly homogeneous work environment where conformity is valued (Ferris, Frink, and Galang 1993). HR managers must understand how policies might negatively affect diversity and seek to

EXHIBIT 17.3
Johnson & Johnson Diversity Statement

Diversity is a central part of the cultures across the Johnson & Johnson Family of Companies. It's a key to our people's passion for improving the health and well-being of people the world over. Further, our commitment to diversity and inclusion is deeply rooted in the values instilled by Our Credo and is exemplified in a number of our companies' programs and activities.

We recognize that differences in age, race, gender, nationality, sexual orientation, physical ability, thinking style and background bring richness to our work environments. Such differences help us connect better with the health needs of people in communities around the world.

We believe that attracting, developing and retaining a base of employees that reflects the diversity of our customers is essential to our success. We also believe success hinges on relationships with diverse professional and patient organizations, civic groups and suppliers.

Source: Reprinted from Johnson & Johnson (2016).

change those that do. These changes are frequently difficult, as "diversity is not a problem to be solved, but an ongoing and lengthy process" that comes into existence with "small, everyday actions taken by people at all levels of the organization" (Kreitz 2008, 104). No single best way exists to create an inclusive culture that values diversity, but suffice to say here that the full organization needs to be involved.

Federal, State, and Private Resources to Improve Diversity

Diversity may have been driven initially by state and federal laws, but the positive benefits come when it is integrated throughout the organization. This integration occurs through the strong support of management and is institutionalized by organizational policies and processes. Diversity should become a goal of the organizational strategic plan, and measures should be established to hold managers accountable. In addition, recruiting, succession planning, and training should be seen as keys to achieving diversity.

The following are resources that may assist an organization in improving its diversity:

- *Office of Minority Health*. This office is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs to eliminate health disparities (http://minorityhealth.hhs.gov/).
- *US Government Accountability Office publications.* One title related to this topic is *Diversity Management: Expert-Identified Leading Practices and Agency Examples* (www.gao.gov/assets/250/245069.pdf).
- *Institute of Medicine reports:* The institute offers this relevant report: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (www.nap.edu/openbook.php?record_id=12875).
- *Institute for Diversity in Health Management*. This organization works to expand leadership opportunities for ethnic minorities in healthcare management (www.diversityconnection.org/diversityconnection/about-us/About-the-Institute.jsp).

Chapter Summary

Diversity is an important concept in today's business environment. Across the globe, nations have experienced the influx of expatriate workers and immigrants, who have radically shifted the mix of employees and customers.

Companies have responded by identifying barriers and setting goals to increase the diversity of their workforce and to retain and satisfy the needs of their increasingly diverse stakeholders.

Culture and race are aspects of diversity but are not the same as ethnicity. Ethnic groups have common languages, behavioral norms, views of the world, backgrounds, and ancestry. The US government has set five categories for race and ethnicity, although there are many variations of these. People should be careful when lumping others into racial and ethnic categories, as stereotyping and ethnocentrism can result.

National culture differences are expressed in what is valued by that culture. One major way national cultures differ is in the importance placed on individualism versus collectivism. Collective cultures, as seen in Asian countries, emphasize group responsibility and accountability, while individualistic cultures, as often seen in the United States, focus on self-interest. When individuals from different cultures work together, their approaches and motivations can be misunderstood, perhaps resulting in distrust.

Gender and age are also significant diversity issues in the workplace. Although great progress has been made, significant barriers remain for women at work. These barriers tend to remain because men often do not recognize them, although most men do see increased female representation in leadership as positive.

Different generations work together but tend to have different values and motivations. Each generation has both positive and less-than-ideal attributes, which differ from others. For example, members of the baby boom generation tend to be accountable and adaptable, whereas generation X members value diversity and problem solving. Understanding differences allows one to correctly interpret behaviors.

Diversity in healthcare is important, as racial and ethnic disparities continue to occur in minorities' healthcare access and outcomes. Barriers arise when providers lack cultural awareness or harbor conscious or unconscious biases.

Issues regarding diversity became prominent in the workplace as a result of legislation beginning in the 1960s that promoted equal pay and affirmative action. However, diversity management is more than these legal mandates; it seeks to develop a culture that promotes the unique differences of people to gain economic benefits for the firm. The benefits for a company include developing a strong ethical foundation, improving decision making, reducing conflict, connecting employees with the organization and the community, and enhancing recruitment and retention of a diverse workforce.

To leverage diversity, organizations need the support and commitment of top management, who model proper behaviors and create policies and processes to promote diversity. Healthcare CEOs should become their organization's chief cultural officer and work to eliminate diversity barriers

that limit employee and customer satisfaction. Toward this end, The Joint Commission and the US Department of Health and Human Services have suggested comprehensive steps for healthcare organizations to take.

Organizations should also closely examine their HR systems and policies to be certain they promote, not restrict, diversity. Often, traditional HR practices have introduced bias in evaluations and promotions. HR managers must understand how their policies and processes affect the level of organizational diversity and adjust accordingly.

Obtaining a happy, productive, diverse organization is not a problem to be solved but a long process to be engaged in. There is no single way to undertake this journey, but ultimately everyone in the company needs to be involved and its efforts integrated throughout the organization. Diversity should become a company goal, with measures to hold managers and executives accountable for recruiting, succession planning, and training.

Chapter Resources

For an expanded discussion of international culture and diversity, see the following two sources:

1. *Hofstede model* (http://geert-hofstede.com/). The Hofstede model uses five dimensions to distinguish among different cultures: power distance, individualism, masculinity, uncertainty avoidance, and long-term orientation. The website allows comparisons of countries along these dimensions.
2. *GLOBE model* (www.ccl.org/leadership/pdf/assessments/globestudy.pdf). GLOBE consists of nine dimensions that encompass society practices and values: uncertainty avoidance, power distance, institutional collectivism, in-group collectivism, gender egalitarianism, assertiveness, future orientation, performance orientation, and humane orientation.

Chapter Questions

1. What advantages accrue with a diverse employee population?
2. What is an ethnic group?
3. How does nationality differ from ethnicity?
4. How might ethnocentrism create problems for an organization?
5. How do cultural differences influence the choices an organization may make?

6. What are the differences between generations?
7. How does affirmative action differ from diversity management?
8. How can organizations better align their human resources systems to promote diversity?

Chapter Cases

Diversity Efforts at Novant Health

Novant Health—consisting of 14 medical centers, 24,000 employees, and more than 1,100 physicians across Virginia and South Carolina—sought to become more inclusive, which would further its efforts to become a world-class healthcare system. To accomplish this goal, Novant established six diversity action committees:

1. Workforce
2. Care/Operations
3. Service Line Planning
4. Community Involvement
5. Supplier
6. Marketing and Government Relations

The manager of each area was asked to lead his or her respective committee. Each committee had 8 to 12 members, who reported to the manager and were considered influential. The system's chief diversity officer was also a member of each committee. Moreover, the system had seven business resource groups, chaired by management-level employees, which focused on different diversity issues: women's; generational; Asian; black/African American; Hispanic/Latino; lesbian, gay, bisexual, and transgender; and veterans and disabled. To integrate all of these committees, Novant created a diversity council.

By 2012, each diversity action committee had established specific goals, some of which were later used to determine bonuses. These goals included the following:

- Keep retention of black employees and employees of the underrepresented gender the same as other groups.
- Reduce low-acuity emergency department visits by improving access and education regarding alternatives for low-income populations.
- Increase market share among Hispanics and blacks by offering screening and preventive care.

- Raise the percentage of supplies purchased from "diversity" suppliers to above 11 percent.

Novant believed its committee structure and diversity efforts allowed it to better fulfill its mission and serve its patients. Its leadership suggested that diversity had become an integral part of Novant's operations and "no longer isolated initiatives or projects." However, it recognized that much could still be done to continually improve its services and meet the growing needs of diverse populations.

Source: Adapted from Institute for Diversity in Health Management (2015).

Case Questions

1. What are the positive and negative aspects of creating multiple committee structures to address diversity across a large system?
2. What else could Novant do to promote diversity?

Problems in a Diverse Culture

MediHealth, a healthcare support firm in India, experienced great growth in its business of providing coding, billing, and accounts receivable management for international firms. From a small group of 25 employees, it had grown in three years to employ more than 250 people. Although part of the same company, the various work segments differed in many ways. For example, the accounts receivable group worked mostly at night and dressed casually. Workers from the billing and coding group wore more traditional dress and often used their local languages during meetings.

MediHealth's human resources director, Neel, was proud of his work in recruiting qualified, productive employees and expanding the workforce in an organized, constructive manner. His plan was to employ loyal workers who would stay with the firm for many years. In addition, he recruited nationally across India for diverse employees. Employees hired early on seemed to remain, but those hired in the past two years experienced high turnover. The turnover rate now exceeded the industry average, and Neel was concerned because the bulk of those leaving were hires he made specifically to increase the company's diversity.

Creating a diverse workforce seemed to be only a first step. Managing the diversity to retain the employees and increase their unity and productivity now seemed even more important, especially considering employee comments such as the following:

(continued)

(continued from previous page)

I feel like a complete outsider in the company. I am from north India and do not understand the language spoken by the employees in my team. I have taken repeated initiatives to bond with the team, but I always feel as the odd one out.

The CEO's talk about the organizational commitment to quality is a farce. [The employee further indicated that she had been passed over for a promotion and was told that because she was a woman, she would not able to complete the required travel.]

My children's day care closes at 6:00 p.m., but if there is work, I am supposed to complete it before I go. Sometimes I also work on holidays and there is no policy of compensatory-off. There are all men in the top management, and no one seems to understand the issues and concerns of a woman here.

Neel felt depressed. It seemed his efforts to diversify the company were coming apart. He had brought workers with varied backgrounds from all across his country, but his efforts appeared short-lived.

Source: Adapted from Pant and Vijaya (2015).

Case Questions

1. What issues of diversity may be affecting turnover?
2. What could Neel do to address the concerns of his employees?

Chapter Activity

Read the summary of "Cognitive Intelligence: Number of Women in Group Linked to Effectiveness in Solving Difficult Problems" at www.sciencedaily.com/releases/2010/09/100930143339.htm (Massachusetts Institute of Technology 2010). Write a paragraph describing how this research helps emphasize the need to consider diversity in organizations to successfully solve problems.

18

CONFLICT MANAGEMENT AND NEGOTIATION

Learning Objectives

After studying this chapter, readers should be able to

- appraise the meaning and application of conflict to organizations,
- recognize and differentiate among the types of conflict,
- realize the issues surrounding polarization, and
- summarize the skills involved in negotiation.

Key Terms

- BATNA
- Conflict
- Interests
- Intergroup conflict
- Interpersonal conflict
- Intragroup conflict
- Intrapersonal conflict
- Nontask organizational conflict
- Polarization
- Positions
- Process conflict
- Relationship conflict
- Task conflict
- Zero-sum games

Conflict and negotiation are present daily in healthcare. Anyone who says differently has never stepped into a hospital or physician's office or has failed to be part of a team with challenging output goals. If managed appropriately, conflict can improve decision making and further an organization's mission. However, if poorly managed, conflict can quickly become destructive. Organizations that manage conflict well can succeed, while those that do not can become dysfunctional collections of competing individuals. The need for negotiation—a component of conflict management—arises when conflict surfaces. Negotiation skills facilitate the successful use of conflict. This chapter addresses both.

Conflict Basics

Although a consistent, accepted definition is lacking, **conflict** has been defined as a "competitive or opposing action of incompatibles" (Merriam-Webster 2015a). The importance of the concept in our society can be measured by the fact that the term appears in the top 1 percent of word searches at Merriam-Webster.com. Another definition, offered by De Dreu and Gelfand (2008, 6), describes conflict as

> a process that begins when an individual or group perceives differences and opposition between itself and another individual or team about interests and resources, beliefs, values, or practices that matter to them.

As suggested, conflict arises when two or more parties have opposing views, positions, needs, or interests that are perceived as incompatible. In other words, conflict is said to occur when one party faces the potential of gaining something at the expense of another. It can originate from a variety of sources, such as differing values, assumptions, and goals. Situations of conflict often feature the following elements:

- Parties (groups or individuals) have opposing interests and hold the perception that only one interest can be met.
- Opposing parties often do not recognize and acknowledge opposing interests.
- Opposing parties believe the other side will seek to achieve its own interest at the expense of the other.
- Existing relationships of opposing parties are a reflection of their past interactions.
- Actions are taken or efforts are made to gain the parties' interests.

Although conflict was initially seen as an evil that should be eliminated from organizations, more recent management scholars have highlighted conflict's productive potential (Rahim 2011). In other words, conflict can result in positive as well as negative outcomes. Positive outcomes from conflict that facilitate organizational goals include the following (Rahim 2011):

- Innovation, creativity, and positive change
- Improved organizational decision making
- Discovery of synergistic solutions
- Increased individual and group performance
- Enhanced clarity and understanding of assumptions and intentions of parties

- Displays of actual values and belief systems of an organization
- Increased group cohesiveness

Of course, conflict can escalate and quickly produce dysfunctional outcomes, such as the following (Rahim 2011):

- Job stress, burnout, and employee dissatisfaction
- Diminished communication between and among employees and groups
- Heightened distrust and suspicion
- Damaged relationships
- Decreased job performance
- Increased resistance to change
- Diminished employee loyalty and organizational commitment

Conflict in healthcare organizations has also led to patient safety errors, poor morale, and distrust (Givan 2010). Sadly, most healthcare professionals lack even basic skills and training to resolve conflict (Geradi 2003; Patton 2014). The determination of whether organizational conflict becomes positive or negative rests largely with the employees' skills, abilities, and conflict management capabilities. As such, conflict management is one of the major roles of all healthcare managers as they deal with the many healthcare professionals who work in their organization.

Types of Work-Related Conflict

Four types of work-related conflict are discussed in this chapter: (1) task conflict, (2) process conflict, (3) relationship conflict, and (4) nontask organizational conflict. **Task conflict** occurs when different opinions arise about work details and goals—that is, about what is to be accomplished. **Process conflict**, on the other hand, involves disagreements about how a job gets done. **Relationship conflict** results from differences in values, personality, political beliefs, and style. **Nontask organizational conflict** develops from disputes regarding "company policies, hiring decisions, benefits, organizational culture, organizational leadership or power" (Bruk-Lee, Nixon, and Spector 2013, 340).

Poorly managed, these four types of conflict can needlessly stress employees. Relationship and nontask organizational conflict, in particular, can generate anger and frustration that can increase physical strain and cause health problems, including high blood pressure and higher risk for cardiovascular disease (Rozanski, Blumenthal, and Kaplan 1999). Relationship conflict can engender negative emotions, damage working relations between and among people, hurt overall morale across the company, and make future interactions difficult.

Structural Problems Lead to Conflict, Escalation, and Polarization

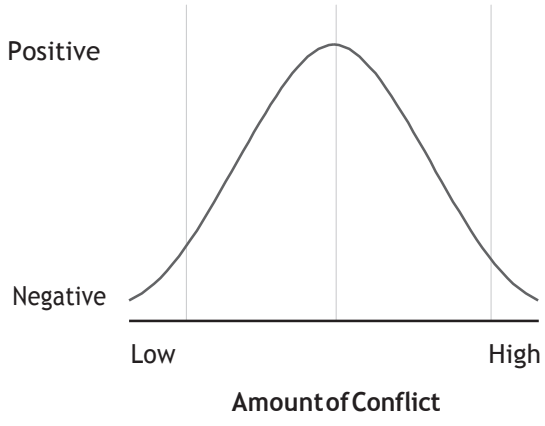
A doctor became frustrated when he called a nursing unit at lunchtime and no one immediately answered the phone. After eight rings, he slammed the phone down, stomped over to a nurse standing nearby, and demanded that she go to the nursing floor to see what was going on. The nurse, who worked in a different nursing unit, told the doctor that she wasn't going to that floor but would pass on his message once she arrived at her own nursing station. This response further enraged the doctor, who grabbed the nurse's arm and began yelling at her. The nurse then lost her temper, jerked her arm away from him, and made a derogatory remark about his ethnic heritage. The doctor then really "lost it" and slapped the nurse. She backed away and called the police, who soon arrived and charged the doctor with assault.

Conflicts that escalate often produce **polarization**, whereby people—even those who may initially have been neutral—are driven to take sides and adopt extreme positions. When people become polarized, little room is left for agreement. Individuals and groups drift to increasingly radical poles, which makes compromise and resolution increasingly difficult. As shown in the adjacent box, issues can quickly escalate and create detrimental results for an organization.

Interpersonal conflict is a leading source of employee stress and a significant reason for employee turnover. Some observers estimate that more than half of employee retention problems can be tied to poorly handled conflict (Runde and Flanagan 2013). In addition, approximately 26 percent of chief nursing officers who left their position reported leaving because of conflicts with their CEO (Jones 2008).

That said, at times a manager may need to stimulate conflict if little exists. As shown in exhibit 18.1, a low-conflict environment can actually retard organizational outcomes and result in stagnation and complacency. A properly functioning organization experiences a moderate amount of conflict that encourages improved solutions and decision making. Enlightened managers design methods to introduce conflict in critical processes. Why don't more

EXHIBIT 18.1 Amount of Conflict and Organizational Impact



managers inject conflict in their organizations? Conflict often is unpleasant, and many managers seek to avoid it—even if its long-term effects could be positive.

Zero-Sum Games and Competition

One aspect of society that promulgates conflict is the degree of competition that occurs in a culture. Cultures that encourage competition, such as in the United States, produce winners and losers, thereby engendering conflict. As can be seen in many sports, winning becomes paramount, and coaches and players may even engage in unethical and illegal behaviors to "beat" their opponents. Purely competitive contests result in **zero-sum games**, where one party wins at the expense of the loser. Almost all sports contests are designed to end with one winner and one or more losers. Likewise in business, activities such as seeking employment and bidding for contracts often become competitive, zero-sum games.

Competition also frequently occurs among groups. This is especially true in healthcare, where professional group loyalties are strong. Physicians, therapists, nurses, and most other clinical groups value their group's priorities and point of view more highly than those of outsiders. Professional differences lead to competition when "Turf battles, differences of knowledge level and experience, and rare opportunities for group conversation lead to a competitive atmosphere where everyone is struggling" (Geradi 2003). What often results is a cycle of competition, hostile interaction, and escalation followed by more competition (Osland et al. 2007).

As the adjacent box discusses, when "beating the competition" becomes the focus, dysfunctional competition is likely. Dysfunctional competition occurs when individuals and groups seek to finish ahead of others and "win" rather than focus primarily on self-improvement.

Cheating Athletes

In athletics, there are almost always winners and losers. "To the victors go the spoils" is an apt statement for athletes, as the winners of high-profile contests can earn millions of dollars in salary, bonuses, awards, or endorsements. However those who "come close" but do not win receive relatively little. For example, the third-place finisher of the 2015 US Open golf tournament received about one-third of the amount the winner, Jordan Spieth, took home (Wagner-McGough 2015).

The pressure to win, unfortunately, encourages cheating—sometimes in sophisticated ways that are difficult to discover. One example is Lance Armstrong, who won the Tour de France bicycling race seven times before race officials proved that he cheated by using performance-enhancing drugs, or "doping," to gain a competitive edge in his racing. Once his cheating was discovered, Armstrong was stripped of his titles and banned from cycling for life (Roan and Slater 2015). This is just one example, among many, of athletes and teams who have been compelled to win at any cost—be it through doping or deflating balls to below-regulation standards, as occurred in the National Football League in 2015 (Hume 2015).

Healthcare is not immune to winning at any cost. Large egos bereft of humility often pit very intelligent people, competing for limited resources, against each other. As a result, conflict can occur and easily escalate. In addition, some healthcare providers commit fraud, which is now estimated at billions of dollars per year. As with the athletes described in the box on page 303, some providers feel they must cheat to win. But many eventually get caught and ultimately lose (Piper 2016).

However, competition among groups is not always dysfunctional. It can encourage individuals and groups to achieve higher goals than might otherwise be set. As long as good sportsmanship occurs and efforts are focused on playing by the rules while pushing one's energies to constantly improve, competition functions well. As implied earlier, conflict in healthcare is unavoidable. However, if they manage it properly, organizations can learn from conflict. It becomes a means to "help us better perceive ourselves, the people we work with, and what we are trying to achieve together" (Marcus 1995).

Intrapersonal, Interpersonal, Intergroup, and Intragroup Conflict

Conflict also exists at different levels, as exhibit 18.2 illustrates. **Intrapersonal conflict** arises because of an individual's "roles, values or goals" (Osland et al. 2007); **interpersonal conflict** occurs between two or more individuals and may be caused by personality, values, and style differences; **intergroup conflict** occurs between two or more groups, such as different departments; and **intragroup conflict** happens among members of a group.

Conflict emerges in the workplace for many reasons. Opposing feelings, competitive pressures, power struggles, big egos, jealousy, compensation issues, or just having a bad day may trigger conflict. While some might think almost any situation could create conflict, much conflict results from poor communication and the inability to control one's emotions (Myatt 2012a). Communication—specifically, its absence—afflicts all organizations and directly affects conflict. As discussed in chapter 16, communication is identified as a perennial problem in all organizations. It breaks down when humans inappropriately interject their

EXHIBIT 18.2 Levels of Conflict

Intrapersonal	Self
Interpersonal	Two or more people
Intergroup	Two or more groups
Intragroup	Single group

uncontrolled emotions in work relationships and decisions. Such communication breakdowns frequently lead to angry confrontations and an escalation of conflict. Expressions of anger during conflict often result in damaged work relationships and inability to communicate (Van Kleef and Cote 2007).

Conflict also occurs in healthcare for work environment reasons. The healthcare workplace is characterized by ambiguous outcomes, complexity, high degrees of competition, forced cooperation, time pressures, and directives to change. These conflict triggers, described in more detail in the following list, exist because of the nature of healthcare (Marcus 1995):

- *Ambiguity:* Healthcare information and outcomes can be interpreted in different ways by different people through the lens of their own knowledge, expectations, values, and experiences.
- *Complexity:* Healthcare organizations bring together a large number of people, who are involved in and affected by the numerous decisions made.
- *Competition:* Different healthcare departments, professions, and organizations often compete for limited resources, power, prestige, and status.
- *Obligatory cooperation:* Information must be rapidly and accurately exchanged for the care of patients. Responsibility for patient care is transferred across shifts and from one provider to another.
- *Time pressures:* Time is critical in healthcare decision making. Adverse consequences can result if tests, communications, and care are late.
- *Change:* Changes in technology, reimbursement methods and rates, professional responsibility, social expectations, knowledge, and information are constantly occurring in healthcare.

Managing Conflict

To offset the inherently difficult nature of healthcare, effective healthcare leaders learn to properly manage conflict. One survey reveals that managers spend about a quarter of their time dealing with conflict (Acuna 2013). An article published in a leading business journal stated that "if you cannot or will not address conflict in a healthy, productive fashion, you should not be in a leadership role" (Myatt 2012a). Those who make a habit of avoiding conflict over the long run will fail. Conflict rarely diminishes and becomes positive if left to itself. It requires good managers who can recognize conflict, diagnose its cause(s), and intervene to resolve or moderate it. With this understanding, many companies have initiated training to provide their managers with conflict resolution skills.

Maimonides Medical Center's Approach to Reducing Hospital Conflict

Conflict occurs daily in hospitals. Big egos, critical life-and-death decisions, a high level of work interdependence, strong professional identities, and gender differences combine to produce an extreme environment of conflict and distrust. This conflict increases medical errors and poor morale. To address employee conflicts, Maimonides Medical Center, a large urban hospital in Brooklyn, New York, created a process to change behaviors that lead to conflict.

Maimonides has known its share of organizational conflicts. Heavily unionized, it endured a three-week-long nurses' strike in 1998, for example. In an effort to improve physician relationships

(continued)

Training can involve many aspects of conflict and focus on a variety of topics. Best practices often include tying the training to the employee's work circumstances and situation. For example, conflict resolution training for physicians could connect to their clinical experience and practice among interdisciplinary teams (Geradi 2003; Timothy 2015). Overall, training should help people accomplish the following (Myatt 2012a):

- *Define acceptable behavior:* The way people should treat each other must be clearly articulated.
- *Address conflict proactively:* Leaders should actively seek out potential conflict and proactively intervene. They must understand the tensions in the workplace and work to moderate concerns before they flare into conflict.
- *Understand the involved parties' motivations:* Leaders should learn what those involved in the issues want to accomplish and take action to help all achieve their goals.
- *Use conflict as an opportunity for learning and growth:* Leaders who properly use conflict can stimulate innovation and open new perspectives.

The box below describes the effort of a large medical center to manage conflict. As receommended earlier, the organization's first step was to define in detail those behaviors that were acceptable and the consequences for those who chose to behave outside these guidelines.

Conflict management has been referred to as the process of negotiating differences (Tinsley 2001). Simply defined, *negotiation* is "a formal discussion between people who are trying to reach an agreement" (Merriam-Webster 2016). Conflict management usually refers to a proactive approach to handling conflict. High-functioning organizations do not simply wait for workplace disputes to erupt and then decide how to resolve them. Instead, they implement conflict management policies and procedures that are consistent with organizational goals and objectives (Lipsky and Avgar 2010). Organizations that successfully

negotiate differences avoid harmful conflict, reach agreements, and produce consistently positive results.

Negotiation Skills

Considering the close association between conflict and negotiation demonstrated earlier, negotiation skills are critical for any leader or manager in healthcare. Negotiation is a constant activity in healthcare organizations and is vital to preempting and resolving conflict. Items that are negotiated range from simple schedules to organization-changing strategies. Successfully negotiated agreements not only solve a problem but also improve the parties' relationship.

Many books and guidelines have been published describing the art of negotiating. However, only a few basic tenets are required to engage in successful negotiation. They include the following:

(continued from previous page)

and engender mutual respect, the hospital and unions created the physician-written Code of Mutual Respect in 2005, which established seven key principles of expected behavior: (1) professionalism, (2) respectful treatment, (3) appropriate language, (4) appropriate behavior, (5) prompt feedback, (6) confidentiality, and (7) communication. To enforce employee compliance with the code and deal constructively with violators, the hospital added the following five complementary strategies, which were implemented by both union and management:

1. Formal and informal leadership development
2. A respect hotline for reporting violations
3. Trained managers and leaders to mediate issues with code violators
4. Crucial-conversations training
5. Measurement of compliance to the code

Training physicians to investigate alleged code violations by other physicians helped to more quickly resolve problems and lessen hospital conflicts. Physicians' commitment to the Code of Mutual Respect has contributed to improved communication and patient safety. The effort to embed these changes is long term and requires continued buy-in and collaboration from all stakeholders.

The Code of Mutual Respect can be found in its entirety at www.maimonidesmed.org/media/file/codeofmutualrespectrev709.pdf.

Source: Adapted from Givan (2010).

- *Focus on the issues, not personalities and people.* Separate the issues at hand from the people involved in the negotiation. Too often, people become personally invested in a negotiation, become emotional, and make personal attacks. To focus on the issues, both parties must seek to understand how the other perceives the situation, avoid assigning blame, and employ active listening. Having a good relationship prior to the negotiation is one of the best ways to begin a negotiation.
- *Do not bargain over positions.* There is a big difference between positions and interests. **Positions** are the expressed desires or presented proposals of the parties involved, whereas **interests** are a party's real

Negotiating in the Press

Negotiating managed care contracts has become very difficult in the past decade. Rather than hammering out agreements privately, many healthcare organizations are taking their contract complaints to the public, where they paint their opponent as unreasonable and exert external pressure to gain power in the negotiation.

In Tennessee, Hospital Corporation of America (HCA) took part in a very public disagreement during its 2003 negotiations with BlueCross of Tennessee. HCA took out full-page newspaper ads that claimed BlueCross was not fair in offering only 5.9 percent rate increases even while raising its rates 15 percent in the past three years. BlueCross responded publicly that HCA's rates were already so high that if BlueCross awarded the requested rate increase, HCA's rates would be 20 percent higher than those of other hospitals and thus would significantly increase BlueCross's costs. One BlueCross executive was quoted as saying, "With hospitals across the state experiencing the same financial difficulties and challenges, we just can't understand why HCA's rates are so out of line." HCA responded with data that showed its revenue per patient was actually lower than at other hospitals.

Source: Adapted from Wheat (2003).

needs, desires, fears, and goals. Interests are, in effect, the underlying objectives that a given position should achieve. However, stated positions often do not reflect the real desires, so positions can clash with interests.

Begin negotiations by clarifying the interests of both parties; this allows the parties to work together to address the real problem and come up with solutions that are satisfactory to both. Conversely, starting negotiations with positions may result in greater resistance to alternatives. Seeking to align interests leads to win–win outcomes and prevents parties from moving to confrontation and conflict.

- *Establish ground rules for negotiating*. For any significant negotiation, the parties need to agree on the process, timing, participants, and conduct. Establishing a common framework facilitates successful negotiations and prevents parties from taking their grievances to the press (Jensen 2013), as demonstrated by the example provided in the box below.
- *Generate novel win–win solutions*. Separate the solution-generating stage from the evaluation stage. Agree that options will be explored first. This stage may be undertaken in a brainstorming session or through other means. After multiple options have been generated, evaluation of potential solutions should begin.
- *Use objective criteria*. If interests seem opposing, set objective criteria that can resolve differences. Establish parameters that are legitimate and practical, and search for scientific and professional standards that both parties can accept.
- *Understand the BATNA*. **BATNA** stands for "best alternative to a negotiated agreement." Each party should already have established its BATNA

and be ready to consider its next choice if the current negotiation failed. The more valuable the BATNA is to a party, the stronger the negotiating position the party holds. For example, if you are negotiating for a new job, how hard you push for a higher salary than the one offered depends on your BATNA. Without a clear idea of your BATNA, you negotiate blindly. Recognizing your negotiating power comes from understanding your BATNA. Furthermore, knowing your BATNA allows you to know when to walk away from the negotiation. You leave once your BATNA becomes better than the potential result of the negotiation (Osland et al. 2007).

Many people regard negotiations as stressful. Negotiation places people in a situation of mutual dependence, bereft of total control. People negotiate because they cannot mandate what they want and must come to an agreement with other parties. In addition, negotiating is unpredictable. It is difficult to know how others will react and what will be the result. This uncertainty brings a significant amount of stress. Other parties may be uncooperative and competitive. They may inject strong emotions into the process. Negotiating also is stressful because of the lack of feedback on the negotiator's performance. Even if you reach an agreement, knowing if it was the best result or if you damaged relationships may be difficult (Leary, Pillemer, and Wheeler 2013).

Stressed negotiators are less effective in reaching successful agreements than are negotiators who remain physiologically stable. Those who felt threatened and experienced more stress were found by one study to reach lower-quality deals (O'Connor, Arnold, and Maurizio 2010). A primary way to manage stress is to be prepared and become skillful in managing emotions. This skill can be achieved by reacting to needs and not to expressed emotions. People need to be emotionally prepared to negotiate, even if they expect no problems. Anxieties, hurt feelings, and resentments may be hidden, ready to burst forth. They should prepare for others' and their own emotions and deal with them productively (Leary, Pillemer, and Wheeler 2013).

At times, as shown in the box on page 310, parties will try to use emotions and stress to their advantage. If the hospital negotiators in this case had allowed the union representative's negative emotions to infect the bargaining session, the results could have been very undesirable.

Allowing negative emotions to dominate negotiations injects tension and distrust in the process, minimizing communication and options, and parties may even reject potential agreements even if they are better than their BATNA. On the other hand, encouraging positive emotions permits greater collaboration and cooperation, open communication, more options, and the potential for the best agreement, as long as it exceeds the BATNA (Fisher and Shapiro 2005).

Deceptive Emotions in Negotiating

A hospital's service workers' labor contract had expired, and the dreaded time arrived to open negotiations with the labor union. The union was known for its tough and often nasty tactics. Predictably, the union presented a demand for a high salary increase of 18 percent over two years, whereas the hospital proposed 7 percent over three years. The lead union negotiator became angry and accused the hospital of negotiating in bad faith. After the hospital team tried to postively engage him for about 15 minutes, he got up, hurled a curse word at them, and left the room. The other union negotiators remained in the room and almost immediately suggested reaching an agreement before the lead negotiator returned. The hospital team soon realized that the antics were mostly for show and an attempt to manipulate the negotiations. The hospital team proceeded by examining the real needs of both parties and ignored the inappropriate behavior of the union's lead negotiator.

Ultimately, successful negotiations should produce agreements that all parties feel good about over time. People need to perceive that the negotiated outcomes were fair and mutually beneficial. In addition, the parties involved in the negotiations should, at a minimum, depart with their personal relationships undamaged and, one hopes, improved. Following are some ways to ensure solidified relationships (Krivis 2006; O'Hara 2015; Thompson 2013):

- *Make small talk, and give people space to tell their stories*. New information can come to light, and people, if upset, should be able to vent. This space can also help with establishing rapport.
- *Be professional and, if needed, challenge people respectfully*. Use nonjudgmental terms such as "I think" or "it seems to me." Stress what the parties have in common, and use "we" much more often than "I" to constructively engage the other party. Avoid demeaning words that might trigger strong emotions, such as "you wouldn't understand," "you never," "calm down," "what's your problem," or "why don't you be reasonable?"
- *Approach the negotiation as a joint problem-solving effort*. Be creative in developing positive, innovative solutions.
- *Ask questions and listen*. Watch body language to better understand the emotions behind the words.
- *Be aware of cultural values and biases*. Your biases might cause you or the other party to view the situation as different from what it really is.

Chapter Summary

Conflict and negotiation are common occurrences for healthcare leaders. Appropriately managed, both can contribute to improved decision making and to meeting the organization's goals. However, poorly managed conflicts and negotiation can become destructive. Conflict begins when parties perceive

differences between or among themselves related to important resources, beliefs, values, and practices. Conflict can arise from many sources and can contribute positively or negatively to an organization's operations. Positive conflict can improve innovation, creativity, decision making, performance, communication, and group cohesion. Negative conflict can produce stress, burnout, dissatisfaction, damaged communication, distrust, poor job performance, resistance, and diminished loyalty and commitment.

Conflict in healthcare has also resulted in patient safety errors and poor morale. Although many healthcare professionals lack the basic skills to resolve conflict, conflict management is a critical function of healthcare managers.

Different types of work-related conflict include task conflict, which occurs regarding work details and goals; process conflict, regarding how to do a job; relationship conflict, regarding values, personality, political beliefs, and style; and nontask organizational conflict, regarding policies, benefits, culture, leadership, and power. Poorly managed, these conflicts can cause not only stress but also health problems for employees. Escalating conflicts can also create polarization, driving parties to take extreme positions.

Interpersonal conflict leads to employee stress and turnover. Potentially more than half of employee retention problems result from poorly handled conflict. This trend is also seen for top managers in healthcare, with more than one-quarter of chief nursing officers reporting they left their positions because of conflicts with their CEOs.

Good managers understand that a moderate level of conflict should be maintained in their organization. They recognize when and where positive conflict can be engendered. However, many managers avoid introducing conflict, as it may be an unpleasant experience.

The US culture promotes competition that frequently produces winners and losers. These zero-sum games occur when one party wins at the expense of the loser. Almost all sports contests engage in zero-sum games. Likewise, among professional groups in healthcare, competition can become a destructive cycle of conflict. When winning—or finishing ahead of all other competitors—becomes the primary goal, competition can be dysfunctional. However, competition can be positive if rules are clear and participants display good sportsmanship.

Conflict also exists at different levels. These include intrapersonal conflict, interpersonal conflict, intergroup conflict, and intragroup conflict. In these categories, conflict happens for many reasons, but it most frequently occurs as a result of poor communication and the inability to control one's emotions.

In healthcare, conflict results because of the structure of the work environment. Healthcare work settings involve much ambiguity, complexity, competition, obligatory cooperation, time pressures, and change. All of these factors contribute to conflict in an organization and require leaders to become

masters of conflict management. Conflict management can be facilitated by training, which many firms have instituted.

Conflict management refers to the process of negotiating differences, where negotiating means reaching agreements. Organizations that are proactive and resolve potential conflicts with successful negotiation produce better results than those that address conflict as it arises. Basic components to negotiation consist of focusing on issues, not personalities; bargaining about interests, not positions; establishing ground rules for negotiating; generating novel win–win solutions, using objective criteria; and understanding the BATNA, or the best alternative to a negotiated agreement.

Many people find negotiating stressful, as it places them in a situation of mutual dependence, is unpredictable, may involve strong emotions, and could end in difficult-to-understand results because of the common lack of feedback. However, highly stressed negotiators are less effective in reaching successful agreements; negotiators need to be prepared and become skillful in managing emotions. Allowing negative emotions in a negotiation can create tension and distrust and allow suboptimal choices to be made.

To create an environment that encourages successful negotiations and improved relationships, parties should consider making small talk, acting in a professional and respectful manner, looking at negotiation as a joint problem-solving effort, asking questions and listening, and being aware of potential cultural values and biases.

Overall, conflict and negotiations are daily events at most healthcare organizations. Those who master conflict management and negotiation bring a strong skill set to their work setting.

Chapter Questions

1. Why does conflict develop?
2. What can individuals and groups do to make conflict positive?
3. From your own experiences, identify examples of (a) task conflict, (b) process conflict, (c) relationship conflict, and (d) nontask organizational conflict.
4. How can healthcare professional differences increase the probability of negative conflict?
5. All leaders face conflict. What should you do to prepare yourself to improve your skills in managing conflict?
6. In negotiation, what is the difference between positions and interests?
7. What is a BATNA? State the BATNA you identified in a recent negotiation you have had.

Chapter Cases

Negotiating Medical Staff Privileges

Dr. Mell, the chief medical officer of a busy tertiary medical center, was having a good day. Well, he was until Dr. Daer, a leading cardiologist at the hospital, approached him in the doctors' lounge and insisted on speaking with him about an urgent quality problem. After retiring to Dr. Mell's office, Dr. Daer stated that a certain primary care physician (PCP) was, in his opinion, incompetent at reading EKGs (electrocardiograms). Dr. Daer claimed that this PCP's incorrect reading of EKGs led to the recent death of a patient.

Dr. Daer said that he and all of his partners were planning to propose that only cardiologists be credentialed to read EKGs or, as a concession, that all EKGs would be "over-read" or reread after a noncardiologist looked at them—and the hospital would pay for these over-readings. This was a matter of such importance, Dr. Daer stressed, that he and his partners were ready to present the proposal to the medical executive committee or even take it to the hospital's board of directors.

Dr. Mell, now having a bad day, thanked Dr. Daer for the information, asked him to hold off on presenting his proposal to the medical executive committee or the board, and promised to follow up on his concern and get back to him the next week.

Once alone, Dr. Mell called the chair of the hospital's quality improvement committee to see what quality issues had been reported from PCPs reading their own EKGs. The chair informed Dr. Mell that this issue had been an ongoing battle between the cardiologists and PCPs. Five years earlier, new credentialing criteria were established for all physicians seeking EKG reading privileges. However, the cardiologists were surprised to discover that many of the PCPs met the criteria, and the cardiologists responded by voicing their concerns. Overall, the quality improvement committee had not found evidence that warranted taking away this privilege from PCPs. However, because of the friction the conflict had caused, the chair told Dr. Mell, several PCPs started to refer their patients who needed a cardiologist to other groups that practiced at other hospitals.

Clearly, Dr. Mell had a serious problem to resolve. He thought about the situation and recognized that a distinction existed between the positions and the interests expressed. The positions—what people were demanding—were contrary. The cardiologists' position of reading all EKGs was incompatible with the PCPs' position of being allowed to read their own patients' EKGs. The interests of both parties—their goals—were

(continued)

(continued from previous page)

not incompatible, however. Both groups desired the continued long-term relationship among the medical staff and high-quality patient care.

To approach the issue effectively, Dr. Mell realized that he needed to involve key stakeholders: the hospital's executive administrative team, the medical staff president, and key cardiologists and PCPs. He made appointments to meet with all of them the following week.

Dr. Mell's challenge was to open lines of communication, reduce the ongoing conflict, and reach a win-win solution. For the negotiation, he had to determine how to align the seemingly contradictory interests of the two groups of medical staff to meet not only their needs but also the needs of the hospital overall, as well as maintain a high quality-of-care standard. To proceed, Dr. Mell established the following key guidelines:

- *Ensure that communication takes place.* Establish a way for real communication to begin between the two groups of physicians.
- *Build relationships.* Bring the groups together to establish trust and long-term connections.
- *Get people off their positions.* Explore the parties' interests or goals to move them away from their expressed positions.
- *Facilitate effective negotiation.* During meetings, ensure that professional language is used and appropriate engagement occurs. Keep the process moving, steer away from collisions and intimidation, and use the position of authority to ensure a safe environment.
- *Provide a reality check.* Make certain the physicians understand the possible negative outcomes if a successful negotiation does not take place.
- *Bring workable new ideas.* Come up with win-win ideas, but do not present them to both sides until the ideas are vetted by each side separately.
- *Consider an outside mediator.* If failure remains a possibility, consider bringing in an outside mediator.

Now he just needed to move ahead with this task.

Source: Adapted from Mellman and Dauer (2007).

Case Questions

1. What did Dr. Mell identify as the critical issues to be addressed?
2. What else might he do to facilitate the conflict resolution?

The CEO and the Physician

Methods Hospital enjoyed a near-monopoly position in its mid-sized, conservative, Midwest community of 350,000 people. Methods was a tax-exempt, 325-BED tertiary care hospital in the system that historically had been very successful. For the past 75 years, the hospital board prided itself in having a great relationship with its employees and medical staff. Every year for more than 25 years, an annual holiday party was held that almost everyone attended. However, two years ago, in the midst of reimbursement reductions, the hospital hired a new CEO—Jillian—who instituted many changes, one of which was to cancel the holiday party.

Almost concurrently, two large physician groups began talking about the need to be entrepreneurial and to create profitable healthcare services to maintain their income. One group was the largest local orthopedic practice in the system, generating 15 percent of Methods's revenues and 25 percent of its profits. The orthopedists engaged an architect and showed other physicians their drawings of an imaging and surgical center to elicit interest. One set of drawings was left on a table in the hospital's doctors' lounge and was subsequently seen by a hospital employee, who showed it to Jillian.

The other group consisted of the hospital-based emergency department (ED) physicians and pathologists, who began planning a series of walk-in clinics and blood-drawing stations in conjunction with a local pharmacy chain. These plans had been rumored for the past year, but recently a member of the board of trustees commented to Jillian that he had heard from a local pharmacy owner that the pharmacy was getting close to signing a contract with the physicians.

Jillian inherited other problems when she became CEO—one of which was a serious disagreement with the community over reproductive rights. The hospital had quietly allowed contraception services, sterilizations, and selective abortions to be performed at its location for the past 30 years. However, a change in population demographics and politics created a battle over the provision of these services. Although the majority of the community and employees supported the hospital's stance on offering reproductive procedures, an increasingly vocal minority had been trying to make the hospital eliminate them.

Jillian was progressive. When she became CEO, she publicly announced her support for continuing to offer reproductive services in that market, and she verbally sparred with the more conservative orthopedists in general medical staff meetings about the issue, damaging her relationship with them. After the last encounter, one of the orthopedists—the oldest and most eccentric of the group—wrote a letter to the

(continued)

(continued from previous page)

system's board of trustees, demanding that it fire Jillian and threatening to personally lead a protest outside Methods clinics to get rid of this "abortion activist" if the board did not acquiesce. Later, two other orthopedists stopped Jillian in the hallway and assured her that, although they held different personal opinions regarding reproductive rights, they supported her as CEO for all the other good decisions she had made.

Now, the hospital-based ED physicians and pathologists had contracted with the hospital for more than 15 years. When she became CEO two years earlier, one of Jillian's first actions was to renegotiate the existing contracts, which she felt provided much higher compensation to the ED clinicians and pathologists than either should reasonably expect. Both sets of negotiations were tense and did not result in new agreements. In light of the failed negotiations with the pathologists, Jillian drew up a tentative contract with an outside pathology group, which she shared with the current group. Regarding the ED physicians, she invited two national ED physician companies to visit and offer proposals. These actions induced the existing groups to agree to new contracts that effectively lowered their overall earnings by about 20 percent. As might be expected, neither physician group was happy. A few members of both groups remained cordial with her, but most of the physicians avoided even speaking with her.

With rumors now surfacing that both the orthopedists and the ED physicians and pathologists were close to executing contracts to proceed with their new ventures, Jillian felt she had about two weeks to devise a strategy to avert their actions. She believed it critical to intervene, as the plans by both groups to compete with Methods could halve the hospital's bottom line. She assessed her options: (1) Threaten to punish the groups by bringing in other orthopedic groups and placing the hospital-based contracts up for bid when they expired in eight months, (2) ignore their actions and beef up marketing to counter the impact on the hospital's revenue, (3) threaten to joint venture with other physicians to build another surgical center, or (4) joint venture with the two current groups.

Case Questions

1. What conflict management techniques could Jillian have tried earlier?
2. What process might you use to increase the probability of a successful negotiation?
3. What mistakes might Jillian have made?
4. Which option would you take, and why?

Chapter Activities

1. Take the quiz from Nursing Times (2011) titled "What's Your Negotiation Style?" at www.nursingtimes.net/quiz-yourself-whats-your-negotiation-style/5032100.fullarticle. Write an outline of your style and the strengths and weaknesses of the style.
2. Play the "Two Dollar Game" at http://ocw.mit.edu/courses/sloan-school-of-management/15-667-negotiation-and-conflict-management-spring-2001/lecture-notes/about_game.pdf (Rowe 2001). This game illustrates negotiation and conflict management.

N

19

ORGANIZATIONAL DESIGN

Learning Objectives

After studying this chapter, readers should be able to

- compare the meaning and use of chains of command in organizations;
- differentiate between organizational structure and organizational design;
- apply principles of organizational design to improve work settings;
- comprehend the concepts of division of labor and chain of command;
- discuss the differences between organic organization and mechanistic organization;
- relate how integration and differentiation function in organizations;
- distinguish among types of organizational structures, including functional, multidivisional, and matrix;
- summarize the problems transfer pricing can create; and
- illustrate the different healthcare organizational structures that may address future demands, including horizontal and network structures.

Key Terms

- Accountable care organizations
- Chain of command
- Corporation
- Division of labor
- Functional organizations
- Horizontal structures
- Matrix organizations
- Mechanistic organizations
- Multidivisional organizations
- Network structures
- Organic organizations
- Organizational design
- Organizational structure
- Span of control
- Transfer pricing

o organizational structure is optimal or inherently superior to another. The best organizational structure is one that is crafted to support the organizational context and mission. How the reporting relationships

are designed and function should depend on "the particular task and mission at hand" (Wolff 1999).

Healthcare companies are organized in many different ways, the structuring of which involves choices of services, relationships, locations, and ownership types. For example (Carroll and Rudolph 2006, i4),

> [a] hospital . . . may be public or private, be part of a larger healthcare system, include an emergency department, build research capacity, affiliate with a medical school, do its own billing or outsource to a contractor, or make various other strategic choices. Interdependent groups that must work together effectively and share resources efficiently must be linked and aligned by hierarchy, task forces, information systems, meetings, incentive systems, socialization practices, leadership vision, training, and so forth.

Corporations

Large businesses most often have corporate structures. A **corporation** is a legal structure that allows a group of people to act as a single entity and provides limited liability to its owners (Investopedia 2015). Corporations can own and sell property, engage in business, and sue and be sued. The owners of the corporation are liable only to the extent of their investment in the corporation. As healthcare organizations have increased in size, many have adopted the corporate structure.

Healthcare corporations in the United States have become extremely important to the economy. In fact, 10 of the largest 50 for-profit companies are healthcare corporations. The largest, CVS Health, had almost $140 billion in revenues in 2014 and operates about 7,700 retail pharmacies and 900 walk-in clinics (Lorenzetti 2015). In contrast, the largest US not-for-profit healthcare system is Ascension Health, which operates 131 hospitals and has 34,000 affiliated physicians and operating revenues of $17.1 billion (Greene 2014).

Corporations often comprise a very large conglomeration of different units, products, and services. As such, their organizations can be subdivided into three structural levels: the corporate level, the business unit level, and the functional unit level. As seen in exhibit 19.1, which distills CVS Health into a very simple structure, the corporate level involves the CEO and board, who decide what business the organization should be in (or should exit), how to raise and allocate financial capital, and how to direct and monitor the overall company. The business unit level involves the strategic business units (SBUs), which focus on the development, marketing, and provision of products or services. The functional unit level includes the functions that support the business unit and corporate levels. These may include human resources (HR), legal, financial, and other administrative services.

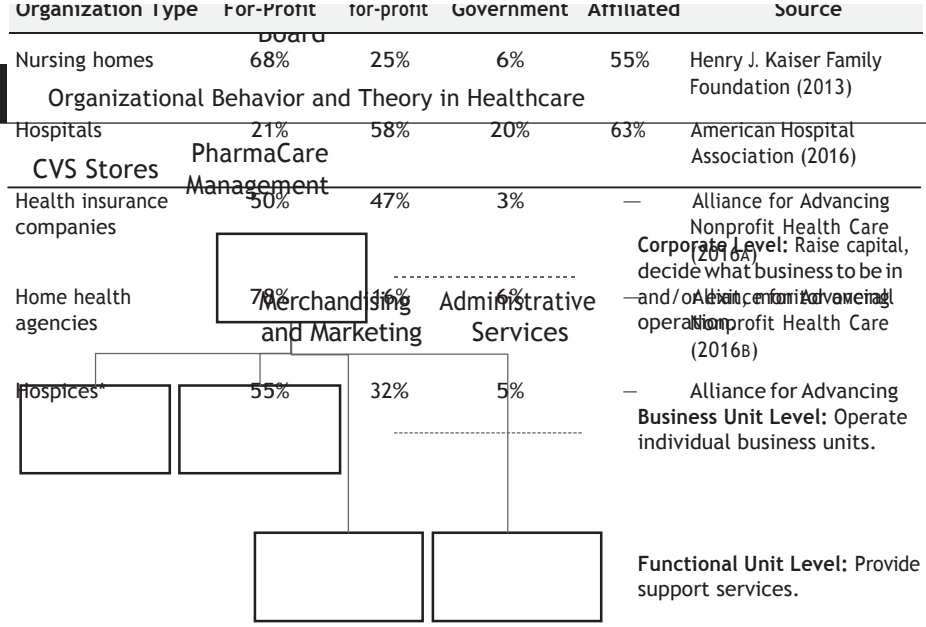


EXHIBIT 19.1 CVS's Three Levels of Organization

Organization Type	For-Profit	for-profit	Government	Affiliated	Source
Nursing homes	68%	25%	6%	55%	Henry J. Kaiser Family Foundation (2013)
Hospitals	21%	58%	20%	63%	American Hospital Association (2016)
Health insurance companies	50%	47%	3%	—	Alliance for Advancing Nonprofit Health Care (2016A)
Home health agencies	78%	16%	6%	—	Alliance for Advancing Nonprofit Health Care (2016B)
Hospices*	55%	32%	5%	—	Alliance for Advancing Nonprofit Health Care (2016C)

* 9% other.

Companies can be either for-profit or not-for-profit. For-profit organizations exist to provide goods and services to financially benefit their owners, and they pay taxes. Not-for-profit organizations are tax exempt and exist to provide some type of community benefit. Their "profits," or excess earnings, cannot be given or accrue to individuals. Healthcare professionals, such as doctors and dentists, often organize into professional corporations, which implies that the owner must have a license to practice (Mancino 2012).

Healthcare organizations may also be owned and operated by various parties, where ownership type varies by the industry segment. As can be seen in exhibit 19.2, with the exception of hospitals, the majority of healthcare organizations are for-profit entities. Home health agencies have the highest

EXHIBIT 19.2 Healthcare Organizations by Percentage of Ownership

percentage of for-profit businesses, at 78 percent, while only 21 percent of hospitals are for-profit.

Organizational Structure and Organizational Design

Organizations choose how to structure their reporting relationships in a number of different ways. **Organizational structure** describes the way a company arranges its tasks, work, and people to create a product or service and achieve its goals. An organization's structure depends on its culture, management preferences, company size, geographic dispersion, and array of products and services (Walston 2014). A similar term, **organizational design**, normally refers to the alignment of an organization's structure—including its roles and processes for formal reporting relationships—with its mission and goals. Organizational design includes deciding what the organization will make internally rather than buy from others, breaking jobs into optimal subtasks, designating roles, acquiring or developing technology, and instituting and enforcing policies toward achievement of its mission.

The role and scope of duties vary substantially from organization to organization. Small organizations, such as single-physician practices, may have all staff report to a single person—be it an office manager or the physician—and may give staff many overlapping and shared duties. As organizations grow and more employees are added, duties become more specialized and responsibilities divided.

Division of Labor

Prior to the Industrial Revolution, most businesses were small and run by craftsmen, who handled the full creation of a product. However, the Industrial Revolution introduced new technologies, which created factories that required more workers to run them efficiently. As more employees clustered in organizations, employers sought greater productivity by specialization through a division of labor. **Division of labor** is the segmentation of tasks and roles into smaller components that are performed by separate individuals or groups. A prime example is the assembly line, which segregates work into simple repetitive tasks to reduce unnecessary motion and labor. Workers become specialized and perform more limited duties.

An American who contributed greatly to the concept of division of labor and today's business structures was Frederick W. Taylor. He argued that the "principal object of management" was to maximize the economic benefits for the employer. To this end, he applied science to maximize employees' efficiency, using time-and-motion studies to reduce unnecessary movements, eliminate waste, and standardize processes and practices. Scientific management was one of the first theories to address management as a scientific problem. As a result, businesses sought to optimize their work by altering how their organizations were structured. For his work, Taylor became known as the father of scientific management (Kanigel 2005).

Healthcare heavily follows the principle of division of labor. For example, in a hospital operating room, the roles are clearly and narrowly defined. Surgeons, anesthesiologists, scrub and circulating nurses, and technicians work together to "produce" a successful operation. Each has specified roles. For example, scrub nurses and circulating nurses have distinct jobs. Scrub nurses, wearing sterile gowns and gloves, monitor and provide equipment to the surgeon, whereas circulating nurses, who are not "scrubbed in," perform duties such as retrieving supplies and assisting with documentation. Although assembly lines do not exist in the provision of healthcare, healthcare jobs are segmented. Each role generally requires different education and training, and most workers would have difficulty performing another's duties.

Division of labor has benefits. Specialization allows employees (providers, in healthcare) to gain expertise in their own narrow area. Training can be better coordinated, and professional standards can be established and maintained. However, coordination of patient care can become more difficult. Division of labor requires that a great deal be coordinated and that the product (in healthcare, often the patient) be "handed off" to other personnel. As the box below shows, however, care coordination often fails and no one seems to be in charge.

Some healthcare organizations use liaisons, case managers, task forces, and other personnel to seek coordination across specialized positions. Others have sought to "reengineer" the processes, duties, and relationships and collapse the many fragmented positions into fewer, less specialized jobs (Walston, Lazes, and Sullivan 2004).

Who Is in Charge of Healthcare?

During a seminar with a group of health care administrators, we asked the participants to diagram the cycle of service that ensues when a patient is wheeled off for, and eventually brought back from, a series of medical tests. After several minutes of discussion about the place of aides, nurses, doctors, and lab technicians in the cycle, the task was completed. As they sat admiring their handiwork, one of the administrators said aloud—as much to himself as to the group—"My goodness! No one is in charge." This insight proved to be a valuable one that we have since seen in other organizations. His explanation went like this: Our hospital is organized and managed by professional specialty—by functions like nursing, housekeeping, security, pharmacy, and so on. As a result, no single person or group is really accountable for the overall success and quality of the patient's experience. The aides are accountable for a part of the experience, the nurses for another, the lab technicians for another, and so on. There are a lot of people accountable for a part of the service cycle, but no one has personal accountability for an entire cycle of service.

Source: Reprinted from Albrecht and Zemke (2008, 38).

Span of Control

Another structural decision managers must make is how many individuals should report to a manager. This concept is known as **span of control**. The effective size of a span of control depends on a number of factors, including the skills and competencies of both the manager and subordinates, employee retention rates, and variability of the work.

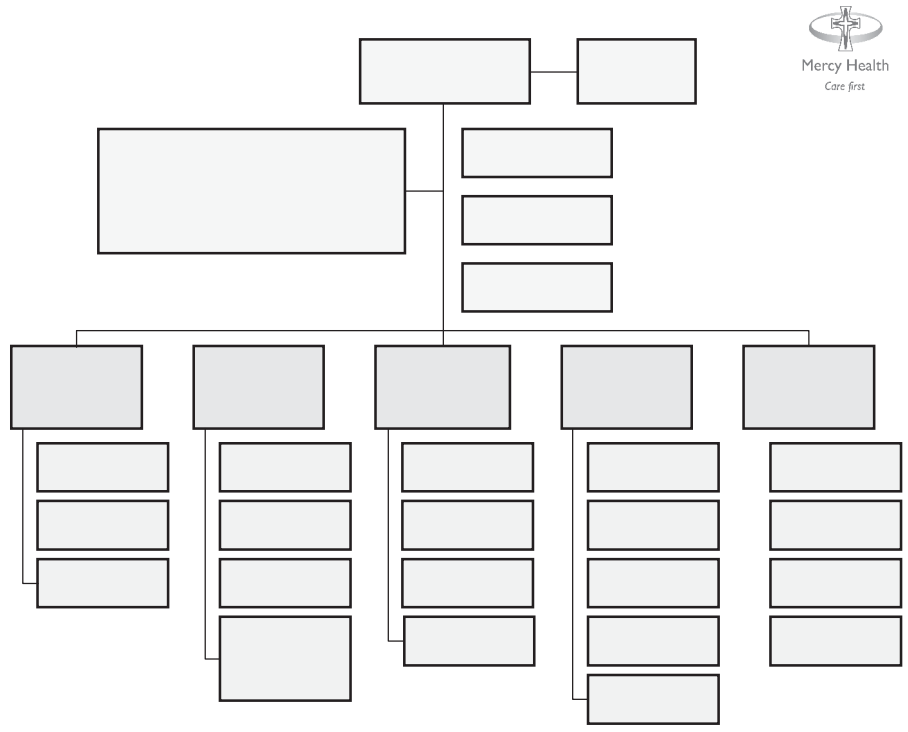
Chain of Command

A management concept that is complementary to span of control is **chain of command**. A chain of command forms the hierarchy—the formal reporting structure—and delineates the direction for formal company communication and decision making. In this way, employees know who is responsible for what decisions and to whom they report. All organizations have some form of a chain of command.

Traditionally, healthcare, as many industries, operated with a relatively small span of control and a clear chain of command in a very hierarchical organization. For example, exhibit 19.3 shows Mercy Health's organizational chart, which displays its span of control. Mercy Health employs more than 6,500 people and provides a wide variety of hospital and nonhospital care in Australia. As seen in the exhibit, all supervisors have a relatively small span of control, the group CEO has nine people reporting to him or her, and each area CEO or executive director has between three and five direct reports.

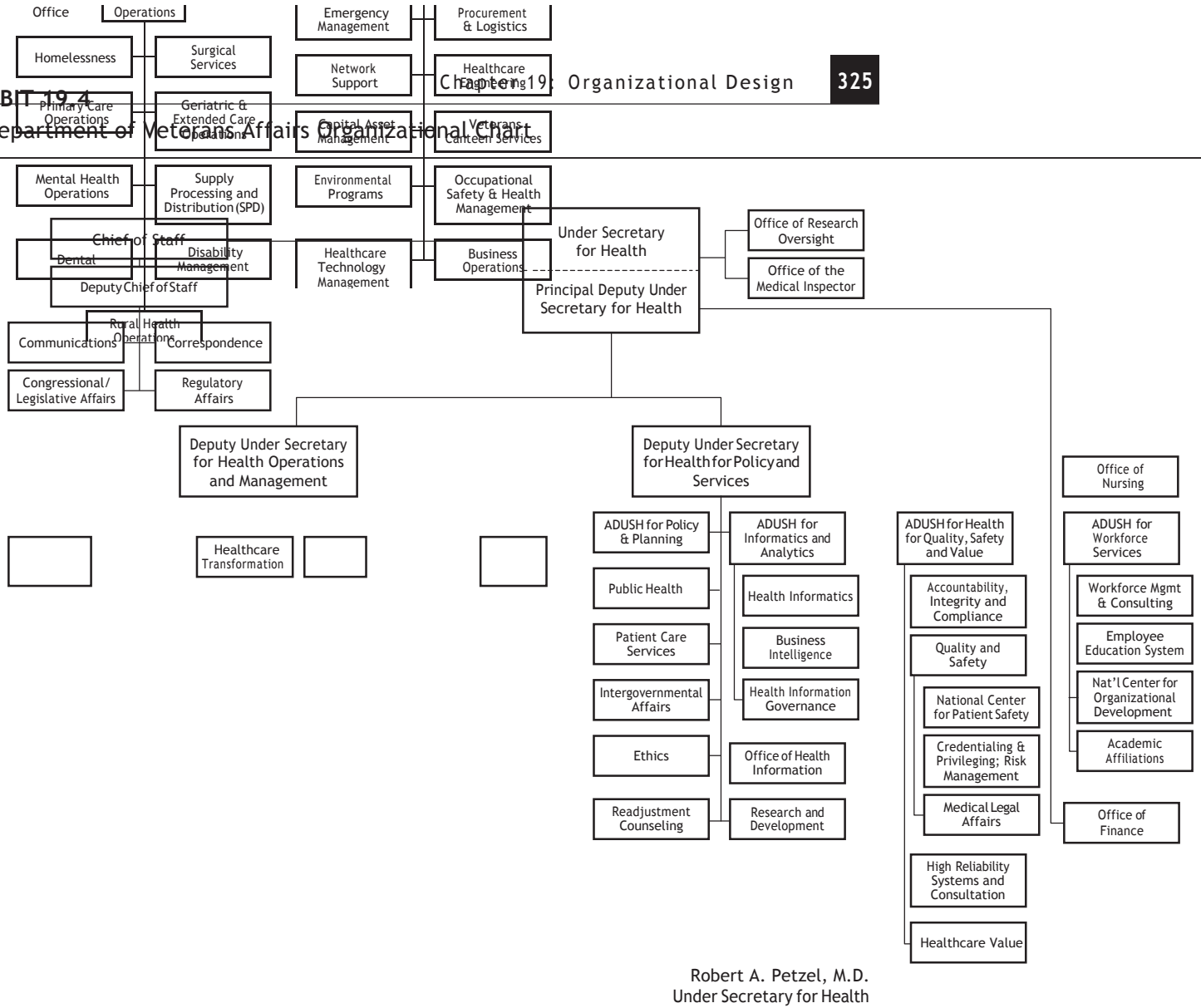
Contrast this chart to the US Department of Veterans Affairs (VA) organizational chart in exhibit 19.4. The VA has a much more hierarchical structure for its almost 300,000 employees and $50 billion budget.

EXHIBIT 19.3 Mercy Health Organizational Chart



Source: Reprinted from Mercy Health (2015).

EXHIBIT 19.4
US Department of Veterans Affairs Organizational Chart



Source: Reprinted from US Government Printing Office (2011).

Many organizations, however, within and outside healthcare, have attempted to expand their spans of control and delete layers of management. For example, I once worked for a large hospital company, HealthTrust Inc., that sought economies of scale by combining regions, thus forming a very flat, nonhierarchical structure with 21 hospital CEOs reporting to a regional vice president (see exhibit 19.5).

Flat organizations with larger spans should reduce costs by reducing the number of managers and increase the responsibility, autonomy, and authority of the remaining managers. Some firms—such as W.L. Gore, Value Corporation, and Basecamp (formerly 37Signals)—have had success in operating with flat, nonhierarchical structures. Effective, large spans of control empower employees and decentralize decision making. W.L. Gore has more than 10,000 employees and operates with only three hierarchical levels and many self-managing teams of 8 to 12 members. To this point, W.L. Gore's CEO stated (Kastelle 2013):

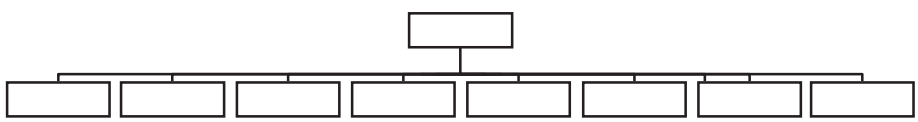
> It is far better to rely upon a broad base of individuals and leaders who share a common set of values and feel personal ownership for the overall success of the organization. These responsible and empowered individuals will serve as much better watchdogs than any single, dominant leaders or bureaucratic structure.

Traditionally, a span of control of no more than 7 or 8 employees was recommended. However, analysis of US business has found the average span of control to be 11 in service industries and 16 in healthcare organizations (Davison 2003).

Flat organizations are still relatively rare (Kastelle 2013). They present problems such as limited advancement potential, the formation of informal cliques, expressions of unprofessional attitudes, and limited workplace diversity that may occur because of the selection of personnel who "fit" the organizational culture (Finley 2014). Flattened structures may also have unintended consequences, such as increasing the centralization of decision making, diminishing the desired autonomy, and decreasing communication (Wulf 2012).

Flat structures have been found to be more appropriate when the environment is rapidly changing and requires constant innovation. Rapidly changing environments necessitate swift communication and flexibility. Some believe that healthcare organizations must move to flat structures with few administrative levels between patients and executives to achieve the quality

EXHIBIT 19.5
HealthTrust Inc. Regional Structure



improvements recommended by the Institute of Medicine's report *Crossing the Quality Chasm* (Cowen et al. 2008). However, flat organizations by themselves, as indicated earlier, do not guarantee an optimal structure; appropriate coordinative mechanisms, information technologies, and cultures need to be put in place.

Organic and Mechanistic Organizations

To properly function, flat organizations need the organic characteristics that Burns and Stalker (1961) attributed to **organic organizations**. As shown in exhibit 19.6, organic organizations are characterized by decentralized and participative decision making, loosely defined roles, and frequent adaptation that brings in new skills and modified roles. They are fluid and flexible, with employees performing a variety of tasks as dictated by circumstances. On the other hand, more traditional organizations are described as **mechanistic organizations**, with greater job specialization, narrow spans of control, and increased centralization of decision making.

EXHIBIT 19.6
Comparison of Organic and Mechanistic Organization Characteristics

Structure	Flat, less specialization	Hierarchical, specialized jobs
Communication	Lateral, diffused	Mostly vertical
Span of control	Wide	Narrow
Decision making	Decentralized	Centralized
Information flows	Diffused throughout	Concentrated at top, flows downward
Ideal environment	Uncertain, dynamic	Stable, unchanging
Levels of management	Relatively few	Many
Advantages	Free flow of information, feeling of teamwork, wider span of control, able to respond quicker to customer needs	Specialization, discipline, less supervision cost, quick decision making for company-wide issues, clear lines of responsibility
Disadvantages	High cost of coordination, complex decision making, high administrative cost, joint specialization, unpredictable work processes, difficult to control	Heavy manager workload, autocratic leadership, rigidity, greater formalization, communication problems

Integration and Differentiation

Many companies seem to be constantly reorganizing their structures, seeking the perfect organizational framework. However, no structure is perfect. The best an organization can hope to do is create an organization that responds to the needs of its external environment and reflects its culture. Companies periodically face tensions between the forces of integration (centralization) and differentiation (decentralization). As discussed decades ago by Lawrence and Lorsch (1967), companies often seek to gain synergies through centralization and direct control of organizational functions.

Centralizing functions and decision making allows managers to make quicker companywide decisions, establishes clear lines of authority, and provides greater standardization. Executives in centralized organizations often feel more in control because they are constantly making decisions, however trivial. On the other hand, decentralization permits lower-level decision making, which can allow quicker responses to customer needs. In decentralized organizations, executives serve more as coordinators and facilitators to decision making.

Structure Types

Although most organizations exhibit variations, they tend to fall under one of three fundamental types of organizational structure: functional, multidivisional, and matrix.

Functional Organizations

Functional organizations divide departments by common duties, tasks, services, or roles. Healthcare is often organized in a functional structure. Many hospitals extend the functional structure even into their C-suite, which may have a chief nursing officer, a chief financial officer, a chief information officer, a chief learning officer, and other executive officers who focus in specialized areas. Functional areas—such as marketing, accounting, business office, maintenance, food services, housekeeping, pharmacy, nursing, laboratory, radiology, and emergency services—are often broken into their own units. Mercy Health, charted in exhibit 19.3, is an example of a functional organization. As can be seen, it is segmented into units for hospitals, palliative care, mental health, finance, procurement, information systems, and so on.

The main advantage of a functional structure is the value that comes with specialization by concentrating similar activities, which develops greater knowledge and skills for specialized personnel and thus higher quality and efficiency. For example, physicians specialize and are grouped into medical departments to concentrate on a smaller skill set and provide higher quality of care. Specialization allows the physician (and other providers) to complete many

more procedures in their specialty, the repetition of which their professional organizations have deemed necessary to maintain competency in that area. In this regard, the American College of Cardiology mandates that "physicians perform and/or interpret a minimum of 500 transthoracic echocardiograms annually" to maintain their skills (American Heart Association 2003). Only by concentrating the service by function (cardiology) can physicians specialize and attain the level of activity necessary to perform this number of procedures to maintain their skills.

A functional organization can also readily standardize processes and products, as specialized tasks are centralized in departments that have responsibility for companywide processes. In this manner, the processes for functions such as finance, marketing, manufacturing, and purchasing are centralized and standardized for their company.

The main disadvantage of a functional structure is the potential for poor communication and coordination among departments. Departments that operate in isolation from others can become siloed, and competition may even arise that can lead to inefficiencies, conflicting goals, and poor quality. To address the many points of interaction, companies must engage a facilitator or liaison, although this position increases coordination costs (Walston 2014).

The potential problems of a functional structure can be amplified in healthcare with its many professions and their own professional standards and guidelines. Adherence to these differing professional tenets can lead to misunderstandings and even competition among organizational members, as information might be withheld, or inefficiencies and conflict can result. In addition, the functional organization with its many units can delay the transfer of timely information and hinder decision making. Functional structures especially impede the horizontal flow of information and make coordination difficult (Luke, Walston, and Plummer 2004).

Authors such as Glickman and colleagues (2007, 344) have suggested that the functional structure in hospitals is an impediment to quality improvement, as

> it limits integration across functions and the ability to develop innovative, creative quality-improvement processes and solutions at the level of the service line. For example, most total quality management projects originate and are implemented at the level of hospital management teams through high-end administrative and support services. However, clinical care is administered at a service-line level by clinicians and teams of complementary health-care professionals (i.e. nurses, therapists, pharmacists, etc). The conflict between central control and local autonomy and accountability is a key issue to resolve for most organizations.

As functional companies expand across geographic regions and increase the number of products they make, their organizational complexity escalates

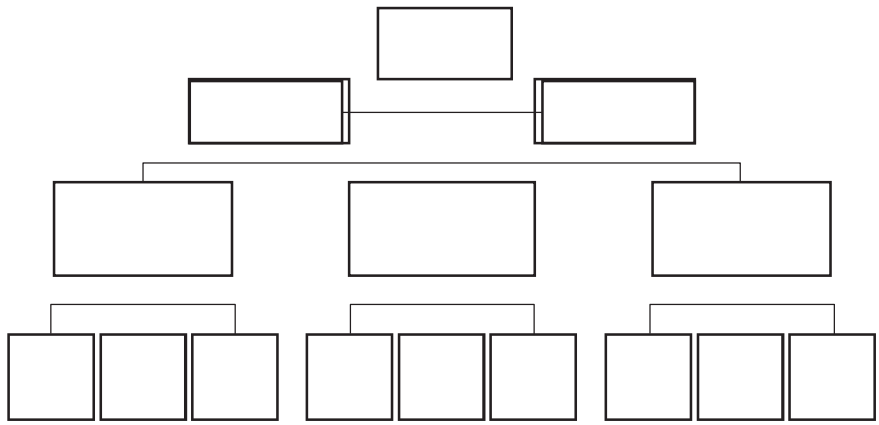
and the information needs and communication demands on managers intensify. At a certain point, executives feel overloaded and unable to address appropriately the heavy demands to coordinate such a large, functionally organized structure. It has long been suggested that information overload as a result of organizational growth moved many firms to abandon a functional structure and reorganize as a multidivisional company (Chandler 1962).

Multidivisional Organizations

Multidivisional companies are popular in business today, as more than 90 percent of large US corporations use this structure (Hills and Jones 2012). In **multidivisional organizations**, a parent company is divided into segments or divisions made up of separate businesses or profit centers so that day-to-day operations occur at a divisional level, allowing the units to act independently. As shown in exhibit 19.7, similar functions are placed in each business unit. For example, instead of having one centralized HR department, each division may have its own HR department.

Divisional leaders, under the parent company's direction, manage and organize their business units. They control and direct their day-to-day divisional resources and operations. Tasks performed in functional multidivisional organizations are duplicated and performed in each division. The greater autonomy encourages innovation and responsiveness to localized needs and frees corporate executives to focus on overall strategy, company direction, and overall divisional operations. Executives can use the similar statistics from their divisions to compare and evaluate performance across the company. This ability facilitates companywide understanding regarding the performance of divisional products and services and allows parent-company executives to make better decisions about allocation of money and resources to competing divisions.

EXHIBIT 19.7
Multidivisional Organization



One advantage of a multidivisional structure is the ability it affords the organization to better allocate financial capital. Some observers, including Williamson (1975, 148), have suggested that the parent company's improved ability to allocate resources is the primary advantage of the multidivisional organization:

> Investment proposals from the several divisions are solicited and evaluated by the general management. .... [T]his assignment of cash flows to high yield uses is the most fundamental attribute of the [multidivisional] enterprise.

Multidivisional structures are created not just to accommodate size but also to expand into dispersed geographic areas where the cultures, markets, customer preferences, politics, and regulations may vary significantly. These companies may establish a multidivisional structure that features international, country-specific, or geography-specific divisions. For example, Baxter—a very large healthcare supply company with 50,000 employees—divides its company into Asia/Pacific, Europe/Middle East/Africa, Latin America, and North America regions (Baxter 2016).

Organizations can also be divided by products and service lines if the products and services differ significantly from each other by customer and content. For instance, Johnson & Johnson has divisions of consumer healthcare, medical devices and diagnostics, and pharmaceuticals. Each division requires different skills and has distinct customers, competitors, and markets. The division leaders can more easily address their specific consumer needs and better develop strategies for their specific markets than leaders in a different type of structure might be able to.

Likewise, hospitals and health systems are organized as multidivisional structures around service lines, such as general surgery, cardiovascular, geriatrics, plastic surgery, and orthopedics. Creating divisions around service lines has become common and is seen to reduce costs and improve quality by reducing "unexpected variations in clinical processes and operations" (Cantlupe 2013). Using service lines permits healthcare organizations to create effective metrics, protocols, and care pathways to reduce costs and improve patients' experiences. In healthcare, this type of division leadership generally includes a physician–hospital partnership arrangement. The box on page 332 illustrates one method for partnering with physicians in a service line organization that has resulted in improved quality and lower costs.

The decentralization of functions to a multidivisional setting eliminates many in-division coordination problems but may introduce other company-wide coordination challenges. In-division coordination of functional activities (e.g., finance, HR, marketing, engineering, research and development) is facilitated because the activities are located together and controlled by divisional

Service Line Divisions at Ridgeview Medical Center

Ridgeview Medical Center, in Waconia, Minnesota, restructured in 2003 by organizing around service lines. Each of its eight service lines is managed by an administrative lead who partners with at least one physician. Representatives from each line serve on the medical staff executive committee. Unlike a formal co-management arrangement, Ridgeview's approach does not include a management fee nor performance bonuses. Instead, physicians who engage in service line work are paid an hourly stipend to compensate for time spent away from their practices.

Giving physicians a voice in service line management has made doctors, particularly those in independent practice, more willing to engage in quality and efficiency projects. For example, the three competing obstetric groups, two of which are independent, are working together to reduce inductions at fewer than 39 weeks' gestation. The service lines' focus on implementing evidence-based practices results in less variation in care, and that means improved processes for staff and consistency for patients and their families. Quality improvement translates not only to better care but also reduced readmission rates and lengths of stay.

Source: Reprinted from Aston (2015).

leaders. However, this structure divides and duplicates functions among divisions. Coordination and standardization by the parent company thus become difficult to accomplish. As a result, differing systems and duplicated efforts negatively affect costs and quality. The duplication, unless appropriately managed, may result in inefficiency, redundancy, and uneven quality.

Transfer pricing can also be a common problem in multidivisional organizations. Transfer pricing refers to the price set for goods and services that are transferred between divisions of the same company. Divisional units frequently sell services and products to other divisions in the same firm. Establishing a fair transfer price is difficult. As mentioned, one advantage of a multidivisional organization is the increased ability to hold divisions accountable for their performance, which can generate competition among divisions. However, when transference of goods and services occurs across divisions, contradictory incentives and unproductive competition may result. The division producing the good or service desires the highest transfer price, yet the receiving division desires the lowest. Transfer prices may be set at market prices, costs, or somewhere in between. Few companies ever fully eliminate this tension among divisions (Duhaime, Stimpert, and Chesley 2012).

Matrix Organizations

Matrix organizations involve multiple reporting relationships, generally to both a functional manager and a product or service line manager. They allow horizontal and vertical coordination to concurrently occur. As can be seen in exhibit 19.8, a matrix structure features two bosses. The departmental managers handle the traditional vertical relationships, and the project managers address horizontal relationships that cut across the functional departments. A matrix structure organizes workers into both functional and project or service

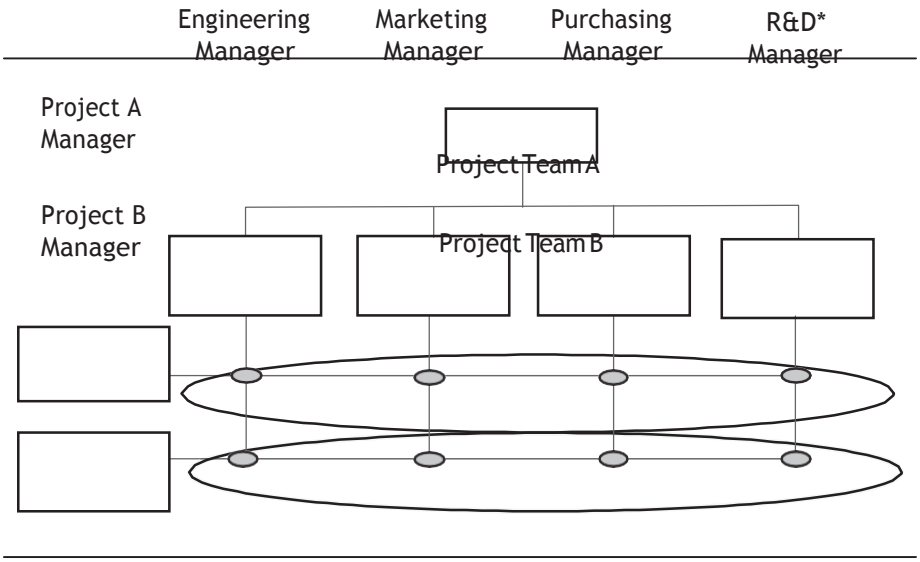


EXHIBIT 19.8
Matrix Structure

Source: Walston (2014).
*R&D = research and development.

line groups, such that employees are assigned to a project or service line team while continuing to work in their functional department. In this way, matrix organizations can incorporate the strengths of the functional and multidivisional structures and compensate for their weaknesses.

Most large organizations use some variant of matrix structures, and these structures are common in project-driven industries, such as construction, aerospace, and telecommunications. Prominent companies such as Boeing, Procter & Gamble, IBM, Nokia, Unilever, and Cisco often use matrix structures (Galbraith and Quelle 2009).

Many hospital clinical care areas also have adopted the matrix structure. Decades ago, about one-fourth of all large teaching hospitals in the United States reported using matrix structures "to promote the coordination and integration of functional department personnel" (Burns and Wholey 1993, 108). This arrangement superimposes a clinical manager on top of the functional structure such that, as mentioned earlier, employees report to both a unit manager and their functional supervisor. This structure builds in the necessity for interaction, lateral communication, and interchange between the clinical and support personnel, which is critical to improving coordination and breaking down silos. It allows a company to obtain the efficiencies from a functional structure while permitting a mechanism to coordinate programs and projects across the departments. Matrix structures in healthcare also provide managers the authority to oversee clusters of patients whose clinical management can then be tracked and treated across the care continuum (Persily 2013).

Matrix structures tend to work best in companies that develop innovative, project-based products. Divergent staff from various disciplines—who

normally would not work together—may form as a project team to develop a new drug, airplane, or automobile. Instead of being assigned a cross-departmental task that requires coordination and cooperation across an organizational boundary and then returning results to the department that assigned the task, staff in matrix organizations function as cross-departmental teams to jointly and collaboratively accomplish their work. Efforts are focused on completion of a project or product development, not on the specialized duties of functional units.

Many healthcare companies have adopted at least partial matrix structures because of the increasing market pressures and complexity of healthcare delivery. They believe that only through a matrix structure can they achieve the quality improvements needed in patient care. As such, they have used a matrix structure in organizing interprofessional teams, which brings together members of different departments to work on specific objectives. As healthcare moves into accountable care organizations, which require coordination of care rather than traditional treatment of illness, matrix arrangements may engender the needed cooperative behavior among providers and producers of healthcare (Persily 2013).

Matrix structures can create problems, however. Any time two people are jointly responsible for anything, cooperative behavior can quickly be tested, as when the two bosses have divergent goals. Power struggles can erupt and hinder performance. Employees may also be unclear about which of their bosses has responsibility for which decisions or duties. The two-boss challenge runs contrary to traditional command-and-control management and has been difficult for many organizations to adopt successfully. The matrix organization, although popular in the 1970s, was declared a fad by some management experts, who suggested that its complexity caused too much confusion and could actually become detrimental to innovation (Peters and Waterman 1982).

Of course, the success or failure of a matrix structure depends substantially on how it is implemented. A lack of precision in and attention to adopting matrix structures can result in ambiguity, conflict, and diminished performance (North and Coors 2010, 120):

> Poorly implemented matrix reporting relationships can misalign goals and mismatch authority and responsibility. Multiple reporting relationships can result in ambiguity and conflict for employees. In the end, dotted lines can simply become blurred lines, allowing performance to suffer.

The amount of authority given to a project or service line manager can significantly affect the success of using a matrix structure. At one extreme, the project manager may be given no budgetary control or authority over employees and serves as a liaison and team leader while the functional manager has authority and responsibility for the performance, costs, and evaluation of

employees. Under this approach, the project manager's primary responsibilities are documenting milestones and communicating the project's progress to functional managers. Without authority, the project manager becomes essentially a cheerleader, whose lack of authority can substantially delay projects and key decisions.

A more moderate approach gives project managers budgetary control over the project and the authority to recruit resources from different functional units as the functional managers act in a supporting role but remain responsible for evaluating the performance of their employees who are assigned to projects. This option provides greater authority to project managers, but employees remain tied to their departments, which is where their evaluations take place.

A third approach permits both project and functional managers to share financial responsibility. Shared responsibility accentuates the critical need for a good relationship between the two managers, as they must be able to collaborate, share decision making, and communicate well to make this option work. This is often the structure used, as previously mentioned, in large medical centers where administrators and clinicians share responsibility for a program or project. North and Coors (2010) suggested that, in healthcare, results created by shared-authority matrix structures function much better than those produced by the other two matrix structure approaches.

Advantages and Disadvantages of Different Structures

All organizational structures offer both advantages and disadvantages. No ideal organizational structure exists, but some work better in certain conditions. Exhibit 19.9 displays each structure and the environmental conditions for which it is best suited. For example, a functional structure may be ideal in stable markets for small firms that are centralized geographically and deliver a relatively small number of products and services.

As shown, use of a multidivisional structure may benefit large organizations positioned in geographically dispersed markets that hold distinctive consumer preferences. This structure also may be applicable for conglomerates that operate business units, which offer diverse products and services. On the other hand, matrix structures appear best suited for companies that seek to develop new products and services for changing markets.

In particular, matrix structures may be more successful for product- and project-oriented firms that exist in markets that are rapidly changing as a result of technological innovation. In addition, they are more effective than the other structures if their customers' tastes and preferences are also shifting.

However, few organizations use only one type of these structures; combinations and amalgams of the structures are most common. For instance, a functional structure might be used for support departments such as accounting

EXHIBIT 19.9 Advantages and Disadvantages of Functional, Multidivisional, and Matrix Structures

Functional	• Specialization and standardization across company	• Growth-induced information overload on top executives • Creation of silos and lack of communication among departments	• Small firms that are geographically centralized and produce a modest number of products and services • Stable markets
Multidivisional	• Adaptability to local conditions • Uniform monitoring and comparisons among divisions • Reduction of information overload on top executives • Focus on allocation of capital and overall strategies	• Duplication of functions • Inefficiency • Less standardization among units	• Large firms with divisions in geographically dispersed, distinct markets that may change independently
Matrix	• Collaboration and interaction among departments	• Two-boss challenge • Inefficiency • Difficult to manage	• Firms that are developing products and projects • Uncertain markets with changing technology and consumer tastes

Source: Walston (2014).

and finance to ensure consistent, standard oversight across the organization. Yet at the same organization, a multidivisional geographic structure might be employed for product sales to allow for customization as needed by customers in different markets. Healthcare corporations often exhibit such mixed structures, with functional support areas of information technology, patient accounts, purchasing, payroll, and credentialing services centralized, while patient care services are decentralized into multidivisional units.

Possible Future Structures in Healthcare

Current and future changes in the US healthcare system, including mandates of the Affordable Care Act (ACA), are altering the way healthcare will be provided, which may necessitate modifications to governance structures. In part, the ACA establishes **accountable care organizations** (ACOs), defined by the Centers for Medicare & Medicaid Services (2015) as "groups of doctors, hospitals, and other health care providers, who come together to give coordinated high quality care." In addition, most groups will be paid for

services by some type of adjusted capitation reimbursement. These changes will considerably alter the relationships among patients, providers, and payers.

Structures will need to change as well, as ACOs must be accountable for the quality, cost, and care of the defined ACO population; be affiliated with a legal structure that can receive and distribute bundled shared-savings payments; include primary care physicians; implement clinical and administrative management systems; and ensure coordination of care (Ronning 2010). This transition has been difficult for many healthcare organizations that have been organized in primarily functional structures that have generally operated independently.

Future organizational structures will have to be more inclusive and expand to allow local provider organizations to have the authority and ability to better manage care. Possible new structures include group practice arrangements, networks of individual practices, partnerships and joint ventures between providers, and other hybrid arrangements. Although hospitals are predicted to be at the forefront of ACO creation, many other providers and groups have an opportunity to form and design these organizations (Bennett 2012). Integration of the functional and matrix forms of governance will be critical to the success of ACOs.

Changing structures to meet the needs of ACOs is expected to be difficult. Many of an ACO's structural requirements appear to resemble the integrated delivery systems that were created, and mostly failed, in the 1990s. These structures needed to align physicians, other providers, and hospitals to properly coordinate patient care, which proved to be very challenging. Designing a structure that accomplishes such alignment will be critical to the success of ACOs (Burns and Pauly 2012).

Horizontal Structures

Significant imagination and innovation will be needed to design organizational structures that achieve alignment and coordination. Horizontal and network structures may provide some of the flexibility necessary for ACOs to function appropriately. **Horizontal structures**, also called process structures, have few layers of management and are composed of self-managing, multidisciplinary teams organized around core processes. These teams, which work autonomously or semi-autonomously, are trained to make decisions and provide self-direction to complete a "cycle" of care. The few managers become trainers and coaches, and the teams focus on patient satisfaction, all of which reduces the need for supervision. Large companies, such as General Electric and AT&T, have experienced success using horizontal structures (Ungson and Wong 2008).

Network Structures

Network structures, also called modular or virtual organizations, allow for flexibility and decentralization. In this structure, managers coordinate and

direct relationships both internal and external to their company. The company may partner with external firms for development, production, and sales. Nike is a good example of this type of structure; it acts like a virtual organization through the companies with which it contracts to produce most of its almost 100 million shoes annually. Nike owns no manufacturing facilities and links networks through technology. Internal functions focus on marketing and design, with most other functions outsourced (Pal 2008; Wokuch 2001). Network organizations require network partners to establish trusting relationships so that the network companies can concentrate on what they do well and subcontract tasks outside their competencies to others. Such relationships minimize the need for administrative overhead and function well in uncertain and changing markets.

Organizational Structure and the Environment

Although an optimal structure will never exist, the choice of organizational structure should relate to the internal and external environments of a company. Each structure has pluses and minuses, but the degree of complexity and uncertainty in and surrounding a firm suggests which structure may be best for the organization to use. Complexity increases as a firm grows in size and spreads geographically. Likewise, increased market competition creates a more complex environment. Uncertainty can arise from technological advances, legislation and policy changes, and other factors.

Low levels of complexity and uncertainty diminish the need for organizational flexibility and allow centralization. As shown in exhibit 19.10, functional organizations may be preferred for low-complexity and low-uncertainty situations. As complexity and uncertainty increase, the other structures should be considered, with the horizontal and network structures being ideal in environments with high complexity and uncertainty.

Governing Boards

Most businesses are overseen by a governing board—a board of directors in for-profit organizations or board of trustees in not-for-profit settings. The same is true in the healthcare industry. A properly functioning board is critical for a successful organization. Simply stated, a board's primary responsibilities are to provide overall policy direction and oversight and to select the organization's CEO, who generally reports to the board.

Governing boards widely vary in their composition, structure, and operation (Kovner and Knickman 2011). Individual hospital boards in the United States seat an average of 13 members, with healthcare system boards

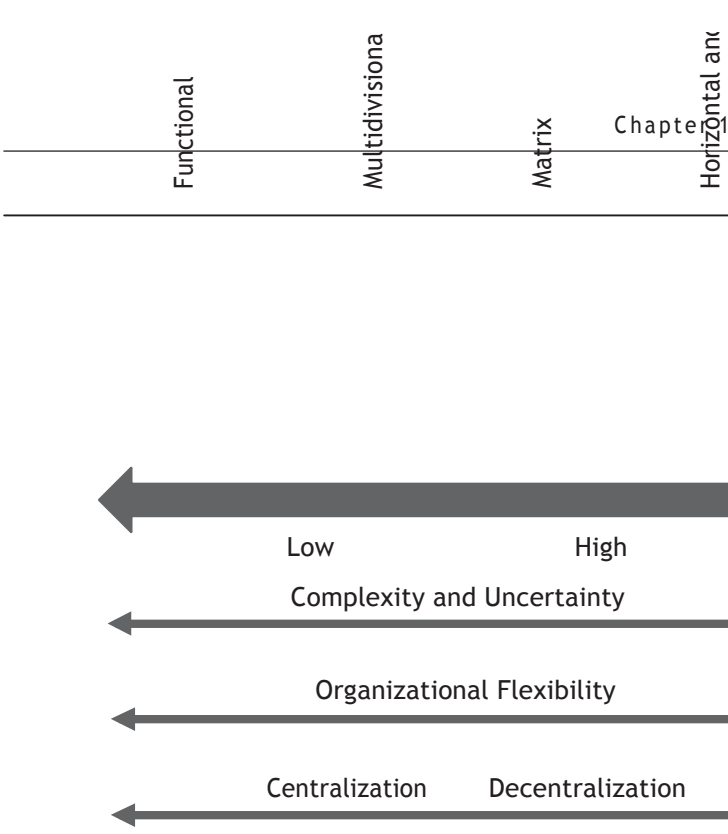


EXHIBIT 19.10
Organizational Structures and Environment

averaging 16 members. In the recent past, healthcare system boards have become more important by exercising greater fiscal and strategic responsibilities than has traditionally been in their scope (Center for Healthcare Governance 2014). As local authority and governance increase in importance, the role and proper functioning of governing boards will likewise become more important. Governing boards will need to include members with the necessary skills and competencies in an array of areas to appropriately plan, evaluate, and execute. The increasing complexity of healthcare systems will require greater selection, training, and participation of board members.

Chapter Summary

The manner in which organizations are structured varies widely. No one structure stands out as always better than others; instead, an organization's structure should be crafted to fit its environment and assist in meeting its mission and goals. All organizations have some form of a chain of command, which is the official channel for reporting and formal communication. Large businesses most often use a corporate structure, which allows a group of people to act as a single entity and limits their liability. Healthcare corporations are among the biggest firms in the United States. Corporations can be segmented into three structural levels: corporate, business unit, and functional unit. Each has different roles, with the corporate role deciding the overall business portfolio; the business unit level directing the development, marketing, and provision

of products and services; and the functional unit level supporting the other two levels.

Companies can be either for-profit or not-for-profit. For-profit organizations pay taxes and exist to make profits for their owners. Not-for-profits are tax exempt and provide some type of community benefit. Healthcare organizations may be either for-profit or not-for-profit; the percentage of each type varies according to the industry segment.

Organizational structure involves how a company arranges its tasks, work, and people, while organizational design refers to the alignment of an organization's structure. The role and scope of employees' duties vary widely, depending on the size of the organization and many other factors. Prior to the Industrial Revolution, most businesses were small and craftsmen handled all aspects of product creation. As companies grew with the introduction of new technologies, greater specialization and a division of labor occurred. Scientific management, promoted by Frederick W. Taylor, fostered specialization and time-and-motion efficiencies.

Healthcare workers are highly specialized. Specialization permits enhanced expertise, training, and professionalization. However, coordination often becomes problematic. The lack of coordination remains a problem in healthcare. Healthcare organizations use liaison positions and committees to coordinate across specialized departments.

Another structural concept is span of control, which refers to the number of subordinates who report to a manager. The effective size of a span of control depends on the abilities of the manager and subordinates, retention rates, and variability of work. Complementary to this is the concept of chain of command, which is the formal reporting structure of a company. Traditionally, healthcare has had a relatively small span of control and clear chain of command. However, in the past few decades, more organizations have experimented with flat structures with larger spans of control. Flat structures are effective in rapidly changing environments that require consistent innovation if appropriate coordinative mechanisms are in place to ensure seamless functioning.

Flat organizations can be considered organic organizations, with decentralized decision making, loosely defined roles, and fluid and flexible employees. Traditional organizations are often described as mechanistic organizations.

Organizations constantly struggle with tensions between centralization and decentralization. Centralizing operations allows relatively quick company-wide decisions, clear lines of authority, and standardization. However, decentralization permits lower-level decision making, aiding in responsiveness to customers' needs.

Three fundamental organizational structures exist: functional, multidivisional, and matrix. Functional organizations divide their structures by

function, such as marketing, accounting, and housekeeping. Their advantages include specialization, by concentrating similar activities, and standardization of processes and products. However, poor communication and coordination may arise as functions are separated, which often occurs in healthcare.

As companies grow bigger and more complex, most move to a multidivisional organization that divides the company into segments or divisions encompassing separate businesses or profit centers. This type of organization allows increased flexibility and independence for day-to-day operations at a divisional level and frees corporate managers to focus on strategic decisions. However, it also duplicates functions across the organization. Divisions can be based on geography (e.g., international versus domestic) or on product or service lines. In healthcare, many organizations are structuring around service lines such as cardiovascular, geriatrics, and orthopedics.

Although multidivisional structures help with coordination among functions, they do divide and duplicate functions across the parent company. Coordination and standardization across the full company can become difficult and result in inefficiencies, redundancies, and uneven quality. In addition, transfer pricing—the price set for goods and services transferred between divisions—can create competition and tension among divisions.

Matrix organizations involve multiple reporting relationships to both functional and product or service line managers, which allows horizontal and vertical coordination. Most large companies and many hospital clinical areas use some type of matrix structure. This structure builds in the need for lateral communication and interchange between both clinical and support personnel to improve tracking and treatment of patients.

Matrix structures can cause difficulties. The two-boss challenge can create tension and power struggles. Its success or failure can be attributed to the amount of authority the project or service line manager is given.

Advantages and disadvantages exist for all organizational structures. However, functional structures may work well in stable markets for smaller firms that deliver a small number of products and services. Likewise, multidivisional structures may benefit larger organizations dispersed geographically. Matrix structures may be best for product- and project-oriented firms whose markets are rapidly changing, along with their customers' tastes and preferences.

A result of ongoing changes in the US healthcare system may be the establishment of the accountable care organization as the primary means to provide care, for which innovative healthcare structures may be required. New frameworks may include networks, partnerships, joint ventures, and integrated forms of functional and matrix structures. Any or all of these may rely on aspects of horizontal and network structures.

Organizational structures should adapt to the level of companies' complexity and uncertainty. Low-complexity and low-uncertainty environments

call for functional structures, more rigidity, and centralization. High levels of these factors set the stage for greater flexibility and decentralization.

As stated, no optimal structure exists. The choice and success/failure of any structure depend on numerous factors, both internal and external to the organization. Understanding those influences and the needs of the alternative structures can greatly assist and benefit a healthcare manager.

Governing boards are in place in most public and private healthcare organizations. They have responsibility for overall company policies, oversight, and selection and evaluation of the organization's CEO. Properly functioning governing boards are essential to the success of healthcare organizations.

Chapter Cases

The Fragmented University Healthcare Venture

One university had a great opportunity to establish an international healthcare campus in Asia. The host government had invited selected universities from around the world to create a global healthcare campus and would provide subsidies and loans for five years, which should be sufficient to attract an adequate number of students to become self-supporting. The satellite campus was to be both a training and a clinical site.

Who would be in charge of the satellite campus was a bit muddled.

A few years earlier, the university had established an office of global engagement to increase the school's international presence. The VP of global affairs

Chapter Questions

1. How do chains of command exist in every organization?
2. What does it mean to be a for-profit healthcare organization?
3. What are the advantages and disadvantages of division of labor?
4. What factors influence the optimal size of a span of control?
5. Although flat organizational structures reduce layers to improve communication, what are some of the problems they can create?
6. What are the primary differences between an organic organization and a mechanistic organization?
7. What is the advantage to healthcare organizations for using functional structures?
8. How does transfer pricing affect multidivisional organizations?
9. In what situation might it be best to use a matrix structure?
10. What types of structures may be needed to confront the challenges of a changing healthcare market?

was a former dean and reported directly to the university president. At the same time, the vice president of the university's health system was technically in charge of all healthcare provision. Both the global VP and the health system VP seemed to have responsibility for establishing this venture.

It seemed that the decision to proceed with the venture was much easier to achieve than organizing it. In addition to the global VP and health system VP, the VP of student affairs and the provost for academic affairs on the main campus demanded a presence and commensurate authority. Policies and procedures on the satellite campus, including admission criteria, were to be the same as on the main campus, with little input from those working at the satellite campus. However, the individual who had been hired as satellite campus president wanted full authority to run the remote operation and wished to report directly to the main university president, because he almost immediately clashed with the global VP, to whom he was scheduled to report. As a result of the poor relationship, the satellite campus president was given responsibility for only a portion of the satellite campus functions, and a satellite campus provost for academic affairs was hired, as a peer of the satellite campus president, who was to report to the global VP. Neither the global VP nor the health system VP had a direct relationship with the university provost or the VP of student affairs. All reported directly to the president of the university, who had made the decision to establish the satellite campus but would not be involved in developing operational processes and strategies.

The chain of command for this structure was complicated, with individuals reporting to multiple bosses. For example, the satellite campus provost, although technically a direct report of the university provost, also reported to the global VP, the health system VP, and the head of his faculty department. Most of his reporting and coordination took place through the global VP, but his evaluation was conducted by his department head. Plus, the major areas at the satellite campus reported to different supervisors on the main campus, so ultimately the university president was the only person to have everyone report to him. Therefore, when disagreements arose that could not be settled among peers, the only person in the university who could resolve them was the university president who rarely took the time to do it. As a result, most areas of disagreement were not addressed at all.

Standing committees were established to govern the satellite campus. These included three at a general level and three at a campus level. The general committees were Leadership, Academic Affairs, and Student Affairs, and the campus committees were Recruitment, Clinical Affairs,

(continued)

(continued from previous page)

and Operations. The composition and responsibilities of each committee were as follows:

Leadership Committee

Role: Coordinate activities of the satellite campus, and resolve problems and formulate policy

Composition: Health system VP, global VP, assistant VP student affairs, campus president, campus provost, assistant global VP for finance, six department heads

Chair: Assistant global VP for finance

Academic Affairs Committee

Role: Discuss and recommend academic policies for the satellite campus

Composition: Campus provost, recruitment personnel, registrar office personnel, six department heads

Chair: Jointly chaired by the campus provost and a department chair

Student Affairs Committee

Role: Discuss and recommend student affairs policies for the satellite campus

Composition: Campus provost, assistant VP student affairs, satellite campus and main campus recruiting personnel

Chair: Assistant VP student affairs

Campus Operations Committee

Role: Oversee the physical and operational decisions at the satellite campus

Composition: Campus president, campus provost, campus finance officer, campus operations manager

Chair: Campus president

Campus Clinical Affairs Committee

Role: Ensure clinical quality and safety

Composition: Clinic manager, campus provost, campus finance officer, operations manager, three healthcare staff

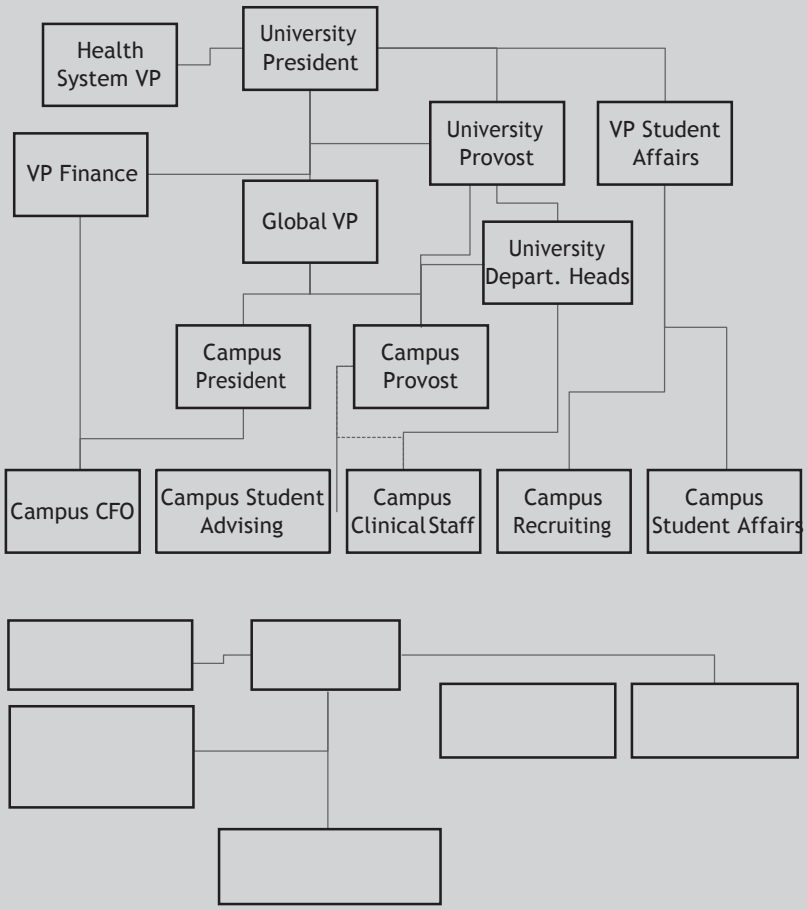
Chair: Clinical manager

Campus Recruitment Committee

Role and Duties: To conduct student recruitment activities

Composition: Campus recruitment personnel, campus president, campus provost, three campus faculty

Chair: Campus recruitment director



The committees were to meet monthly to conduct business. However, because of the 14-HOUR time difference between the main campus and the satellite campus, scheduling and holding the meetings consistently were difficult. The Student Affairs Committee and the Campus Recruitment Committee each met once, were not sure what they were to accomplish, and never met again. The Campus Operations Committee met

(continued)

(continued from previous page)

only sporadically. The Academic Affairs, Clinical Affairs, and Leadership committees did meet monthly, but reports seemed hurriedly prepared and abbreviated for the Leadership Committee because the agenda was always long and key people frequently did not attend.

Many, including the VP of global affairs, felt it essential that the committees meet monthly as previously planned. The issue was raised a number of times in the Leadership Committee, where those involved tacitly agreed but always found excuses not to hold the committee meetings. The VP of global affairs did not want to raise the issue to the university president, so the meetings were not held.

Likewise, making decisions and creating policies became a big challenge. Campus administrators frequently had difficulty deciding to whom or to what group decisions needed to go. To be certain all bases were covered, the issues were often taken to multiple parties, resulting in multiple, contrary decisions. For example, the campus administrators convinced the VP of global affairs that a major change in the admission criteria was necessary. However, the health system VP and the VP for student affairs, who were responsible for recruitment on the main campus, refused to consider any change. The proposal was ultimately referred to and died in a main campus committee. As a result, campus administrators failed to bring up many issues that needed to be addressed, and those that were brought forth often languished for months before being decided on. Campus administrators continued to act but were regularly frustrated.

Case Questions

1. Why are committee structures often superimposed over organizational structures?
2. Why did the committee structure fail to fully function? What could be done to make it work?
3. What structural changes would you recommend? Why?

The Case of a Flat Structure but Centralized Control

Although a flat structure has been promoted as a means to decentralize decision making, decentralization does not necessarily occur. The style of decision making and the way information flows through an organization can be distinct from the type of structure used. Conversely, tall, hierarchical organizations can decide to decentralize decision making without altering their structure.

HealthBest Inc. decided to eliminate two regions and one layer of management, predicting that these changes would reduce costs and speed decision making. The Western Region was created, with 21 hospital CEOs reporting directly to the regional VP. All CEOs met with key regional and corporate managers shortly before the structural changes were to be announced. The corporate chief operating officer (COO), Hud, explained the rationale, stressing the need for quicker decisions as the company faced more aggressive competition. He showed a slide that stated, "A flatter structure for a more competitive environment." All of the CEOs seemed to be positive about the changes.

At the end of the meeting, a question-and-answer session was held. One CEO asked which decisions the CEOs were going to be able to make now that they could not before and wondered if they would change the six-month budget preparation process or alter their signatory authority. Currently, each CEO could approve costs of up to $25,000, and the regional VPs up to $100,000. Hud appeared embarrassed and finally replied that the regional VP would clearly decentralize the decision making, but no changes in the budget process or signatory authority were contemplated. He explained that the decentralization would occur as the regional VP saw fit, but that this would be a very challenging year for the company and everyone was going to have to perform at a much higher level.

Hud then went on to discuss the new incentive structure, which allowed CEOs and regional VPs to earn a bonus of up to 80 percent of their base salary if they achieved certain—mostly financial—objectives. Hud felt certain that these could be achieved with the new, flat structure.

Upon returning to their hospitals, the CEOs didn't see many differences in their relationship with their regional VP, except that more data were required weekly. Reports on man-hours, patient satisfaction, quality indicators, and projected monthly financial data were added to the CEOs' duties. In addition, the regional VP could be expected to call at any time—sometimes several times a week—to ask questions about the submitted data. On the other hand, if the CEOs needed an approval or had a situation that required the regional VP's input to resolve, it could take days to reach her.

Case Questions

1. What was the relationship between a flat structure and the decision-making process for the region?
2. What would need to occur to change the decision-making process? Did the overall structure need to become flat for this change to take place?
3. What else should the region do to become more efficient?

Chapter Activities

1. Read the article from Greatboard.org titled "Best Governance Practices: Not Just for Goliaths" at www.greatboards.org/newsletter/2015/greatboards-newsletter-summer-2015.pdf (Totten 2015). Write a one- to two-page paper on how hospital governance practices are evolving and are found to be more effective.
2. Read the article about the problems in governance in Canada's healthcare systems at www.aims.ca/site/media/aims/Governance%20in%20Health%20Care.docx.pdf (Gross 2013). What recommendations does this article call for? How does this situation differ from that in the United States?

STRATEGY AND CHANGE MANAGEMENT 20

Learning Objectives

After studying this chapter, readers should be able to

- articulate the importance of and interrelationships among an organization's strategy (including its values, mission, vision, and strategic direction), behaviors, and activities;
- perceive the difference between a mission and vision;
- realize the critical function of leaders in directing change;
- apply methods to overcome resistance and implement planned change; and
- recognize the role of leaders in a change effort.

Key Terms

- Gap analysis
- Mission
- Values
- Vision

Organizations are formed to efficiently and effectively accomplish a purpose for their stakeholders. Company purposes vary greatly. A profit-oriented company might seek to maximize wealth for its shareholders, while a service organization might provide healthcare to the poor. Establishing and instilling a purposeful direction for an organization is a critical function of organizational leaders. Embedding this purpose throughout an organization can be a challenging, long-term process that can involve organizational development and change management efforts.

The purpose of an organization is often expressed through its values, mission, and vision statements. If appropriately used, these statements identify who the organization serves, how it serves them, and what type of relationship it expects to have with its stakeholders. These become statements of commitment and help define how to measure success, stating "what an organization does, how the organization accomplishes it, and what the desired outcomes are" (Walston 2014, 121).

These declarations should be accurate, convincing, and explicit and reflect the principles and desires of the organization's key stakeholders, who might be the owners, shareholders, trustees, or community leaders. Properly crafting and adhering to the values, mission, and vision can be critical to organizational success (Luke, Walston, and Plummer 2004); organizations that fail to do so invite conflicting priorities, wasted resources, indecision, and a frustrated workforce (Ice 2007).

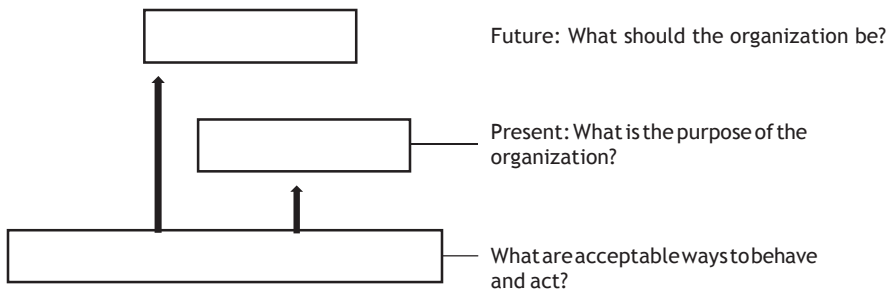
Values, Mission, and Vision

As exhibit 20.1 illustrates, the values of an organization are the foundation of its mission and vision. **Values** are overarching principles or standards that signal how people should behave and act; an organizational values statement tells employees what is acceptable and unacceptable conduct. The **mission** should mirror these values in articulating the organization's ideals and purpose—why it exists. The **vision** depicts the organization's desired future state. As can be seen, values, mission, and vision are highly interrelated and, if suitably constructed, allow stakeholders to comprehend and express the organization's desired behaviors, purpose, direction, and priorities.

Values

Most successful organizations are values based and practice clear, relevant values (George 2001). Values need to be fully incorporated into the organization's decisions and processes, which should include employee hiring and firing, performance reviews, promotions, and incentive structures. In addition, values define the ethics that guide decisions, actions, processes, and resolution of conflicts. If observed, values become essential guiding principles for all company actions and are the foundation of organizational culture. All internal and most external stakeholders should know them, accept them in their hearts and minds, and incorporate them into their behaviors and actions;

EXHIBIT 20.1
Interrelationship Among Values, Mission, and Vision



values statements should not be written just to hang on a wall (Nelson and Gardent 2011; Walston 2014).

Appropriately lived values in hospitals may be a key factor in lowering patient mortality rates (Curry et al. 2011). This finding supports the notion that values should endure across time. Organizational strategies will adapt, but values should remain consistent.

An organization's values should be the ultimate measure to determine whether it has succeeded or failed. Just achieving goals, while necessary, is not sufficient. If goals are attained but values are compromised, the outcomes should be considered a failure. For example, as shown in the adjacent box, physicians may have succeeded in facilitating interrogation methods or in making money, but they did so by violating their professional values, making their efforts not just a failure but also unethical or illegal. Similarly, when organizations realize stellar financial goals but disregard their values in the process, their supposed success is exposed as fraud or abuse. Whether or not they engaged in criminal activity, compromised values can have a devastating impact on employee morale.

Too frequently, organizations create nice value statements but fail to root them in their culture. Value statements become marketing slogans and window dressing—visible on a wall but ignored in practice. I once worked for a company that espoused written values of service, honesty, and respect, but everyone who worked there

Medical Ethical Violations

Medical professionals were accused of violating their professional ethics standards in designing and practicing the US Central Intelligence Agency's controversial interrogation methods of terror suspects at Guantanamo Bay prison in Cuba. The accusation suggests that the psychiatrists and other medical doctors "betrayed the most fundamental duty of the healing professions" by designing and directing the torture program. The American Medical Association and the World Medical Association have expressed concerns that these physicians did not uphold their ethical standards to protect their patients' well-being, as stated in the Hippocratic Oath, the Patient's Bill of Rights, and the Universal Declaration of Human Rights—all of which have been adopted by their professional organizations and the United Nations.

Source: Collins (2014).

Prominent Cardiologist Sentenced for $19 Million Billing Fraud Scheme

On November 20, 2013, in Newark, N.J., Jose Katz, of Closter, N.J., was sentenced to 78 months in prison and three years of supervised release, and ordered to pay $19 million in restitution. Katz, a well-known cardiologist and the founder, CEO, and sole owner of two large medical services companies in New Jersey and New York, pleaded guilty to one count of conspiracy to commit health care fraud. He also pleaded guilty to one count of Social Security fraud arising from a separate scheme to give his wife a "no show" job and make her eligible for Social Security benefits. According to court documents, from 2004 through 2012, Katz conspired to bill Medicare Part B, Medicaid, Empire BCBS, Aetna, and others for unnecessary tests and unnecessary procedures based on false diagnoses and for medical services rendered by unlicensed practitioners.

Source: Internal Revenue Service (2015).

knew that financial outcomes were all that mattered and the stated values were disregarded. Ultimately, ignoring the stated values badly damaged the company's culture, reputation, morale, and long-term viability, as was the case with Enron (discussed earlier in the book), whose stated values were "respect, integrity, communication, and excellence" (Branson 2013).

People need strong moral values to remain motivated. Few employees can be highly motivated and engaged for a long time if the primary reason for their firm's existence is—implicitly or explicitly—profit maximization. Emphasizing only profits has long been seen as flawed and unsustainable (Drucker 1959). Seeking to maximize profits must occur in the context of other values; otherwise, an organization will lose its direction and employee support over time (George 2001).

Mayo Clinic, widely respected as among the best healthcare organizations in the world, states that its values guide its actions and define its existence. These values include the following (reprinted from Mayo Clinic 2015):

Respect
Treat everyone in our diverse community, including patients, their families and colleagues, with dignity.

Compassion
Provide the best care, treating patients and family members with sensitivity and empathy.

Integrity
Adhere to the highest standards of professionalism, ethics and personal responsibility, worthy of the trust our patients place in us.

Healing
Inspire hope and nurture the well-being of the whole person, respecting physical, emotional and spiritual needs.

Teamwork
Value the contributions of all, blending the skills of individual staff members in unsurpassed collaboration.

Excellence
Deliver the best outcomes and highest quality service through the dedicated effort of every team member.

Innovation
Infuse and energize the organization, enhancing the lives of those we serve, through the creative ideas and unique talents of each employee.

Stewardship
Sustain and reinvest in our mission and extended communities by wisely managing our human, natural and material resources.

Mission

Most organizations establish written mission and vision statements. The vast majority (85 percent) of large companies that participated in a 2006 study reported that they had written mission statements (Holland 2007). A mission statement spells out the organization's ongoing purpose and identifies the scope of its products and markets (David 1993). This mission should be the driver of organizational strategies and should use organizational values as its foundation. In addition, the mission should suggest factors that highlight an organization's success, such as goals and key performance indicators (Walston 2014). Basically, the mission needs to tell what the organization does, why it does what it does, for whom it does it, and what value it delivers (Frigo 2003; Luke, Walston, and Plummer 2004). In other words, a mission statement should define the organization's products or services, standards and values, customers or service population, and unique contributions. In addition, a mission statement should describe what the organization does differently or better than others (Walston and Chou 2011). For example, the mission statement of the University of Utah Health Sciences Center (2016) states that its purpose is to provide patient care, educate, and conduct research to improve the health and quality of life for the people of Utah and beyond in an excellent and compassionate manner:

> Our Mission
> The University of Utah Health Sciences Center serves the people of Utah and beyond by continually improving individual and community health and quality of life. This is achieved through excellence in patient care, education, and research; each is vital to our mission and each makes the others stronger.
> - We provide compassionate care without compromise.
> - We educate scientists and health care professionals for the future.
> - We engage in research to advance knowledge and well-being.

However, mission statements, like values, have little worth if they are not properly expressed and lived. Mission statements often fail to accurately communicate their essential elements. Frequently, they are too similar among organizations—"long on lofty ideals and objectives"—and do not distinguish the organization from its competitors (Bourgeois, Duhaime, and Stimpert 1999). For instance, as Richard Branson (2013) remarked,

> The mission statement for the pharmaceutical giant Bristol-Myers reads, "To discover, develop and deliver innovative medicines that help patients prevail over serious diseases." Well, you can't argue with that, but surely this can be said of every drug company on the planet. Why would a person choose to buy Bristol-Myers' products or invest in its stock, rather than its competitors?

Novartis Mission Statement

Our mission is to care and cure.

We want to discover, develop and successfully market innovative products to prevent and cure diseases, to ease suffering and to enhance the quality of life.

We also want to provide a shareholder return that reflects outstanding performance and to adequately reward those who invest their money, their time and their ideas in our company.

Source: Reprinted from Novartis (2015).

Holland (2007) estimated that only 10 percent of mission statements "say something meaningful" in the way of establishing why the firm should be chosen over others. Healthcare mission statements too frequently include meaningless declarations such as "providing world-class services" and "the highest quality of care."

Some mission statements are concise and terse; others are long and wordy. They should be long enough to contain the necessary components but short enough to be remembered. If a mission rambles on and on, employees will fail to remember and use it to guide their behaviors and actions. Shorter mission statements are easier to remember and communicate. The general recommendation is for mission statements to contain no more than 35 words (Collis and Rukstad 2008). At the other extreme, one public entity created a mission statement that was 1,200 words long, which was incomprehensible (Branson 2013).

Missions should motivate action. To do so, they must be written in understandable language that employees can clearly comprehend. For instance, Google's (2015) mission statement is "to organize the world's information and make it universally accessible and useful." This mission statement is written in concise, clear language that focuses on actionable areas that employees can understand.

In addition, a mission statement must balance a company's quality with financial performance and reflect reality. If it mentions only quality outcomes but the organization's operations and metrics focus heavily on financial returns, then employees can become cynical and disengaged. Many healthcare organizations' missions have been found to focus on quality and forget the importance of financial performance (Clarke 2009). At Novartis, a large, global pharmaceutical company, the mission statement (shown in the box below) integrates its focus on innovation with financial returns, which more accurately captures the reality for the firm.

Vision

Contrasting the present nature of a mission, a vision—as defined earlier—portrays a desired future state. A clearly articulated, widely held vision can help create a positive organizational culture with motivated employees. Vision statements should be short enough that employees and other stakeholders can remember and

refer to them during planning and decision making. When deeply held and prominently exhibited, good vision statements can positively affect other stakeholders (Coleman 2013). Some firms have simple vision statements, such as the Alzheimer's Association's (2016) "A world without Alzheimer's disease" or Amazon's "Our vision is to be earth's most customer centric company; to build a place where people can come to find and discover anything they might want to buy online" (Hull 2012). Both of these statements define what their respective company would like the future to be or what it should become.

Clear visions inspire confidence and empower employees by informing them of the preferred future for their company. Visions should permeate the culture and engender direct action. Also, they should challenge and focus employees yet promote loyalty and commitment.

LifePoint Health (2015)—a healthcare provider of inpatient, outpatient, and post-acute services in 21 US states—has crafted a relatively simple but clear vision statement:

> We want to create places where:
> - People choose to come for healthcare,
> - Physicians want to practice, and
> - Employees want to work.

This vision plainly indicates that LifePoint Health's leadership desires to create a company of choice for patients, physicians, and employees. It is short enough to remember and can provide meaningful direction to motivate employees.

Gap Analysis and Organizational Change

Once organizations have established their mission, vision, and values, they should make the statements actionable. Companies commonly undergo a **gap analysis**, an environmental scan (both internal and external) that compares the organization's current performance and status with its values, mission, and vision (see exhibit 20.2). The gap analysis identifies those areas in which the company is not performing in a way that meets its stated expectations. From these results, strategic options are generated from which goals, objectives, and action plans are created and implemented to effect the changes needed to align performance with the expressed values, mission, and vision.

A gap analysis can be developed by asking the following questions (Walston 2014):

- Which stakeholder groups' needs are not being met?
- What key actions must be taken to attain the vision?

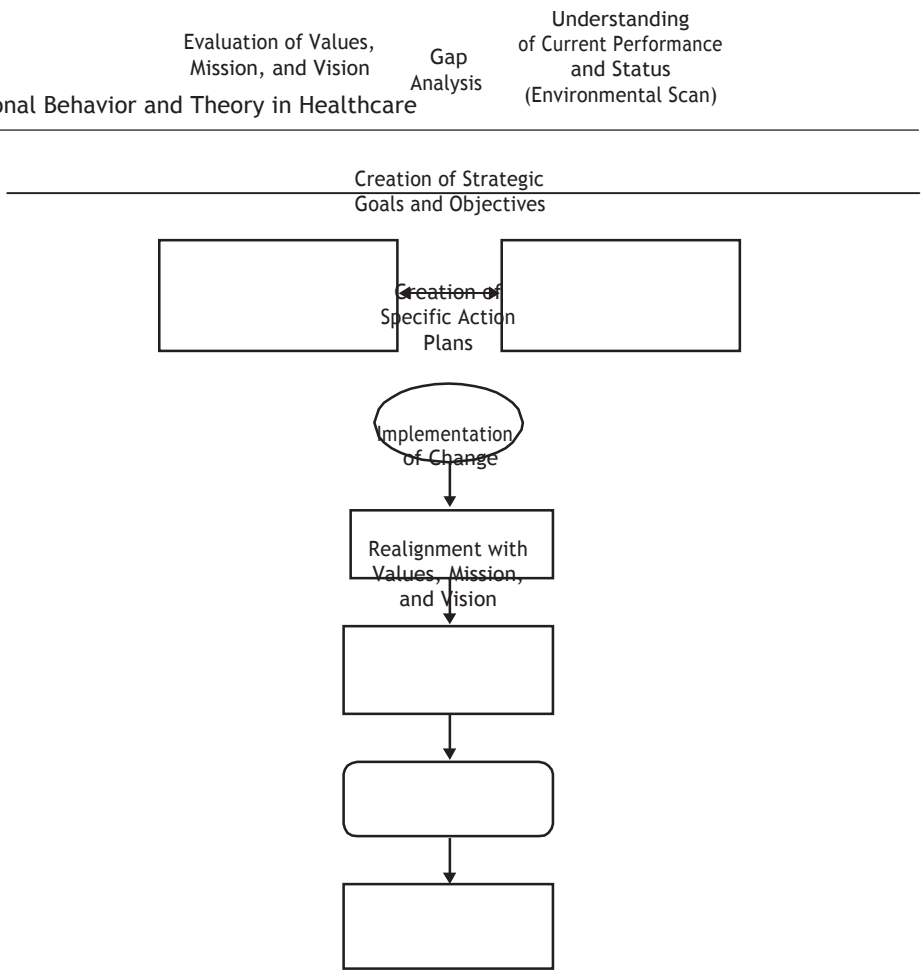


EXHIBIT 20.2 Gap Analysis from Values, Mission, and Vision

- What previous goals were not achieved? How did this lack of achievement affect the mission?
- How is the organization living its values? What can be done to emphasize and fully incorporate the values into the daily work life?
- What are the core organizational weaknesses that may be preventing the organization from living the mission?
- What critical external threats exist that have to be addressed for the organization to continue providing mission-based products and services?
- How is the organization's financial health, and how does this status affect its strategic position?

Companies must change to remain relevant. Healthcare companies today must periodically reinvent and adapt their products, services, and processes. A majority of companies engage in several major changes a year, yet organizational change is a difficult charge for most firms, and about 40 percent are not successful (Maurer 2009). Change does not happen by itself. A well-crafted plan for change may not be implemented for many reasons, but viable companies both plan and implement change. In fact, the ability to

implement change is probably a more important skill set than the ability to plan for change (Raps 2004).

Healthcare organizations are now under particular pressure to significantly change how they operate and to create integrative structures—such as medical homes and accountable care organizations—that improve quality, lower costs, and meet key stakeholder needs. Positive, sustainable change has to be fully embedded in the culture and processes, and it must be grounded in the values, mission, and vision—otherwise, efforts will be superficial. Aligned change effectively institutes new ways to organize, function, and perform.

Leadership

To implement change successfully, leaders need appropriate skills to alter and integrate the people they lead, the technology available, and the structure in place. Exhibit 20.3 shows how these three components interact with each other and how they can be moved toward positive change. As described in chapter 9, transformational leaders motivate their people, design innovative processes and methods through their technology, and craft optimal relationships through their structure—all of which interact with the others and cannot be done separately. The capability to configure people, technology, and structure to produce high performance is a key managerial skill.

Leadership is inherently difficult because of its complexity and somewhat contradictory nature. Leaders must clearly convey their organization's vision and, at the same time, lead day-to-day operations. Pressure from daily management responsibilities can distract leaders from strategic, vision-related

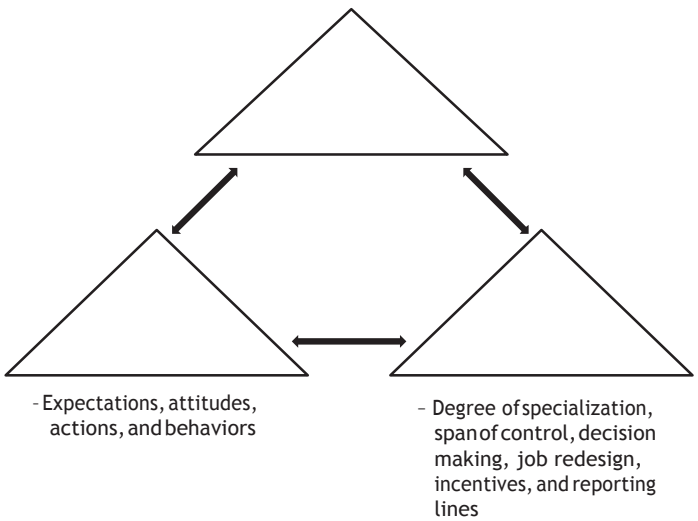


EXHIBIT 20.3 Three Types of Change and Their Interactions

Source: Adapted from Robbins et al. (2014).

activities. Every day, executives are barraged by innumerable meetings, regulatory demands, ceremonial obligations, and pressures to improve financial performance. Successful leaders have to balance these short-range, daily demands with the long-term, vision-related change efforts (Walston 2014).

Achieving this balance necessitates strong management abilities that few have. "Rare is the business leader who can articulate and instill a long-term vision and manage the day-to-day operations with the requisite obsession for detail" (Rowe and Nejad 2009). Successful leaders learn to juggle these priorities. They obtain skills to deal with daily operations and facilitate vision-driven change. They manage continuity and change simultaneously.

Facilitating change requires identifying problems and removing obstacles. Generally, people do not like change and may resist it. Resistance is a very common obstacle to change efforts. Making changes often affects job security and upsets cultural norms, power bases, and company processes. At its worst, organizational change can become a competitive, hostile process that promotes resistance from key stakeholders (Lindblom 1994). Resistance occurs naturally as part of a change process and should be recognized and appropriately addressed (Lewis, Romanaggi, and Chapple 2010).

A display of resistance does not imply that employees are disloyal. Leaders should understand their reaction as a natural expression and welcome employee feedback that may be negative. Maintaining open communication, although often uncomfortable when resistance is discussed, allows concerns to be dealt with and the change implemented to lasting effect. Managers who choose not to understand the resistance to change may take untoward actions with unfortunate consequences that impede change from taking place. I have seen leaders who encounter resistance lash out by enforcing discipline, making threats, and showing anger—reactions that often engender visible compliance but commonly reinforce resistance when these leaders are not present.

Leaders can take steps that allow them to better understand resistance and facilitate the change process. As can be imagined, communicating with employees remains critical. Employees need to know how current and future environments require change to achieve the organizational mission and vision. Employees and other stakeholders should feel a sense of urgency regarding implementing the change, and answering the following questions can help create a safe environment in which to move forward (Wilson 2014):

- Why is the change needed?
- What change is coming or expected?
- What new behaviors or actions does the change require?
- What steps should those affected by the change expect to take (and when)?
- What is not expected to change?

Many of these questions involve communicating why the change is needed and what will happen. An important point to make is what should not change. Often, leaders stress the values, relationships, and culture they desire to retain or issues of job security. Additionally, if employees comprehend what will occur, how it will affect their behaviors and actions, and when different activities will take place, they will resist less, engage more, and coalesce to make the change happen.

Overall, only about one-third of US workers feel engaged, which Gallup defined as "involved in and enthusiastic about their work and workplace. Day after day, they are passionate about their jobs and feel a profound connection to their company" (Harter and Nelson 2015). Some observers have suggested that this rate might be only 44 percent for employees in US hospitals (Sherwood 2013). Yet all stakeholders recognize that employee engagement is critical to positive patient experiences and excellent hospital performance in today's environment, in which there is increased emphasis on HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores (*Healthcare Executive* 2015). Given this focus, healthcare leaders must put their energies into drivers such as commitment to living the organizational mission, hiring and promoting proper personnel, open communication, feedback, and employee recognition to create the appropriate culture and level of satisfaction needed to achieve the organizational values, mission, and vision.

Many different change models exist. The Agency for Healthcare Research and Quality (AHRQ 2015) promotes a change model called the Comprehensive

1. Create a sense of urgency	Understand the science of safety
2. Create a guiding coalition	Assemble the team and engage the senior executive
3. Develop a shared vision	Identify defects through sensemaking
4. Communicate the vision	Understand the science of safety, and identify defects through sensemaking
5. Empower others to act	Understand the science of safety, identify defects through sensemaking, and implement teamwork and communication
6. Generate short-term wins	Implement teamwork and communication
7. Consolidate gains and produce more change	Identify defects through sensemaking
8. Anchor new approaches in culture	Understand the science of safety, and implement teamwork and communication

EXHIBIT 20.4 Relationship Between Kotter's Eight-Step Change Model and AHRQ's CUSP Toolkit Modules

Unit-based Safety Program (CUSP), based on Kotter's eight-step model of change (Kotter and Rathgeber 2006), to improve patient safety. The relationship between the eight steps and AHRQ's modules is shown in exhibit 20.4. CUSP focuses on using tools relevant to clinicians in the context of a hospital environment at a unit level. The toolkit to institute CUSP is available at www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/index.html.

Chapter Summary

Organizations exist for different purposes that often are expressed through their values, mission, and vision statements. If used correctly, these statements define who and how an organization serves. Most successful organizations are values based and openly practice their values. Companies that fail to do so often experience conflicting priorities and frustrated employees.

Values are the foundation of an organization from which the mission and vision should be derived. Values tell what behaviors are appropriate and inappropriate. They form the ethical atmosphere to guide employees and should remain consistent over long periods. People need strong ethical values to remain motivated.

A mission communicates the reasons an organization exists. Most large companies have written mission statements. Mission statements should define the products or services a company delivers, its standards, the customers it serves, and the value it delivers. The best mission statements differentiate the company from others and explain why someone should choose the firm over its competitors. To be short enough to remember and motivate employees to action, a mission statement should contain no more than 35 words.

A vision describes an organization's desired future state. Clearly articulated visions can also motivate and inspire employees. As with a mission, a vision should be short enough to be easily remembered. As such, it can permeate the organizational culture and direct action.

Organizations commonly conduct gap analyses to evaluate how well they are achieving their values, mission, and vision. A gap analysis identifies areas to improve and allows goals, objectives, and action plans to be created to better meet the stated values, mission, and vision.

Companies must change to remain relevant in today's turbulent marketplace, yet many are not successful in implementing change efforts. Healthcare organizations, especially, face many challenges related to the transition to new integrative structures such as medical homes and accountable care organizations. Sustainable change must be embedded in an organization's culture and grounded in its values, mission, and vision. Change takes place through people, technology, and structure, which are interrelated. Transformational leaders must

be able to motivate their people to design innovative processes and methods with their technology and craft optimal relationships through their structure.

Successful leaders manage the seeming contradiction between leading day-to-day operations and directing a vision. They learn to juggle priorities, facilitate change, and manage continuity and change simultaneously.

Resistance frequently arises during change efforts. Generally, people do not like change and may resist it. Leaders must recognize that resistance is a normal part of the change process and welcome feedback and encourage communication. Care must be taken not to display untoward actions, such as anger and threats, which commonly reinforce resistance. Leaders need to take action to communicate why the change is needed, what is expected as part of the change, what effects the change will have on behaviors and actions, and when the change must take place. If change is handled in this manner, employees are less likely to resist and more likely to remain engaged.

Chapter Resource

The State of the American Workplace: Employee Engagement Insights for U.S. Business Leaders is a report of findings from Gallup's survey of the American workplace from 2010 through 2012. It explores the trend of US employee engagement and the impact of engagement on performance, and it discusses what companies can do to encourage engagement. Published in 2013, it can be requested for download at www.gallup.com/services/178514/state-american-workplace.aspx.

Chapter Questions

1. Why should values be the foundation of the mission and vision statements?
2. How do mission and vision differ?
3. Why is being values driven so important to an organization?
4. What should a mission statement contain?
5. Why should a mission statement contain no more than 35 words?
6. What is a gap analysis?
7. How does changing just one of the three components of people, technology, and structure potentially affect the other two?
8. Why do people resist change?
9. What can a leader do to lessen the organizational resistance to planned change?

Chapter Cases

Pegasus Health's Integration of Care

Healthcare for about 500,000 people in Canterbury, New Zealand, the South Island's largest and most populous region, seemed gridlocked: Patients consistently were required to wait very long periods in the emergency departments as hospitals there were chronically over capacity. This was a result of many factors, one of which was that many patients came to the hospital for treatment of minor conditions, such as the removal of skin lesions and treatment for heavy menstrual bleeding.

Waiting times for procedures at hospitals had become not only a problem but also a political embarrassment. The issue came to a head in 2006, when the central government introduced regulations to sanction hospitals if they failed to provide treatment to approved patients within six months of their referral. The local district health board responded by arbitrarily removing from its waiting list about 5,000 patients with the longest waits. The local health board justified the removal to the press by saying that if patients could wait for more than six months, they must not need the surgery.

All of a sudden, the primary care general practitioners (GPs) found their referrals to hospitals being sent back to them without any clear explanation. Angry providers and patients flooded the press with stories, retold in the news with gruesome headlines. The coverage generated a sense of shock and dismay in the Canterbury health system.

On top of this fiasco, recent studies had projected the need for another 500 hospital beds, 20 percent more GPs and nurses, and another 2,000 residential care beds for Canterbury by 2020, which was financially infeasible. And even if the money from the government could be found, attracting the additional 8,000 healthcare professionals needed for the new facilities would be next to impossible.

Something had to be done. The CEO and senior staff, who included the hospital and area physicians and community health groups, were asked to develop a vision for what the health system should look like in 2020, and how it should be changed. They were given a wallet-sized card signed by the CEO giving them "permission" to change the system.

To communicate that the health system had to change and that healthcare stakeholders could change it—and indeed had the responsibility to do so—a "showcase" event was held for more than 2,000 employees and health professionals. At this forum, participants, who came from across the health system, presented the challenges that the system was

facing and asked what they could and would do to improve it. The event occurred in a warehouse, where attendees went through a variety of challenging scenarios. Central questions were posed: How would you like to be treated? Who would you work with to achieve that? How would you, personally, transform the system? The process went on for six weeks, and several common messages emerged:

1. There had to be one healthcare system in Canterbury. "One system, one budget" became a mantra, even though different sources of public and private contributions funded the system.
2. Healthcare needed to be patient centered, not hospital centered.
3. Integrated health and social services needed to exist.

From these themes, a series of goals were established, including the following:

- Services should enable people to take more responsibility for their own health and well-being.
- To the extent possible, people should stay well in their own homes and communities.
- When people need complex care, it should be delivered in a timely and appropriate manner.

Recognizing the challenging task ahead, the group then developed new principles to guide their actions:

- Those in the health system—from primary to community to hospital to social care, whether public employees, independent practitioners, or private and not-for-profit contractors—had to recognize that there was "one system, one budget" in Canterbury.
- Canterbury had to get the best possible outcomes with the resources available, rather than individual organizations and practitioners lobbying for more money.
- The goal was to deliver "the right care, right place, right time by the right person," and a key measure of success was to reduce the time patients spent waiting.

When the goals and principles were presented to the Canterbury District Health Board for adoption, the principles were viewed as the

(continued)

(continued from previous page)

more important of the two, and the board endorsed these principles to begin the change process.

Change efforts began almost immediately with the full system, including the hospitals, GPs, specialist physicians, home nurses, community pharmacies, laboratories, and social care. They needed to work together in new ways to act as a single integrated health and social care system. Only in this way could patient services be improved and the budget be balanced.

Changing people, technology, and structure began. A great deal of skills training ensured the improvement of managerial and innovation abilities. Participants were required to develop projects for change in their own areas and then implement them. In addition, business development units were established to assist clinical and process changes. For example, one group redesigned the flow in the radiology department; another redesigned the processes for acute medical and surgical admissions.

Changes did not come at once. Two years after the initial push for change, some participants were more engaged than others. As one physician stated when asked how deeply the changes had reached into the hospital, "I don't know. But there are more people who feel they have a voice and an influence on what can be done than last year, and then two years ago, and then five years ago. And that is good."

Greater integration was achieved by altering the incentive structures. Hospitals had been reimbursed on the basis of their volumes, which encouraged hospital activity even if this location was not the optimal setting for care. Clinical teams were also given assurances that they would not lose resources for improved efficiencies. For example, phone consults with GPs had not been reimbursed and, therefore, were limited in use. With the changes, these became much more important and eliminated many visits to the emergency and outpatient departments. Also, external contracts became transparent, centered on trust and cooperation, and based on agreed-upon margins with fixed budgets.

HealthPathways, electronic guidelines for best practices and clinical pathways, helped reduce conflict between managers and clinicians. The system delineated which patients should be treated by GPs and which were to be referred to hospital specialists. Critical to these almost 500 pathways were the intensive process and interaction between the GPs and specialists that formed a sense of partnership and trust.

The creation of the pathways and additional funding encouraged GPs to learn spirometry and to remove complex skin lesions. Patients

began arriving at the hospital fully worked up and having all of the tests necessary for their specialist evaluation. Other programs, such as Acute Hospital Management System and Community Rehabilitation Enablement and Support, were added. Both had positive effects of reducing hospital demand. Readmission rates were reduced to 1.7 percent.

Results appeared to be positive. Employee and physician satisfaction increased. Efficient processes reduced service times. For instance, 70 percent of radiology scans were completed within an hour. The waiting list for gallbladder surgery decreased from 300 patients to 100. Furthermore, the financial deficits became surpluses. Overall, the Canterbury District Health Board took significant steps to integrate healthcare among its hospitals, GPs, specialists, and community providers, and results suggest a higher-quality and more efficient system.

Source: Adapted from Timmins and Ham (2013).

Case Questions

1. What caused the healthcare situation to become a crisis?
2. What did the leaders do to motivate action to change?
3. How did their change process follow the guidelines in this chapter? Deviate from the guidelines?
4. How can an organization bring together diverse parties, who have different incentives, to design a better system?

Don't Lecture Me, Son

A new employee showed up for work at a prestigious southwestern US healthcare system. He had just finished a master of health administration degree and was excited to put his new skills to use. His first assignment, which he had requested, was in the business development office. On his first day in his new department, he was presented the health system's values, which he was told to memorize and begin living. They were as follows:

Health Values Statements

LOVE
Treat yourself and others with dignity and respect
Be patient and forgiving
Serve others with love

(continued)

(continued from previous page)

LEARN
Listen, ask, and be receptive
Improve every day
Understand the business
Create a learning environment

LEAD
Provide direction and vision
Acknowledge excellence
Demonstrate honesty
Develop relationships
Dare to make a difference
Lead by example

He wanted to make a difference and began working with others to put these tenets into practice. However, he quickly found that if he varied from written policy, which he often did not know even existed, he would either get an e-mail from his supervisor or be summoned to her office to be told he could not do what he had done and to go back and undo it. Furthermore, scheduling a time with his boss was almost impossible. She told her employees that she was far too busy to meet with them. He noticed that her employees often loitered outside her office and then tried to speak with her while she walked to her next meeting.

After four months on the job, he had the occasion to be called to his supervisor's office again to be criticized about one of his decisions. He was frustrated, and when asked why he made the decision he had, he pulled out the healthcare system's values and read those under "Lead." His supervisor reddened and told him, "Don't lecture me, son!" This ended the discussion and, although he was not called into her office again, he knew his prospects at the healthcare system were bleak.

Case Questions

1. What is your appraisal of the healthcare system's values statement?
2. How did the employee notice that the values statement was not being lived?
3. What did the supervisor do to destroy the meaning of the values statement?
4. What would you do if you were the employee?

NICU Nurses

By Britt Berrett

Hospitals are filled with silos—teams, departments, groups, and divisions whose staff display similar attitudes and behaviors defined by barriers. Individuals gravitate toward creating groupings, whether according to the color of their uniform or the place of their work.

Such was the case at a large, urban tertiary referral center. With more than 900 beds and 3,000 employees, the organization had been described as siloed and dysfunctional. In response, the executive team was determined to bridge these gaps and bring alignment with organizational goals and strategies.

While many would agree that a silo mentality creates organizational inefficiencies and confusion, there is a reason for creating silos. A silo provides a protective barrier around those who are part of the defined group. While members of a silo may bemoan overall organizational disjointedness, they find solace, satisfaction, and even pride in their individual unit's performance.

The neonatal intensive care unit (NICU) was one such example. It enjoyed superior financial performance and high patient and employee satisfaction. Unfortunately, its interest in overall organizational success ended at the doors of the unit. When asked to help other departments or participate in hospital committees, the employees were reluctant or flatly refused. The head of the NICU was also rigid about what costs were charged to her unit and what revenues were credited. For example, she was able to negotiate to have respiratory therapy revenues credited to her department, but the personnel expense was retained in the respiratory therapy department.

Assume you just became the hospital's new CEO. You are proud of the quality of the NICU but recognize that its staff's unwillingness to share and fully participate as colleagues is damaging to the hospital. You have a meeting with the NICU head in three hours and need to decide how you should approach this vexing problem.

Case Questions

1. What are the major issues involved in this case?
2. How would you approach this problem?
3. How does an organization engage siloed units and operating areas?

(continued)

(continued from previous page)

Follow-Up

After serious thought, the head of the NICU decided that a compelling mission and vision would provide the framework for interdepartmental dialogue and discussions that would confirm the interdependence in healthcare. The NICU properly functioned only when it collaborated and coordinated with every other area of the hospital. Hospital leaders were able to demonstrate this truth to NICU staff by creating real-life examples that tied the hospital's new mission and vision to actual behaviors.

Breaking down the barriers between silos was confirmed by all the stakeholders as necessary to meeting their collective mission and vision. Working together allowed all to begin to fulfill their vision for the future. This was the first step in responding to the embedded organizational silos.

Chapter Activities

1. The US Veterans Administration (VA) has faced many challenges in the past decade. For example, in 2015, the VA Office of Inspector General (OIG) found extensive, protracted delays and mismanagement at VA hospitals and clinics (Richardson 2015). The OIG (2015) also published a call for the VA's managers to make "mission-driven decisions," stating:

> VHA's [Veterans Health Administration] primary mission is, and should be, the delivery of high quality health care. VHA has a number of critical missions that include: (1) the provision of quality healthcare, (2) the training of tomorrow's healthcare providers, (3) the provision of healthcare to all citizens in a time of national disaster, and (4) the advancement of medical research. VA must consistently make decisions to ensure that veteran's healthcare is always the highest priority mission. Within VHA, the first test of a management decision should be an assessment of its impact upon the delivery of quality health care.

This mission is complicated by the vast number of care sites—more than 1,500—across the United States and its territories. In addition, the VA is subject to seemingly constantly changing laws.

Read page 4 of the OIG's (2015) report at www.va.gov/oig/pubs/VAOIG-2015-MMC.pdf. Write about the factors that impede the ability of the VA to make mission-based decisions. Why might these decisions and influences have caused the patient-related problems the VA has experienced?

2. Read PricewaterhouseCooper's survey titled "Culture's Role in Enabling Organizational Change" at www.strategyand.pwc.com/media/file/Strategyand_Cultures-Role-in-Enabling-Organizational-Change.pdf (Aguirre, von Post, and Alpern 2013). Write a two-page paper on the influence of culture on organizational change based on PwC's findings.
3. Read the Society for Human Resource Management report titled "2007 Change Management" at www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2007%20Change%20Management%20Survey%20Report.pdf (Benedict 2007). Summarize the document and discuss whether the findings remain applicable. Describe any changes taking place today that were not anticipated by the 2007 survey.

GLOSSARY

Chapter 1

Henri Fayol. A French mining engineer, considered to be one of the founders of modern management, who distilled management practices into 14 principles to frame a general management perspective.

Max Weber. A German sociologist and political economist who postulated that the ideal organization had rules every worker obeyed, competency-based positions, chains of command for decision making, and division of labor.

Organizational behavior. The study of the behavior and influence of individuals, groups, and structures in an organization and their impact on the function and effectiveness of that organization.

Organizational theory. The study of organizations as a whole or populations of organizations that seeks to explain the processes and factors that influence the structure and outcomes of organizations.

Organizations. Socially constructed entities that are goal directed; composed of people tied together in formal and informal relationships; and linked to their external environment through their customers, suppliers, competitors, and government regulators.

Scientific management. A theory, developed by American mechanical engineer Frederick W. Taylor, that human input is among the cheap, interchangeable components that can be "engineered" to maximize efficiency.

Chapter 2

Administrative theory. A principle of bureaucracy and management that seeks a rational way to design an organization.

Contingency approach. The view that personal, situational, and organizational factors dictate different management styles and the effective use of a management style is contingent on internal and external conditions.

Human relations theory. A theory that focuses on organizational development and the influence of people. It originated in the 1930s with the advent of the Hawthorne studies.

Maslow's hierarchy of needs. A theory that human needs fall into five categories. Lower needs must be fulfilled before higher needs can be met.

Open systems theory. A theory that firms are highly influenced by their environments.

Theory X and theory Y. Developed by Douglas McGregor, these contrasting theories describe how managers perceive their employees and how these perceptions affect employee motivation and behavior.

Chapter 3

Double-loop learning. Learning that occurs when the governing variable is questioned, causing shifts in strategies, values, or mission.

Learning communities. A "select group of potential adopters and stakeholders who engage in a shared learning process to facilitate adaptation and implementation of innovations" (Agency for Healthcare Research and Quality 2016).

Learning management systems. Electronic technology that allows the planning, tracking, and outcomes of learning processes. They may include mechanisms to create and deliver instruction, monitor participation, assess performance, and provide student interaction.

Learning organization. An entity in which ingrained structures and culture are in place that constantly facilitate and encourage learning.

Organizational learning. An "organizationally regulated collective learning process in which individual and group-based learning experiences concerning the improvement of organizational performance and/or goals are transferred into organizational routines, processes, and structures" (Schilling and Kluge 2009, 338).

Single-loop learning. Learning that occurs when employees search for solutions within the confines of given goals, values, plans, and rules.

Chapter 4

Autonomy. The ethical principle of making meaningful choices free of interference from others. It is a fundamental principle in medical ethics.

Beneficence. The ethical principle of taking action that benefits others. Beneficence includes the acts of mercy, charity, and kindness and requires active efforts to improve the well-being and status of another.

Corporate social responsibility. The self-regulated ethical behavior that goes beyond legal requirements to promote positive social and environmental improvements; sometimes referred to as *corporate citizenship*.

Distributive justice. The perceived fair distribution of resources, evaluated by the benefits derived and equity in awards.

Egoist model. An ethical model that defines the moral value of action on the basis of whether the foreseeable effects of the action are favorable for the actor. Self-interested behavior is ethical.

Ethical relativism. The concept that an action is considered right or wrong depending on the context and environment in which the action takes place.

Ethics. The often unwritten codes that constrain and guide actions. Context, facts, cultures, beliefs, values, and attitudes influence ethics and how they are practiced.

Fairness, or justice, model. An ethical model that relates to the perceived fairness of actions. Just actions involve consistent, fair treatment on the basis of ethical, religious, or legal standards.

Interactional justice. The perceived fairness of actions, decisions, and treatment of individuals, evaluated by the accuracy of information and the respect and courtesy shown throughout the decision-making process.

Justice. The ethical principle of fairly distributing benefits, risks, and costs and treating all people equally.

Nonmaleficence. The ethical principle of doing no harm. Especially for healthcare practitioners, this principle can be very challenging, as almost every treatment has potential risks. Therefore, the risks and burdens must be weighed against the benefits.

Procedural justice. The perceived fairness of the process by which a decision is made, evaluated by compliance with decision-making processes, level of access, openness, and participation by employees.

Rights model. An ethical model that distinguishes right from wrong on the basis of the underlying intentions. Individual moral or legal rights are paramount.

Utilitarianism. An ethical model that defines the moral value of actions on a valuation of their consequences. Actions are right when they produce positive consequences or the "greatest happiness" for the greatest number of people.

Chapter 5

Dissatisfiers. A set of factors—one of two in Herzberg's two-factor theory—that do not motivate because they do not produce satisfaction. Dissatisfiers may include working conditions, interpersonal relations, job security, and salary; also called *hygiene factors*.

Equity theory. The theory that employees seek to balance their work inputs and the outcomes or benefits they receive compared with those of others.

ERG theory of motivation. The theory (a refinement of Maslow's hierarchy of needs) that motivation results from three factors: existence, relatedness, and growth.

Expectancy. The belief that one's efforts will result in the desired outcomes.

Expectancy theory. The theory that motivation is a function of three linked factors: expectancy, instrumentality, and valence.

External stimuli. Stimuli or means of instigation that originate from outside an individual; also called *operant conditioning*.

Frustration–regression. The concept that people who unsuccessfully seek a higher need become frustrated and regress to pursue a lower need.

Goal-setting theory. The theory that goal-directed work and quantified and clearly defined goals lead to higher performance.

Instrumentality. The belief that one will receive a reward if expected performance is achieved.

Intrinsic stimuli. Stimuli that originate from within an individual.

Job characteristics model. A model that posits job enrichment should be designed with five core characteristics: work variety, work autonomy, work feedback, work significance, and work identity.

Satisfiers. A set of factors—one of two in Herzberg's two-factor theory—that relate to job content and motivate because they have longer-lasting effects than dissatisfiers have. Satisfiers may include achievement, recognition, advancement, and growth.

Two-factor theory. A theory developed by Frederick Herzberg that job satisfaction and dissatisfaction are not opposites but simply reflect different employee needs.

Valence. The value a person places on the expected rewards.

Chapter 6

Burnout. A reaction to chronic high stress characterized by physical or mental collapse.

Distress. Negative, persistent, unresolved stress that may lead to anxiety, withdrawal, or depression.

Emotional intelligence. The capacity to be aware of, to be in control of, and to express emotions as well as to handle interpersonal relationships with empathy and wisdom.

Emotions. Brief, intense episodes of a complex range of feelings that lead to physical and mental changes and influence actions and behaviors.

Employee assistance programs. Benefit programs that generally provide confidential short-term counseling and referrals for employees who face challenges that, if left unmanaged, could seriously affect their work.

Eustress. Positive stress that can motivate greater effort and focus and can result in improved productivity or mastery of a new skill.

Hardiness. The ability to handle stress.

Moods. The background feelings that are less intense but tend to last longer than emotions and affect one's perception of life.

Primary emotions. The feelings people first experience as a response to a situation that include love, joy, surprise, anger, sadness, and fear.

Qualitative overload. Stress caused by being required to use a skill with which the employee is not yet comfortable.

Qualitative underload. Stress caused by doing a job that requires skills far below the training and ability of the employee.

Quantitative overload. Stress caused by having too much work to do in a given period.

Quantitative underload. Stress caused by having too little work to do in a given period.

Role ambiguity. A lack of specificity and predictability about a job, its functions, and its responsibilities because of unclear job descriptions, poor training, and changing job requirements.

Role conflict. The dissonance that arises from being given two or more incompatible or contradictory job demands.

Secondary emotions. Longer-duration feelings that reflect people's mental processing of a situation and the primary emotions it elicited.

Stress. A state of mental or emotional strain that arises from "uncertainty introduced by unexpected events" (Contrada and Baum 2011).

Chapter 7

Affective commitment. The desire portion of commitment that involves the emotional attachment to the organization through acceptance of and attitude toward the organizational goals and values.

Continuance commitment. The need portion of commitment that comprises the mutual relationship between employee and organization.

Fundamental attribution error. The tendency to attribute one's own success to personal/internal traits and failure to external factors, while others' success is attributed to external factors and failure to personal/internal traits.

Halo effect. The effect that occurs when one characteristic or trait dominates and affects the evaluation of people or products.

Job commitment. The degree to which an individual identifies with and is attached to an organization.

Normative commitment. An obligation-based commitment that includes the feeling of duty and meeting of group norms.

Paradigms. The lenses through which people see the world, coloring their expectations of people's behavior and directing their actions in organizations.

Paradigm shift. The changing of a person's paradigms, which can alter her decisions, prepare her for uncertainty, and enhance her ability to learn in the organizational setting.

Perceptions. The ways people experience, process, and interpret stimuli.

Primacy effect and recency effect. The effects that influence people's ability to recall information after receiving either the first or the last items, which tend to be the most easily remembered.

Similar-to-me effect. The effect that occurs when individuals and groups favor and select people who are physically and professionally similar to themselves.

Stereotypes. The categorization of people on the basis of their characteristics, such as race, gender, age, religion, and occupation.

Chapter 8

Coercive power. The ability to use the threat of force to make someone compliant.

Expert power. The ability to influence followers because of the experiences, skills, talents, or knowledge of the person with power.

Formal authority. The right to influence someone.

Harassment. A set of hostile activities that are repeated and systematic and are usually verbal or nonverbal, rather than physical.

Influence. The process of persuading others to do something; it occurs when power is exercised.

Organizational politics. The informal means of gaining power other than through merit or luck.

Power. The capacity to influence others by control over valued resources.

Referent power. The ability to influence followers because of their trust and respect for for the person with power.

Reward power. The ability to promise positive incentives, such as bonuses, raises, promotions, and time off.

Sexual harassment. Unwelcome and illegal sexual conduct or advances that subtly or blatantly threaten the recipient's employment or feeling of personal safety.

Zone of indifference. The range of acceptable tasks employees are willing to do without questioning the rationale of the direction.

Chapter 9

Authentic leadership. An approach to leadership that emphasizes honest relationships with followers and a positive ethical climate.

Behavior theory. The theory that proposes two categories of leadership behaviors: employee-oriented leadership and production-oriented leadership.

Contingency theory. The theory that the best leadership style depends on the situation and context.

Ethical leadership. A model of leadership that emphasizes trustworthy, fair, and honest personal conduct to promote ethical behaviors in followers.

Great man theory. A perspective that exceptionally gifted individuals with prominent traits—such as physical characteristics, personality, and ability—become leaders.

Leader–member exchange theory. The theory that presents a complex, relationship-based approach to leadership, making the interaction between leader and member the focal point of the leadership process.

Path–goal theory. The theory that considers both employee and environmental factors to suggest which leadership style would be most effective.

Servant leadership. A values-based view of leadership that views service as the core function of leadership and a moral and ethical imperative.

Situational leadership. The theory that effective leaders need to understand their environment or situation and respond with a style that matches the existing need.

Trait theory. The theory that a leader is one endowed with superior characteristics and traits that differentiate him or her from the followers.

Transactional leadership. The theory that examines the influences and behaviors of those being led and their interactions with leaders through both rewards and punishments.

Transformational leadership. The theory that leaders inspire and motivate followers to pursue outcomes centered on a sense of purpose and an idealized mission.

Chapter 10

Cultural assessments. A tool for comparing organizational culture with organizational mission and values to identify needs and appropriate interventions.

Individualism versus collectivism. The preference for personal gain (individualism) over benefits for the group (collectivism).

Masculinity versus femininity. The preferences for achievement, heroism, assertiveness, or material rewards (masculinity) over cooperation, modesty, caring, and quality of life (femininity).

Organizational culture. "The pattern of basic assumptions that ... have worked well enough to be considered valid and ... the correct way to perceive, think, and feel" (Schein 1984, 3) for members of a given group.

Power distance. The way power is distributed and the degree to which individuals accept the inequity of power distribution.

Rituals and routines. Collective social activities that reinforce organizational values by engendering active participation from organizational members.

Stories. Narratives that describe the culture's values in action or demonstrate the violation of those values.

Symbols and structures. Images, events, activities, objects, and workplace structures that express or represent an idea or quality, among others.

Time orientation. The degree to which members are willing to defer satisfaction and focus on achieving long-term, rather than short-term, outcomes.

Uncertainty avoidance. The degree to which members feel uncomfortable in ambiguous and uncertain situations and take action to avoid them.

Chapter 11

Coaching. Instruction or training focused mostly on the transfer or improvement of definite skills over a short period.

Content coaching. The process that narrows the focus to a specific knowledge area and skill set.

Delegation. The act of authorizing another to perform a task or duty and, in doing so, allocating and sharing responsibilities to increase productivity and empowerment.

Feedback coaching. The process to help leaders create an individualized development program.

Gofer delegation. The act of delegating specific, detailed actions to a person or team who, after completing the tasks, must immediately return, report, and then wait for another assignment.

In-depth development coaching. The process that extends feedback to include continued consultation and assistance.

Mentoring. Advising or training for long-term employee growth and nurturing to improve leadership capabilities.

Stewardship delegation. The act of delegating that empowers the person or team assigned a task to choose how to complete activities and be responsible for results.

Chapter 12

Balanced scorecard. Reporting mechanism that incorporates financial and nonfinancial aspects of performance to allow a comprehensive, balanced perspective of organizational results.

Competency-based appraisal systems. Mechanisms for evaluating employee performance on the basis of required competencies established for the employee's position.

Forced distribution/stacked or forced ranking. Mechanisms for rating employee performance that require managers to rank their employees across a distribution, much like "grading on the curve."

Gantt charts. Bar charts that show the schedules of a single or multiple projects.

Key performance indicators. Metrics used in performance management that are directly tied to strategic organizational goals.

Numerical rating systems. Mechanisms for rating employee performance on a numeric scale.

Performance management. The "process of establishing performance standards and evaluating performance to ensure that goals are being effectively accomplished" (Osland et al. 2007, 573).

360-degree feedback appraisal system. A mechanism for evaluating employee performance that seeks feedback from those stakeholders with whom the employee being appraised has frequent contact.

Chapter 13

Anchoring bias. A bias that relies too heavily on the initial information received.

Bounded rationality. The idea that individuals' decision making is constrained by available information, their cognitive limits, and the time to make decisions.

Confirming-evidence bias. A bias toward information that supports or reinforces positions or beliefs but against information that discounts or dismisses.

Framing bias. A bias toward how a choice or information is framed.

Garbage can model. A model for decision making that is characterized by chaos caused by the fluid, frequent entry and exit of decision makers who lack clarity and understanding about how decisions are made.

Groupthink. "The tendency for members of a highly cohesive group to seek consensus so strongly that they fail to do a realistic appraisal of other alternatives, which may be more correct" (Osland et al. 2007, 471).

Heuristics. Mental shortcuts or rules of thumb generated from personal experiences and used during problem solving.

Rational decision making. "A method for systematically selecting among possible choices that is based on reason and facts" (WebFinance 2015).

Status quo bias. A bias toward choices that perpetuate the status quo and the current situation.

Sunk cost bias. A bias toward investments that cannot be recovered.

Chapter 14

Creativity. "The development of new ideas ...[and]... the precursor to innovation" (Osland et al. 2007, 319).

Diffusion. The act of spreading and embedding innovation to transform an organization, an industry, or a system.

Disruptive innovation. Innovation that creates radical change and destroys existing organizational competencies.

Innovation. "The implementation of new ideas" (Osland et al. 2007, 319).

Sustaining innovation. Innovation that builds on past successes and organizational competencies and provides incremental improvements.

Chapter 15

Command groups. Groups formed to give directions and orders within their organization.

Formal groups. Groups prearranged by an organization as a command or a task entity.

Forming. The first stage of team building, when a team comes together and an individual transitions into a team member.

Groups. Collections of individuals who interact with each other and share common interests or characteristics.

Informal groups. Groups that are self-formed as a result or for the purpose of work and social interactions.

Interdisciplinary teams. Teams composed of a coordinated group of professionals from different fields who work interdependently but share information and resolve problems systematically and together.

Multidisciplinary teams. Teams composed of professionals from multiple disciplines who tend to work independently and interact formally.

Norming. The third stage of team building, when members establish group rules, which usher in harmony and team cohesion.

Performing. The fourth stage of team building, when members have learned their roles and accepted each other's strengths and weaknesses.

Pooled interdependence. A type of interdependence that requires members to make only discrete, independent contributions to their group.

Reciprocal interdependence. A type of interdependence that requires members to have a team relationship as their work is highly interactive and necessitates immediate responses.

Storming. The second stage of team building, when members begin to resist collaboration with other members and to experience conflict.

Task groups. Groups organized for a specific job or undertaking.

Teams. Evolved groups that have great task orientation, purpose, interdependence, structure, and social familiarity.

Chapter 16

Communication. The process of transmitting information and meaning from one individual or group to another.

Communication channel. The medium through which a message is sent and received.

Decoding. The communication step that assigns meaning to the message.

Dialogue. The free flow of meaning between two or more people.

Encoding. The communication step that transforms a message into signs or symbols.

Feedback. The process in which the sender and receiver engage to validate the message sent and received.

Information richness. The degree of nonverbal or verbal communication used to convey the complexity and importance of a message.

Noise. Distractions that diminish the effectiveness of the communication process.

Nonverbal communication. The process of communicating without words.

Chapter 17

Affirmative action. A policy or action that actively seeks to improve the employment and educational opportunities of members of minority groups and women.

Baby boom generation. A group of people born between 1943 and 1960.

Collective cultures. Cultures that emphasize group responsibility to protect and care for their communities.

Diversity. A wide array of differences and similarities among people in areas such as "ethnicity, race, culture, gender, age, functional and educational backgrounds, lifestyle preferences, tenure with the organization, personality traits, and ways of thinking" (Osland et al. 2007, 366).

Diversity management. The practice of acknowledging employees' differences and allowing employees to use these traits to achieve organizational goals.

Ethnocentrism. The "exaggerated tendency to think the characteristics of one's own group or race are superior to those of other groups or races" (Hofstede 1984, 25).

Generation X. A group of people born between 1961 and 1981 who tend to seek job security and push for efficiency and innovation.

Individualistic cultures. Cultures that value loose social relationships that encourage individuals to take responsibility for themselves and their relatives.

Millennial generation. A group of people born between 1982 and 2005 who tend to be teamwork oriented, to be risk averse, and to value work–life balance.

Postmillennial generation, iGen, or generation Z. A group of people born after 2005 who are comfortable with technology and place a strong value on education.

Chapter 18

BATNA. The best alternative to a negotiated agreement.

Conflict. A situation that arises when two or more parties have opposing views, positions, needs, or interests that are perceived as incompatible.

Interests. In negotiations, a party's real needs, desires, fears, and goals.

Intergroup conflict. Conflict between two or more groups.

Interpersonal conflict. Conflict between two or more individuals that may be caused by personality, values, and style differences.

Intragroup conflict. Conflict among members of a group.

Intrapersonal conflict. Conflict that arises because of an individual's roles, values, or goals.

Nontask organizational conflict. Conflict that occurs regarding corporate policies, hiring decisions, benefits, culture, leadership, or power.

Polarization. A situation in which people are driven to take sides and accept extreme positions.

Positions. In negotiations, the expressed desires or presented proposals of the parties involved.

Process conflict. Conflict that occurs regarding how a job gets done.

Relationship conflict. Conflict that occurs regarding values, personality, political beliefs, and style.

Task conflict. Conflict that occurs regarding work details and goals.

Zero-sum games. Competitions in which one party wins at the expense of the loser.

Chapter 19

Accountable care organizations. "Groups of doctors, hospitals, and other healthcare providers who come together to give coordinated high quality care" (CMS 2015).

Chain of command. The hierarchy, or formal reporting structure, that delineates the direction for formal company communication and decision making.

Corporation. A legal structure that allows a group of people to act as a single entity and provides limited liability to its owners.

Division of labor. The segmentation of tasks and roles into smaller components that are performed by separate individuals or groups.

Functional organizations. Organizations that divide departments by common duties, tasks, services, or roles.

Horizontal structures. Organizational structures, also called process structures, that have few layers of management and are composed of self-managing, multidisciplinary teams organized around core processes.

Matrix organizations. Organizations with multiple reporting relationships, generally to both a functional manager and a product or service line manager, that allow horizontal and vertical coordination to concurrently occur.

Mechanistic organizations. Traditional organizations characterized by greater job specialization, narrow spans of control, and increased centralization of decision making.

Multidivisional organizations. Organizations divided into segments or divisions made up of separate businesses or profit centers so that day-to-day operations occur at a divisional level to allow units to act independently.

Network structures. Organizational structures, also called modular or virtual organizations, that allow for flexibility and decentralization.

Organic organizations. Organizations characterized by decentralized and participative decision making, loosely defined roles, and frequent adaptation that brings in new skills and modified roles.

Organizational design. The alignment of the organizational structure, including its roles and processes for formal reporting relationships, with organizational mission and goals.

Organizational structure. The way a company arranges its tasks, work, and people to create a product or service and achieve its goals.

Span of control. The number of subordinates who report to a supervisor.

Transfer pricing. The price set for goods and services that are transferred between divisions of the same company.

Chapter 20

Gap analysis. An environmental scan—both internal and external—that compares the organization's current performance and status with its values, mission, and vision.

Mission. The organization's ideals and purpose—why it exists.

Values. Overarching principles or standards that signal how people should behave and act.

Vision. The organization's desired future state.

REFERENCES

Abelson, R., and M. Freudenheim. 2003. "The Scrushy Mix: Strict and So Lenient." Published April 20. www.nytimes.com/2003/04/20/business/the-scrushy-mix-strict-and-so-lenient.html.

Acello, B., and B. Hegner. 2015. *Nursing Assistant: A Nursing Process Approach,* 11th ed. Boston: Cengage Learning.

Acuna, A. 2013. "How Much Time Do Managers Spend on Conflict?" Learning4Managers. Published May 21. https://learning4managers.com/dir/conflict_management/. Adams, J. 1965. "Inequality in Social Exchange." In *Advances in Experimental Psychology,* edited by L. Berkowitz, 267–99. New York: Academic Press.

Adler, N. 1991. *International Dimensions of Organizational Behavior*, 2nd ed. Mason, OH: South-Western.

Agency for Healthcare Research and Quality (AHRQ). 2016. "Innovations Exchange Learning Communities." Accessed March 22. https://innovations.ahrq.gov/learning-communities.

———. 2015. "Comprehensive Unit-Based Safety Program (CUSP)." Published August. www.ahrq.gov/professionals/quality-patient-safety/cusp/index.html.

———. 2014. "Disparities in Healthcare Quality Among Racial and Ethnic Minority Groups: Selected Findings from the 2010 National Healthcare Quality and Disparities Reports." Reviewed October. http://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr10/minority.html.

Aguirre, D., R. von Post, and M. Alpern. 2013. *Culture's Role in Enabling Organizational Change*. www.strategyand.pwc.com/media/file/Strategyand_Cultures-Role-in-Enabling-Organizational-Change.pdf.

Air University. 2015. "Biases in Perception of Cause and Effect." Accessed February 23. www.au.af.mil/au/awc/awcgate/psych-intel/art14.html.

Albrecht, K., and R. Zemke. 2008. *Service America! Doing Business in the New Economy*. San Diego: Karl Albrecht International.

Allhealthcare. 2015. "6 Ways Healthcare Workers Can Beat Burn-Out." Accessed February 4. http://allhealthcare.monster.com/benefits/articles/2008-6-ways-healthcare-workers-can-beat-burn-out-.

Alliance for Advancing Nonprofit Health Care. 2016a. "Basic Facts and Figures: Nonprofit Health Plans." Accessed October 26. www.nonprofithealthcare.org/resources/BasicFacts-NonprofitHealthPlans.pdf.

———. 2016b. "Basic Facts and Figures: Nonprofit Home Health Services." Accessed October 26. www.nonprofithealthcare.org/resources/BasicFacts-NonprofitHomeHealthCare.pdf.

———. 2016c. "Basic Facts and Figures: Nonprofit Hospice Services." Accessed October 26. www.nonprofithealthcare.org/resources/BasicFacts-NonprofitHospices.pdf.

Altman, D. 1998. "Key Issues in Community Hospital and Academic Medical Center Consolidations." Commonwealth Fund. Published July 1. www.commonwealthfund.org/Publications/Fund-Reports/1998/Jul/Key-Issues-in-Community-Hospital-and-Academic-Medical-Center-Consolidations.aspx.

Alzheimer's Association. 2016. "About Us." Accessed June 8. www.alz.org/about_us_about_us_.asp.

American College of Healthcare Executives (ACHE). 2015. "ACHE Healthcare Executive 2016 Competencies Assessment Tool." Accessed May 9, 2016. www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

———. 2011. "ACHE Code of Ethics." Amended November 14. www.ache.org/abt_ache/code.cfm.

American Heart Association. 2003. "ACC/AHA Clinical Competence Statement." Accessed June 7, 2016. http://circ.ahajournals.org/content/107/7/1068.full.

American Hospital Association. 2016. "Fast Facts on US Hospitals." Accessed October 26. www.aha.org/research/rc/stat-studies/fast-facts.shtml.

American Medical Association (AMA). 2001. "Principles of Medical Ethics." Revised June. www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page.

American Nurses Association (ANA). 2015. "Code of Ethics for Nurses with Interpretive Statements." Accessed May 26, 2016. http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html.

American Physical Therapy Association (APTA). 2014. "Code of Ethics for the Physical Therapist." Accessed December 8. www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Ethics/CodeofEthics.pdf.

American Psychological Association (APA). 2012. "Stress in America: Our Health at Risk." Published January 11. www.apa.org/news/press/releases/stress/2011/final-2011.pdf.

Amitabha Hospice Service. 2012. "Maori and Pacific Island Customs and Beliefs." Accessed July 20, 2016. www.amitabhahospice.org/public/helpful_info/maori.php.

Anderson, C., and S. Brion. 2014. "Perspectives on Power in Organizations." *Annual Review of Organizational Psychology and Organizational Behavior* 1: 67–97.

Anderson, M., and P. Escher. 2010. *The MBA Oath: Setting a Higher Standard for Business Leaders*. New York: Penguin.

Anderson, N., K. Potočnik, and J. Zhou. 2014. "Innovation and Creativity in Organizations: A State-of-the-Science Review, Prospective Commentary, and Guiding Framework." *Journal of Management* 40 (5): 1297–333.

Antonakis, J., T. Cianciolo, and R. Sternberg. 2004. *The Nature of Leadership*. Thousand Oaks, CA: Sage.

Antonakis, J., and R. House. 2002. "The Full-Range Leadership Theory: The Way Forward." In *Transformational and Charismatic Leadership: The Road Ahead,* edited by B. Avolio and F. Yammarino, 3–33. Oxford, UK: Elsevier Science.

Aquino, K. 2000. "Structural and Individual Determinants of Workplace Victimization: The Effects of Hierarchical Status and Conflict Management Style." *Journal of Management* 26 (2): 171–93.

Arango, T. 2010. "How the AOL–Time Warner Merger Went So Wrong." *New York Times*. Published January 10. www.nytimes.com/2010/01/11/business/media/11merger.html.

Argote, L. 2013. *Organizational Learning: Creating, Retaining and Transferring Knowledge*. New York: Springer Science+Business Media.

Argyris, C., and D. A. Schon. 1978. *Organizational Learning: A Theory of Action Perspective*. Reading, MA: Addison-Wesley.

Arnold, E., and K. Boggs. 2016. *Interpersonal Relationships: Professional Communication Skills for Nurses,* 7th ed. St. Louis, MO: Saunders.

Ascension. 2016. "Healthcare Ethics." Accessed May 4. www.ascensionhealth.org/index.php?option=com_content&view=article&id=32&Itemid=170.

Ashkanasy, N. M., C. E. Hartel, and W. J. Zerbe. 2000. *Emotions in the Workplace: Research, Theory, and Practice*. Westport, CT: Quorum Books.

Aston, G. 2015. "Service-Line Management: A Behind the Scenes Road to Value." *Hospitals & Health Networks*. Published January 13. www.hhnmag.com/articles/3757-service-line-management-a-behind-the-scenes-road-to-value.

Avolio, B., and F. Yammarino. 2002. *Transformational and Charismatic Leadership: The Road Ahead*. Oxford, UK: Elsevier Science.

Ayman, R. 2004. "Situational and Contingency Approaches to Leadership." In *The Nature of Leadership,* edited by J. Antonakis, A. T. Cianciolo, and R. J. Sternberg, 148–70. Thousand Oaks, CA: Sage.

Bailey, M. 2016. "Communication Failures Linked to 1,744 Deaths in Five Years, US Malpractice Study Finds." *STAT*. Published February 1. www.statnews.com/2016/02/01/communication-failures-malpractice-study/.

Baker, D., R. Day, and E. Salas. 2006. "Teamwork as an Essential Component of High-Reliability Organizations." *Health Services Research* 41 (4): 1576–98.

Barker, A. M. 1992. *Transformational Nursing Leadership*. Burlington, MA: Jones & Bartlett Learning.

Barling, J., E. K. Kelloway, and M. Frone. 2005. *The Handbook of Stress*. Thousand Oaks, CA: Sage.

Barnard, C. 1938. *The Functions of the Executive*. Cambridge, MA: Harvard University Press.

Barnes, J. 2009. "Cost of Iraq War Will Surpass Vietnam by Year's End." *Los Angeles Times*. Published April 11. http://articles.latimes.com/2009/apr/11/nation/na-iraq-vietnam11.

Barr, H., I. Koppel, S. Reeves, M. Hammick, and D. Freeth. 2005. *Effective Interprofessional Education*. Oxford, UK: Blackwell.

Bartunek, J. 2011. "Intergroup Relationships and Quality Improvement in Healthcare." *BMJ Quality & Safety* 20 (Suppl. 1): i62–i66.

Bass, B. M. 1995. "The Meaning of Leadership." In *The Leader's Companion: Insights on Leadership Through the Ages*, edited by J. T. Wren, 37–38. New York: Free Press.

———. 1990. *Handbook of Leadership: Theory, Research, and Managerial Applications*, 3rd ed. New York: Free Press.

Bass, B. M., and R. Bass. 2008. *The Bass Handbook of Leadership: Theory, Research, and Managerial Applications*. New York: Free Press.

Battistelli, A., M. Galletta, I. Portoghese, and C. Vandenberghe. 2013. "Mindsets of Commitment and Motivation: Interrelationships and Contribution to Work Outcomes." *Journal of Psychology* 147 (1): 17–48.

Baumbach, J. 2014. "College Football Coaches' Salaries and Perks Are Soaring." *Newsday*. Published October 4. www.newsday.com/sports/college/college-football/fbs-college-football-coaches-salaries-are-perks-are-soaring-newsday-special-report-1.9461669.

Bawany, S. 2014. "Mentoring & Leadership Development." *Leadership Excellence Essentials* 31 (8): 52.

Baxter. 2016. "Corporate Overview." Accessed June 17. www.baxter.com/inside-baxter/about/overview/corporate.page.

Beagrie, S. 2005. "How to Build Effective Teams." *Contract Journal* 428 (6523): 91.

Beard, C., and J. Wilson. 2006. *Experiential Learning,* 2nd ed. Bodmin, Cornwall, UK: MPG Books.

Beauchamp, T., and J. Childress. 2001. *Principles of Biomedical Ethics*. Oxford, UK: Oxford University Press.

Benedict, A. 2007. "2007 Change Management." Society for Human Resource Management. Published April. www.shrm.org/research/surveyfindings/documents/2007%20change%20management%20survey%20report.pdf.

Bennett, A. 2012. "Accountable Care Organizations: Principles and Implications for Hospital Administrators." *Journal of Healthcare Management* 57 (4): 244–54.

Bennis, W. 1959. "Leadership Theory and Administrative Behavior: The Problem of Authority." *Administrative Science Quarterly* 4 (4): 259–60.

Beresford, D. R., N. deB. Katzenbach, and C. B. Rogers Jr. 2003. "Report of Investigation by the Special Investigative Committee of the Board of Directors of Worldcom, Inc." Published March 31. www.sec.gov/Archives/edgar/data/723527/000093176303001862/dex991.htm.

Berner, E. S., and M. L. Graber. 2008. "Overconfidence as a Cause of Diagnostic Error in Medicine." *American Journal of Medicine* 121 (5, Suppl.): S2–S23.

Berriman, J. 2007. "Can Coaching Combat Stress at Work?" *Occupational Health* 59 (1): 27–29.

Betra, K. 2013. "Stereotypes in Healthcare: Why Do They Exist and What to Do with Them?" Published July 4. www.nhg-homer.org/2013/07/stereotypes.html.

Bies, R. J., and D. L. Shapiro. 1988. "Voice and Justification: Their Influence on Procedural Fairness Judgments." *Academy of Management Journal* 31 (3): 248–79.

Biswas, D. 2009. "The Effects of Option Framing on Consumer Choices." *Journal of Consumer Behavior* 8 (5): 284–99.

Blake, R. R., and J. Mouton. 1965. *The Managerial Grid*. Houston, TX: Gulf Publishing.

Blakeney, B., P. Carleton, C. McCarthy, and E. Coakley. 2009. "Unlocking the Power of Innovation." *Online Journal of Issues in Nursing*. Published May 31. www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No2May09/Innovation.html.

Blanchard, K., and S. Bowles. 2000. *High Five! The Magic of Working Together*. New York: William Morrow.

Blanchard, K., and S. Johnson. 2003. *The One Minute Manager*. New York: William Morrow.

Blanchard, K., T. Lacinak, C. Tompkins, and J. Ballard. 2002. *Whale Done! The Power of Positive Relationships*. New York: Free Press.

Bobic, M., and W. Davis. 2003. "A Kind Word for Theory X: Or Why So Many Newfangled Management Techniques Quickly Fail." *Journal of Public Administration and Theory* 13 (3): 239–64.

Bodenheimer, T. 2007. "Building Teams in Primary Care: Lessons Learned." California HealthCare Foundation. Published July. www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuildingTeamsInPrimaryCare Lessons.pdf.

Bornstein, D. 2014. "The Power to Cure, Multiplied." *New York Times*. Published June 11. http://opinionator.blogs.nytimes.com/2014/06/11/the-doctor-will-stream-to-you-now/.

Boundless. 2016. "The Human Side: Hawthorne." Published April 13. www.boundless.com/management/textbooks/boundless-management-textbook/organizational-theor y-3/behavioral-perspectives-30/the-human- side-hawthorne-170-8381/.

———. 2015. *Boundless Management*. Accessed January 26. www.boundless.com/management/textbooks/boundless-management-textbook/.

Bourgeois, L., I. Duhaime, and J. Stimpert. 1999. *Strategic Management: A Managerial Perspective*. Oakbrook, IL: Dryden Press.

Bradberry, T., and J. Greaves. 2009. *Emotional Intelligence 2.0*. San Diego, CA: TalentSmart.

Brady, W., and S. Haley. 2013. "Storytelling Defines Your Organizational Culture." *Physician Executive* 39 (1): 40–43.

Bransford, J., A. Brown, and R. Cocking. 2000. "How People Learn: Brain, Mind, Experience, and School." Washington, DC: Commission on Behavioral and Social Sciences and Education, National Research Council, National Academies Press.

Branson, R. 2013. "Richard Branson on Crafting Your Mission Statement." *Entrepreneur*. Accessed October 29, 2015. www.entrepreneur.com/article/227507.

Brodey, S. 2015. "Can the VA Fire Its Way Out of Its Problems?" *MinnPost*. Published November 10. www.minnpost.com/dc-dispatches/2015/11/can-va-fire-its-way-out-its-problems.

Brown, M. E., and L. K. Treviño. 2006. "Ethical Leadership: A Review and Future Directions." *Leadership Quarterly* 17 (6): 595–616.

Brown, M. E., L. K. Treviño, and D. A. Harrison. 2005. "Ethical Leadership: A Social Learning Perspective for Construct Development and Testing." *Organizational Behavior and Human Decision Processes* 97 (2): 117–34.

Brown, T. 2013. "Healing the Hospital Hierarchy." *New York Times*. Published March 16. http://opinionator.blogs.nytimes.com/2013/03/16/healing-the-hospital-hierarchy/.

Bruk-Lee, V., A. Nixon, and P. Spector. 2013. "An Expanded Typology of Conflict at Work: Task, Relationship and Non-task Organizational Conflict as Social Stressors." *Work & Stress* 27 (4): 339–50.

Brustein, J. 2013. "Microsoft Kills Its Hated Stack Rankings. Does Anyone Do Employee Reviews Right?" *Bloomberg Business*. Published November 13. www.bloomberg.com/bw/articles/2013-11-13/microsoft-kills-its-hated-stack-rankings-dot-does-anyone-do-employee-reviews-right.

Bryant, A. 2011. "Google's Quest to Build a Better Boss." *New York Times*. Published March 12. www.nytimes.com/2011/03/13/business/13hire.html.

Buell, J. 2011. "Key Skills Help Put the Pieces in Place." *Healthcare Executive* 26 (6): 8–16.

Buller, P. 1986. "The Team Building–Task Performance Relation: Some Conceptual and Methodological Refinements." *Group & Organization Studies* 11 (3): 147–68.

Burns, J. M. 2003. *Transforming Leadership: A New Pursuit of Happiness*. New York: Atlantic Monthly Press.

———. 1995. "The Crisis of Leadership." In *The Leader's Companion: Insights on Leadership Through the Ages,* edited by J. T. Wren, 8–10. New York: Free Press.

———. 1978. *Leadership*. New York: Harper & Row.

Burns, L. R., and M. V. Pauly. 2012. "Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s." *Health Affairs (Millwood)* 31 (11): 2407–16.

Burns, L. R., and D. R. Wholey. 1993. "Adoption and Abandonment of Matrix Management Programs: Effects of Organizational Characteristics and Interorganizational Networks." *Academy of Management Journal* 36 (1): 106–38.

Burns, T., and G. M. Stalker. 1961. *The Management of Innovation*. London: Tavistock.

Business Roundtable Institute for Corporate Ethics. 2007. "Shaping Tomorrow's Business Leaders: Principles and Practices for a Model Business Ethics Program." Accessed December 1, 2014. www.corporate-ethics.org/pdf/mbep.pdf.

Butcher, L. 2012. "'Learning Communities' Spread Best Practices Across a System." *Hospitals & Health Networks*. Published December 1. www.hhnmag.com/articles/6063-learning-communities-spread-best-practices-across-a-system.

Butterfield, J. 2011. *Team Building*. Boston: Cengage Learning.

Byham, W. 2008. "Taking Your Succession Management Plan into the 21st Century." Development Dimensions International. Accessed July 10, 2016. www.ddiworld.com/ddi/media/white-papers/gyol_wp_ddi.pdf.

Cabral-Isabedra, C. 2016. "Only 5 Percent of Patients with Advanced Cancer Understand Their Prognosis." *Tech Times*. Published May 24. www.techtimes.com/articles/160537/20160524/only-5-percent-of-patients-with-advanced-cancer-understand-their-prognosis.htm.

Calder, R. 2014. "Madoff Cohort Gets 10 Years." *New York Post*. Published December 8. www.nypost.com/2014/12/08/bernie-madoffs-former-operations-chief-sentenced-to-10-years/.

Cameron, K., and R. Quinn. 1999. *Diagnosing and Changing Organizational Culture*. Upper Saddle River, NJ: Prentice Hall.

Cantlupe, J. 2013. "Hospitals Rethink the Service Line." *HealthLeaders Media*. Published March 25. http://healthleadersmedia.com/page-1/LED-290455/Hospitals-Rethink-the-Service-Line.

Cardy, R., and T. Selvarajan. 2006. "Competencies: Alternative Frameworks for Competitive Advantage." *Business Horizons* 49 (3): 235–45.

Carr, D. 2013. "2014 Healthcare Industry Forecast: Sweeping Change." *Information Week*. Published December 11. www.informationweek.com/healthcare/leadership/2014-healthcare-industry-forecast-sweeping-change/d/d-id/1113028.

Carroll, A., and A. Buchholtz. 2003. *Business and Society: Ethics and Stakeholder Management,* 5th ed. Mason, OH: South-Western.

Carroll, J., and J. Rudolph. 2006. "Design of High Reliability Organizations in Health Care." *Quality & Safety in Health Care* 15 (Suppl. 1): i4–i9.

Cascio, W. F. 2003. "Responsible Restructuring: Seeing Employees as Assets, Not Costs." *Ivey Business Journal* 68: 1–5.

Center for Creative Leadership. 2014. "Leader Effectiveness and Culture: The GLOBE Study." Accessed May 20, 2016. www.ccl.org/leadership/pdf/assessments/globestudy.pdf.

Center for Healthcare Governance. 2014. *National Health Care Governance Survey Report*. Accessed April 5, 2016. www.americangovernance.com/resources/reports/governance-reports/2014/Governance-Survey-Report-update.pdf.

Centers for Disease Control and Prevention (CDC). 2012. "Genomics and Health Resources." www.cdc.gov/genomics/public/index.htm.

Centers for Medicare & Medicaid Services (CMS). 2015. "Accountable Care Organizations (ACO)." Updated January 6. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html.

———. 2014. "HCAHPS: Patients' Perspectives of Care Survey." Updated September 25. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html.

Cerasoli, C., J. Nicklin, and M. Ford. 2014. "Intrinsic Motivation and Extrinsic Incentives Jointly Predict Performance: A 40-Year Meta-analysis." *Psychological Bulletin* 140 (4): 980–1008.

Chadwick, D. 2015. *It's How You Play the Game*. Eugene, OR: Harvest House.

Chandler, A. D. 1962. *Strategy and Structure: Chapters in the History of the Industrial Enterprise*. Cambridge, MA: MIT Press.

Chemers, M. 1995. "Contemporary Leadership Theory." In *The Leader's Companion: Insights on Leadership Through the Ages,* edited by J. T. Wren, 83–99. New York: Free Press.

Chesanow, N. 2013. "Why Some Patients Aren't Following Your Instructions." Medscape Business of Medicine. Published May 29. www.medscape.com/viewarticle/804739.

Chin, W. W., R. G. Hamermesh, R. S. Huckman, B. J. McNeil, and J. P. Newhouse. 2015. "5 Imperatives: Addressing Healthcare's Innovation Challenge." Accessed July 27. www.hbs.edu/healthcare/Documents/Forum-on-Healthcare-Innovation-5-Imperatives.pdf.

Christensen, C. 1997. *The Innovator's Dilemma: When Technologies Cause Great Firms to Fail*. Boston: Harvard Business School Press.

Christian, J. S., and A. Ellis. 2014. "The Crucial Role of Turnover Intentions in Transforming Moral Disengagement into Deviant Behavior at Work." *Journal of Business Ethics* 119 (2): 193–208.

Cialdini, R. 2004. "The Science of Persuasion." *Scientific American* 14 (1, special edition): 70–77.

Clapp, J. 2010. "Diversity Leadership: The Rush University Medical Center Experience." *Hospital Topics* 88 (2): 61–66.

Clark, A. 2005. *Causes, Role and Influence of Mood States*. Hauppauge, NY: Nova Biomedical Books.

Clarke, R. 2009. "A Mission of Value." *Healthcare Financial Management* 63 (4): 144–45.

Clayton, M., and E. Martha. 2009. "Good Days for Disruptors." *MIT Sloan Management Review* 50 (3): 67–70.

Coca-Cola Company. 2014. "Global Diversity Mission." Updated December 31. www.coca-colacompany.com/our-company/diversity/.

Coffman, C., and G. Gonzalez-Molina. 2002. *Follow This Path*. New York: Warner Books.

Cohen, M., J. March, and J. Olsen. 1972. "A Garbage Can Model of Organizational Choice." *Administrative Science Quarterly* 17 (1): 1–25.

Coleiro, D. 2013. "Carving an Identity Through Customer-Focused Innova- tion." PMLive. Published June 12. www.pmlive.com/pharma_news/carving_an_identity_through_customer-focused_innovation_482409.

Coleman, J. 2013. "Six Components of a Great Corporate Culture." *Harvard Business Review*. Published May 6. https://hbr.org/2013/05/six-components-of-culture. Collins, J., and J. I. Porras. 1994. *Built to Last: Successful Habits of Visionary Companies*. New York: HarperBusiness.

Collins, S. 2014. "Doctors May Have Violated Medical Ethics by Helping the CIA Torture Prisoners." ThinkProgress. Published December 17. http://thinkprogress.org/health/2014/12/17/3604746/physicians-human-rights-torture/.

Collis, D. J., and M. G. Rukstad. 2008. "Can You Say What Your Strategy Is?" *Harvard Business Review* 86 (4): 82–90.

Conger, J., and R. Kanungo. 1998. *Charismatic Leadership in Organizations*. Thousand Oaks, CA: Sage.

Contrada, R., and A. Baum 2011. *The Handbook of Stress Science*. New York: Springer.

Cook County Health & Hospitals System. 2015. "Standing Committees." Accessed May 29. www.cookcountyhhs.org/about-cchhs/governance/board-of-directors/standing-committees/.

Covey, S. 2006. *The 8th Habit: From Effectiveness to Greatness*. New York: Free Press.

———. 2004. *Seven Habits of Highly Effective People*. New York: Free Press.

———. 1992. *Principle-Centered Leadership*. New York: Simon and Schuster.

Cowen, M., L. Halasyamani, D. McMurtrie, D. Hoffman, T. Polley, and J. Alexander. 2008. "Organizational Structure for Addressing the Attributes of the Ideal Healthcare Delivery System," *Journal of Healthcare Management* 53 (6): 407–18.

Cross, R., W. Baker, and A. Parker. 2003. "What Creates Energy in Organizations?" *MIT Sloan Management Review* 44 (4): 51–56.

Crossan, M., H. Lane, and R. White. 1999. "An Organizational Learning Framework: From Intuition to Institution." *Academy of Management Review* 24 (3): 522–37.

Cunningham, L. 2015. "In Big Move, Accenture Will Get Rid of Annual Performance Reviews and Rankings." *Washington Post*. Published July 21. www.washingtonpost.com/blogs/on-leadership/wp/2015/07/21/in-big-move-accenture-will-get-rid-of-annual-performance-reviews-and-rankings/.

Curran, C., and M. Totten. 2010. "Board Oversight of Executive Performance and Compensation." *Nursing Economics* 28 (5): 343–45.

Curry, L., E. Spatz, E. Cherlin, H. Krumholz, and E. Bradley. 2011. "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Rates?" *Annals of Internal Medicine* 154 (6): 384–90.

Daft, R. 2012. *Organizational Theory and Design*, 11th ed. Boston: Cengage Learning.

Daft, R., and R. Lengel. 1984. "Information Richness: A New Approach to Managerial Behavior and Organizational Design." In *Research in Organizational Behavior*, edited by L. Cummings and B. Staw, 191–233. Homewood, IL: JAI Press.

Daily News Wire Services. 2003. "General Dissatisfaction in the Army?" Published June 11. http://articles.philly.com/2003-06-11/news/25448013_1_defense-secretary-donald-rumsfeld-body-language-iraq-war-plan.

Dame, J., and J. Gedmin. 2013. "Three Tips for Overcoming Your Blind Spots." *Harvard Business Review*. Published October 2. https://hbr.org/2013/10/three-tips-for-overcoming-your-blind-spots/.

Dana, R. 2000. *Handbook of Cross-Cultural and Multicultural Personality Assessment*. New York: Psychology Press.

Daniels, S., and M. Ramey. 2005. *The Leader's Guide to Hospital Case Management*. Burlington, MA: Jones & Bartlett Learning.

Dartmouth College. 2010. "Common Rater Errors." Updated April 15. www.dartmouth.edu/~hrs/profldev/performance_management/rater_errors.html.

Darzi, L., and G. Parston. 2013. *Global Diffusion of Healthcare Innovation: Report of the Global Diffusion of Healthcare Innovation Working Group 2013*. Wish Foundation. Accessed July 30. www.wish-qatar.org/app/media/503.

David, F. R. 1993. *Strategic Management,* 4th ed. New York: Macmillan.

Davis, T., N. Dolan, M. Ferreira, C. Tomori, K. Green, A. Sipler, and C. Bennett. 2001. "The Role of Inadequate Health Literacy Skills in Colorectal Cancer Screening." *Cancer Investigation* 19 (2): 193–200.

Davison, B. 2003. "Management Span of Control: How Much Is Too Wide?" *Journal of Business Strategy* 24 (4): 22–29.

Dawson, P., and C. Andriopoulos. 2014. *Managing Change, Creativity, and Innovation,* 2nd ed. Thousand Oaks, CA: Sage.

De Dreu, C. K. W., and M. J. Gelfand (eds.). 2008. *The Psychology of Conflict and Conflict Management in Organizations*. New York: Erlbaum.

Delcampo, R., L. Haggerty, M. Haney, and L. Knippel. 2011. *Managing the Multigenerational Workforce*. Farnham, UK: Grower.

Deloitte. 2009. "Ethics and Compliance: The Advantage of a Values-Based Approach." Accessed March 29, 2016. www2.deloitte.com/content/dam/Deloitte/in/Documents/risk/Board%20of%20Directors/in-gc-ethics-and-compliance-a-value-based-approach-noexp.pdf.

Devilly, G. J. 2004. "Assessment Devices." Swinburne University Clinical & Forensic Psychology. Published March 24. www.swin.edu.au/victims/resources/assessment/assessment.html.

Dewe, P., M. O'Driscoll, and C. Cooper. 2010. *Coping with Work Stress*. New York: Wiley.

Digh, P. 1998. "Coming to Terms with Diversity." *HR Magazine* 43 (12): 117–21.

Dixon, P. 2016. "The Future of Medicine and Health Care." Accessed June 5. www.globalchange.com/medicine.htm.

Dobson, K., and D. Dozois. 2008. *Risk Factors in Depression*. San Diego, CA: Elsevier.

Donais, B. 2006. "What Are the Sources of Workplace Conflict?" Mediate.com. Published November. www.mediate.com/articles/donaisB2.cfm.

Doran, G. 1981. "There's a S.M.A.R.T. Way to Write Management's Goals and Objectives." *Management Review* 70 (11): 35–36.

Dovidio, J., and S. Fiske. 2012. "Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Can Contribute to Health Care Disparities." *American Journal of Public Health* 102 (5): 945–52.

Dressler, G. 1999. "How to Earn Your Employees' Commitment." *Academy of Management Executives* 13 (2): 58–67.

Drucker, P. F. 1959. "Long-Range Planning—Challenge to Management Science." *Management Science* 5 (3): 238–49.

Dubinsky, I., K. Jennings, M. Greengarten, and A. Brans. 2010. "360-Degree Physician Performance Assessment." *Healthcare Quarterly* 13 (2): 71–76.

Dubrin, A. J. 2011. *Impression Management in the Workplace: Research, Theory and Practice*. New York: Routledge.

———. 2008. *Essentials of Management*. Mason, OH: South-Western Cengage Learning.

———. 2001. *Leadership,* 3rd ed. New York: Houghton Mifflin.

Duhaime, I., L. Stimpert, and J. Chesley. 2012. *Strategic Thinking: Today's Business Imperative*. New York: Routledge.

Duncan, R., and A. Weiss. 1978. "Organizational Learning: Implications for Organizational Design." In *Research in Organizational Behavior,* edited by B. Staw. Greenwich, CT: JAI Press.

Dyer, W. G. 1987. *Team Building: Issues and Alternatives*. Reading, MA: Addison-Wesley.

Economist. 2008. "Theories X and Y." Published October 6. www.economist.com/node/12370445.

Economy, P. 2015. "10 Secret Communication Skills of the Best Leaders." *Inc*. Published November 5. www.inc.com/peter-economy/10-secret-communication-skills-of-top-leaders.html.

Edelstein, B. 2011. "Examining Whether Dental Therapists Constitute a Disruptive Innovation in US Dentistry." *American Journal of Public Health* 101 (10): 1831–35.

Eichenwald, K. 2012. "Microsoft's Lost Decade." *Vanity Fair*. Published August. www.vanityfair.com/news/business/2012/08/microsoft-lost-mojo-steve-ballmer.

———. 2003. "Tenet Healthcare Paying $54 Million in Fraud Settlement." *New York Times*. Published August 7. www.nytimes.com/2003/08/07/business/tenet-healthcare-paying-54-million-in-fraud-settlement.html.

Einarsen, S., H. Hoel, D. Zapf, and C. Cooper. 2003. "The Concept of Bullying at Work: The European Tradition." In *Bullying and Emotional Abuse in the Workplace: International Perspectives in Research and Practice*, edited by S. Einarsen, H. Hoel, D. Zapf, and C. Cooper, 3–30. London: Taylor & Francis.

Eli Lilly. 2015. "Key Facts." Accessed June 17, 2016. www.lilly.com/About/Key-facts/key-facts.aspx www.lilly.com/Documents/2014-FTE.pdf.

Ewenstein, B., B. Hancock, and A. Komm. 2016. "Ahead of the Curve: The Future of Performance Management." *McKinsey Quarterly*. Published May. www.mckinsey.com/business-functions/organization/our-insights/ahead-of-the-curve-the-future-of-performance-management.

Fairholm, G. W. 1997. *Capturing the Heart of Leadership: Spirituality and Community in the New American Workplace*. Westport, CT: Praeger.

Farrell, G. 2004. "Former HealthSouth CEO Scrushy Turns Televangelist." *USA Today*. Published October 25. http://usatoday30.usatoday.com/money/industries/health/2004-10-25-scrushy-cover_x.htm.

Feinstein, J. 2015. "Why Jim Harbaugh Is Worth $40 Million to the University of Michigan's Football Team." *Washington Post*. Published January 2. www.washingtonpost.com/opinions/why-jim-harbaugh-is-worth-40-million-

to-the-university-of-michigan/2015/01/02/ad591542-9292-11e4-a900-9960214d4cd7_story.html.

Feldman, D. L. 2008. "The Inside of a Time Out." Patient Safety Network. Published May. https://psnet.ahrq.gov/webmm/case/177.

Ferris, G. R., D. Frink, and M. C. Galang. 1993. "Diversity in the Workplace: The Human Resources Management Challenges." *Human Resource Planning* 16 (1): 41–52.

Ferris, G. R., P. L. Perrewé, W. P. Anthony, and D. C. Gilmore. 2000. "Political Skill at Work." *Organizational Dynamics* 28 (4): 25–37.

Fiedler, F. 1964. "A Contingency Model of Leadership Effectiveness." *Advances in Experimental Social Psychology* 1: 149–90.

Fink, G. 2010. *Stress Consequences: Mental, Neuropsychological, and Socioeconomic*. San Diego, CA: Elsevier.

Finley, K. 2014. "Why Workers Can Suffer in Bossless Companies Like Github." *Wired*. Published March 20. www.wired.com/2014/03/tyranny-flatness/.

Fiol, C., and M. Lyles. 1985. "Organizational Learning." *Academy of Management Review* 10 (4): 803–13.

Fisher, R., and D. Shapiro. 2005. *Beyond Reason: Using Emotions as You Negotiate*. New York: Penguin.

Folger, R., and R. Cropanzano. 2001. "Fairness Theory: Justice as Accountability." In *Advances in Organization Justice,* edited by J. Greenberg and R. Cropanzano, 1–55. Stanford, CA: Stanford University Press.

Frezza, B. 2012. "Polaroid, Kodak, Apple: No One Escapes the Winds of Creative Destruction." *Forbes*. Published September 5. www.forbes.com/sites/billfrezza/2012/09/05/polaroid-kodak-apple-no-one-escapes-the-winds-of-creative-destruction/.

Frigo, M. L. 2003. "Mission Driven Strategy." *Strategic Finance* 85 (2): 8–11.

Frisch, C., and M. Huppenbauer. 2014. "New Insights into Ethical Leadership: A Qualitative Investigation of the Experiences of Executive Ethical Leaders." *Journal of Business Ethics* 123 (1): 23–43.

Fuller, J. B., C. Patterson, K. Hester, and D. Stringer. 1996. "A Quantitative Review of Research on Charismatic Leadership." *Psychological Reports* 78 (1): 271–87.

Galbraith, J. R., and G. Quelle. 2009. "Matrix Is the Ladder to Success." *BusinessWeek*. Published August. www.businessweek.com/debateroom/archives/2009/08/matrix_is_the_l.html.

Gallup. 2013. *State of the American Workplace: Employee Engagement Insights for U.S. Business Leaders*. Accessed July 6, 2016. http://employeeengagement.com/wp-content/uploads/2013/06/Gallup-2013-State-of-the-American-Workplace-Report.pdf.

Gamble, M. 2013. "How Ideas Become Innovations: Roundtable with Healthcare Innovation Leaders from UCLA, Ohio State." *Becker's Hospital Review*. Published August 28. www.beckershospitalreview.com/hospital-management-administration/how-ideas-become-innovations-roundtable-with-healthcare-innovation-leaders-from-ucla-ohio-state.html.

Gardner, H. 2012. "Performance Pressure as a Double-Edge Sword: Enhancing Team Motivation but Undermining the Use of Team Knowledge." *Administrative Science Quarterly* 57 (1): 1–46.

Garvin, D. A. 1993. "Building a Learning Organization." *Harvard Business Review* 71 (4): 78–91.

Garvin, D. A., A. Edmondson, and F. Gino. 2008. "Is Yours a Learning Organization?" *Harvard Business Review*. Published March. https://hbr.org/2008/03/is-yours-a-learning-organization.

George, B. 2003. *Authentic Leadership: Rediscovering the Secrets to Creating Lasting Value*. San Francisco: Jossey-Bass.

George, W. W. 2001. "Medtronic's Chairman William George on How Mission-Driven Companies Create Long-Term Shareholder Value." *Academy of Management Executive* 15 (4): 39–47.

Geradi, D. 2003. "Conflict Management Training for Health Care Professionals." Mediate.com. Published November. www.mediate.com/articles/gerardi4.cfm.

Givan, R. 2010. "The Maimonides Medical Center Model: Conflict Resolution Through Mutual Respect and Conflict Resolution Through Mediation." *Dispute Resolution Journal* 65 (4): 11–56.

Glabman, M. 2009. "Disruptive Innovations That Will Change Your Life in Health Care." *Managed Care*. Published January. www.managedcaremag.com/archives/0901/0901.disruptive.html.

Glickman, S., K. Baggett, C. Krubert, E. Peterson, and K. Schulman. 2007. "Promoting Quality: The Health-Care Organization from a Management Perspective." *International Journal for Quality in Health Care* 19 (6): 341–48.

Goleman, D., R. Boyatzis, and A. McKee. 2013. *Leadership: Unleashing the Power of Emotional Intelligence*. Boston: Harvard Business Press.

Goo, S. K. 2015. "The Skills Americans Say Kids Need to Succeed in Life." Published February 19. www.pewresearch.org/fact-tank/2015/02/19/skills-for-success/.

Google. 2015. "About Google." Accessed October 30. www.google.com/about.

Gowans, C. 2012. "Moral Relativism." *Stanford Encyclopedia of Philosophy*. Published Spring. http://plato.stanford.edu/archives/spr2012/entries/moral-relativism.

Graen, G. B., and M. Uhl-Bien. 1995. "Relationship-Based Approach to Leadership: Development of Leader-Member Exchange (LMX) Theory of Leadership over 25 Years: Applying a Multi-level, Multi-domain Perspective." *Leadership Quarterly* 6 (2): 219–47.

Grant, A. 2014. *Give and Take: Why Helping Others Drives Our Success*. New York: Penguin.

Green, A. 2013. "10 Things Only Bad Bosses Say." *US News & World Report*. Published August 23. http://money.usnews.com/money/careers/slideshows/10-things-only-bad-bosses-say.

Greene, J. 2014. "Ascension Health, CHE Trinity Form Integrated Network in Michigan." *Modern Healthcare*. Published May 7. www.modernhealthcare.com/article/20140507/INFO/305079982.

Greenleaf, R. K. 2003. "The Servant as Leader." In *The Servant-Leader Within: A Transformative Path*, 29–74. New York: Paulist Press.

Greer, M. 2005. "When Intuition Misfires." *Monitor on Psychology* 36 (3): 58.

Gregoire, C., 2015. "How Men and Women Process Emotions Differently." *Huffington Post*. Published January 25. www.huffingtonpost.com/2015/01/25/how-men-and-women-process_n_6510160.html.

Greiner, A., and E. Knebel. 2003. *Health Professions Education: A Bridge to Quality*. Washington, DC: National Academies Press.

Grenny, J., D. Maxfield, and A. Shimberg. 2008. "How to Have Influence." *MIT Sloan Management Review* 50 (1): 47–52.

Gross, M. 2013. "Governance in Health Care." Atlantic Institute for Market Studies. Published April. www.aims.ca/site/media/aims/Governance%20in%20Health%20Care.docx.pdf.

Guffey, M., and D. Loewy. 2011. *Business Communication: Process and Product,* 7th ed. Mason, OH: Cengage Learning.

Gustin, S. 2012. "In Kodak Bankruptcy, Another Casualty of the Digital Revolution." *Time*. Published January 20. http://business.time.com/2012/01/20/in-kodak-bankruptcy-another-casualty-of-the-digital-revolution/.

Hackman, J. R. 2011. "Six Common Misconceptions About Teamwork." *Harvard Business Review*. Published June 7. https://hbr.org/2011/06/six-common-misperceptions-abou/.

Hackman J. R., and G. R. Oldham 1980. *Work Redesign*. Upper Saddle River, NJ: Pearson.

———. 1976. "Motivation Through the Design of Work: Test of a Theory." *Organizational Behavior and Human Performance* 16 (2): 250–79.

Haden, J. 2011. "How to Handle the 5 Toughest Management Challenges." Published July 8. www.cbsnews.com/news/how-to-handle-the-5-toughest-management-challenges/5/.

Hall, E. 1959. *The Silent Language*. New York: Random House.

Hallet, T. 2014. "Yukl and Tracey's Influences: Choosing the Most Appropriate Approach to Influence." Mind Tools. Accessed June 10, 2016. www.mindtools.com/pages/article/eleven-influencers.htm.

Hamel, P. C. 2001. "Interdisciplinary Perspectives, Service Learning, and Advocacy: A Nontraditional Approach to Geriatric Rehabilitation." *Topics in Geriatric Rehabilitation* 17 (1): 53–70.

Hamilton, A. 2008. "Why Circuit City Busted, While Best Buy Boomed." *Time*. Published November 11. http://content.time.com/time/business/article/0,8599,1858079,00.html.

Hamilton, C. 2016. "HealthSouth: A Case Study in Corporate Fraud." Accessed May 4. www.arxisfinancial.com/images/pdfs/Fraud-Health_South_Case.pdf.

Hammerly, M., L. Harmon, and S. Schwaltzberg. 2014. "Good to Great: Using 360-Degree Feedback to Improve Physician Emotional Intelligence." *Journal of Healthcare Management* 59 (5): 354–65.

Hammond, J., R. Keeney, and H. Raiffa. 2006. "The Hidden Traps in Decision Making." *Harvard Business Review* 84 (1): 118–26.

Hammond, L., K. Austin, S. Orcutt, and J. Rosso. 2001. "How People Learn: Introduction to Learning Theories." Stanford University School of Education. Published December 27. web.stanford.edu/class/ed269/hplintrochapter.pdf.

Hargrove, M. B., D. Nelson, and C. Cooper. 2013. "Generating Eustress by Challenging Employees: Helping People Savor Their Work." *Organizational Dynamics* 42 (1): 61–69.

Hart, K. 2007. "No Cultural Merger at Sprint Nextel." *Washington Post*. Published November 24. www.washingtonpost.com/wp-dyn/content/article/2007/11/23/AR2007112301588.html.

Harter, J., and B. Nelson. 2015. "Montana Ranks Highest in Employee Engagement for 2013 and 2014." Gallup. Published March 18. www.gallup.com/poll/182033/montana-ranks-highest-employee-engagement-2013-2014.aspx.

Hashimoto, H., H. Noguchi, P. Heidenreich, O. Saynina, A. Moreland, S. Miyazaki, S. Ikeda, Y. Kaneko, and N. Ikegami. 2006. "The Diffusion of Medical Technology, Local Conditions and Technology Re-invention: A Comparative Case Study on Coronary Stenting." *Health Policy* 79 (2–3): 221–30.

Healthcare Executive. 2015. "6 Leadership Strategies for Navigating Perpetual Change in Healthcare." *Healthcare Executive* 30 (4): 42–43.

Healthcare Source. 2014. "HCAHPS and the Bottom Line: 5 Ways to Improve Scores Through Talent and Learning Management." Accessed November 12. http://solutions.healthcaresource.com/2253-hcahps-whitepaper.html.

Healy, J., and M. Paulson. 2015. "Vaccine Critics Turn Defensive over Measles." *New York Times*. Published January 30. www.nytimes.com/2015/01/31/us/vaccine-critics-turn-defensive-over-measles.html.

Heath, C., and D. Heath. 2013. *Decisive: How to Make Choices in Life and Work*. New York: Crown Business.

Heath, D., and C. Heath. 2009. "Why Incentives Are Irresistible, Effective, and Likely to Backfire." Fast Company. Published February 1. www.fastcompany.com/1140924/why-incentives-are-irresistible-effective-and-likely-backfire.

Helyar, J. 2003. "The Insatiable King Richard." *Fortune* 148 (1): 76–81.

Henochowicz, S., and D. Hetherington. 2006. "Leadership Coaching in Health Care." *Leadership & Organization Development Journal* 27 (3): 183–89.

Henry J. Kaiser Family Foundation (KFF). 2013. "Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011." Published June 28. http://kff.org/medicaid/fact-sheet/overview-of-nursing-facility-capacity-financing-and-ownership-in-the-united-states-in-2011/.

Hersey, P., and K. H. Blanchard. 1969. "Life Cycle Theory of Leadership." *Training and Development Journal* 23 (5): 26–34.

Hersey, P., K. Blanchard, and D. E. Johnson. 1996. *Management of Organizational Behavior: Utilizing Human Resources*, 7th ed. Englewood Cliffs, NJ: Prentice-Hall.

Herzberg, H. 2003. "Motivating People." *Harvard Business Review* 81 (1): 87–96.

Herzlinger, R. 2006. "Why Innovation in Health Care Is So Hard." *Harvard Business Review*. Published May. https://hbr.org/2006/05/why-innovation-in-health-care-is-so-hard.

Heskett, J. 2013. "Why Isn't 'Servant Leadership' More Prevalent?" *Forbes*. Published May 1. www.forbes.com/sites/hbsworkingknowledge/2013/05/01/why-isnt-servant-leadership-more-prevalent/.

Hicks, R., and J. McCracken. 2013. "Popcorn Coaching." *Physician Executive* 102 (1): 85–87.

Hills, C., and G. Jones 2012. *Essentials of Strategic Management,* 3rd ed. Boston: Cengage Learning.

Hindo, B. 2007. "At 3M, a Struggle Between Efficiency and Creativity." Bloomberg. Published June 10. www.bloomberg.com/news/articles/2007-06-10/at-3m-a-struggle-between-efficiency-and-creativity.

Hobby, F. D. 2006. "Diversity's Next Challenge." *Healthcare Financial Management* 60 (5): 106–10.

Hoff, T., H. Pohl, and J. Bartfield. 2006. "Teaching but Not Learning: How Medical Residency Programs Handle Errors." *Journal of Organizational Behavior* 27 (7): 869–96.

Hofstede, G. 1984. *Culture's Consequences: International Differences in Work-Related Values*. Thousand Oaks, CA: Sage.

Hofstede, G., G. J. Hofstede, and M. Minkov. 2010. *Culture and Organizations: Software of the Mind—Intercultural Cooperation and Its Importance for Survival,* 3rd ed. New York: McGraw-Hill.

Hofstede Centre. 2016. "Country Comparison." Accessed May 19. https://geert-hofstede.com/countries.html.

Hoium, T. 2014. "Could Walmart Be the Next Giant Failure in Retail?" Motley Fool. Published February 2. www.fool.com/investing/general/2014/02/02/could-wal-mart-be-the-next-giant-failure-in-retail.aspx.

Holland, K. 2007. "In Mission Statements, Bizspeak and Bromides." *New York Times*. Published September 23. www.nytimes.com/2007/09/23/jobs/23mgmt.html.

Hollander, E. P. 1987. "College and University Leadership from a Social and Psychological Perspective: A Transactional View." Presented at the Invitational Interdisciplinary Colloquium on Leadership in Higher Education, National Center for Postsecondary Governance and Finance, Teacher's College, Columbia University, May.

Hooghe, L. 2001. *The European Commission and the Integration of Europe: Images of Governance*. Cambridge, UK: Cambridge University Press.

Horovitz, B. 2012. "After Gen X, Millennials, What Should Next Generation Be?" *USA Today,* May 4.

Hospital Corporation of America (HCA). 2014. "HCA Ethics & Compliance." Accessed December 3. http://hcaethics.com/.

———. 2005. *The High Performance Facility Study*. Nashville, TN: HCA.

Hospital Employees' Union. 2000. "The Workplace Anti-stress Guide." Accessed February 4, 2015. www.heu.org/sites/default/files/uploads/2008_healthsafety/HEU%20anti-stress%20guide.pdf.

Hospital of the University of Pennsylvania. 2008. "Avoidance of Sexual Harassment in the Workplace." Reviewed April. www.uphs.upenn.edu/pahedu/gme/policies/hr60.pdf.

House, R. 1996. "Path-Goal Theory of Leadership: Lessons, Legacy, and a Reformulated Theory." *Leadership Quarterly* 7 (3): 323–52.

———. 1977. "A 1976 Theory of Charismatic Leadership." In *Leadership: The Cutting Edge,* edited by J. G. Hunt and L. L. Larson, 189–207. Carbondale, IL: Southern Illinois University Press.

Howe, N., and W. Strauss. 2007. "The Next 20 Years: How Customer and Workforce Attitudes Will Evolve." *Harvard Business Review* 85 (7–8): 41–52.

Hughes, R. 2008. *Patient Safety and Quality*. Rockville, MD: Agency for Healthcare Research and Quality.

Hull, P. 2012. "Be Visionary. Think Big." *Forbes*. Published December 19. www.forbes.com/sites/patrickhull/2012/12/19/be-visionary-think-big/.

Hume, M. 2015. "Condensing Six Months of the DeflateGate–Tom Brady–NFL Circus into Five Essential Questions and 25 Links." *Washington Post*. Published July 30. www.washingtonpost.com/news/sports/wp/2015/07/30/condensing-six-months-of-the-deflategate-tom-brady-nfl-circus-into-five-essential-questions-and-25-links/.

Humes, K. R., N. A. Jones, and R. R. Ramirez. 2011. "Overview of Race and Hispanic Origin: 2010." Census brief C2010BR-02. Published March. www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.

Humphrey, S., J. Nahrgang, and F. Morgeson. 2007. "Integrating Motivational, Social, and Contextual Work Design Features: A Meta-analytic Summary and Theoretical Extension of the Work Design Literature." *Journal of Applied Psychology* 92 (5): 1332–56.

Hunink, M. G. M., and P. Glasziou. 2001. *Decision Making in Health and Medicine: Integrating Evidence and Values.* Cambridge, UK: Press Syndicate of the University of Cambridge.

Ice, J. 2007. "Strategic Intent: A Key to Business Strategy Development and Culture Change." *Organization Development Journal* 25 (4): 169–76.

Idris, M. 2011. "Over Time Effects of Role Stress on Psychological Strain Among Malaysian Public University Academics." *International Journal of Business and Social Science* 2 (9): 154–61.

Ingrisano, J. 2011. "Do You Delegate? Take This Self-Quiz!" Freestyle Entrepreneur. Published July 6. www.thefreestyleentrepreneur.com/business-management/do-you-delegate-take-this-self-quiz/.

Institute for Diversity in Health Management (IFD). 2015. "Learning Moments Case Study Template." Accessed September 21. www.diversityconnection.org/diversity

connection/workforce-strategies/case-study/Novant_Health_Learning_Moments_Case_Study.pdf.

Institute for Healthcare Improvement (IHI). 2005. *Going Lean in Health Care*. Accessed November 12, 2015. www.ihi.org/resources/Pages/IHIWhitePapers/GoingLeaninHealthCare.aspx.

Institute of Medicine (IOM). 2013. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Published September 6. http://iom.nationalacademies.org/Reports/2012/Best-Care-at-Lower-Cost-The-Path- to-Continuously-Learning-Health-Care-in-America.aspx.

———. 2002. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Published March. https://iom.nationalacademies.org/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf.

———. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Accessed July 28, 2015. www.nap.edu/read/10027/chapter/1.

Internal Revenue Service (IRS). 2015. "Examples of Healthcare Fraud Investigations—Fiscal Year 2014." Updated September 23. www.irs.gov/uac/Examples-of-Healthcare-Fraud-Investigations-Fiscal-Year-2014.

International Labour Organization (ILO). 2016. "Decent Work." Accessed May 13. www.ilo.org/global/topics/decent-work/lang--en/index.htm.

Investopedia. 2015. "Corporation." Accessed October 5. www.investopedia.com/terms/c/corporation.asp.

———. 2013. "5 Most Publicized Ethics Violations by CEOs." *Forbes*. Published February 5. www.forbes.com/sites/investopedia/2013/02/05/5-most-publicized-ethics-violations-by-ceos/.

Irish Times. 2014. "Van Gaal Laments Lack of Teamwork." Published August 16. www.irishtimes.com/sport/soccer/english-soccer/van-gaal-laments-lack-of-teamwork-1.1899494.

Jackson, E. 2012. "The 7 Reasons Why 360 Degree Feedback Programs Fail." *Forbes*. Published August 17. www.forbes.com/sites/ericjackson/2012/08/17/the-7-reasons-why-360-degree-feedback-programs-fail/.

Jacobsen, D. 2012. "6 Big Mergers That Were Killed by Culture (and How to Stop It from Killing Yours)." Globoforce. Published September 26. www.globoforce.com/gfblog/2012/6-big-mergers-that-were-killed-by-culture/.

James, J. 2013. "A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care." *Journal of Patient Safety* 9 (3): 122–28.

Janus, K. 2014. "The Effect of Professional Culture on Intrinsic Motivation Among Physicians in an Academic Medical Center." *Journal of Healthcare Management* 59 (4): 287–303.

Jarousse, L. 2014. "Transforming Governance: Leading in an Era of Reform." *Hospitals & Health Networks*. Published March 11. www.hhnmag.com/articles/5040-transforming-governance-leading-in-an-era-of-reform.

Jensen, K. 2013. "You Can't 'Win' Negotiations Without Rules of the Game." *Forbes*. Published September 3. www.forbes.com/sites/keldjensen/2013/09/03/you-cant-win-negotiations-without-rules-of-the-game/.

Jessup, R. 2007. "Interdisciplinary Versus Multidisciplinary Care Teams: Do We Understand the Difference?" *Australian Health Review* 32 (3): 330–31.

Johnson & Johnson. 2016. "Our People & Diversity." Updated June 6. www.jnj.com/about-jnj/diversity.

Joint Commission. 2016. "Universal Protocol." Accessed March 22. www.jointcommission.org/standards_information/up.aspx.

Joint Commission Center for Transforming Healthcare. 2016. "Hand-off Communications." Accessed May 11. www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1.

Joint Commission Perspectives. 2012. "Joint Commission Center for Transforming Healthcare Releases Targeted Solutions Tool for Hand-Off Communications." Joint Commission. Published August. www.jointcommission.org/assets/1/6/tst_hoc_persp_08_12.pdf.

Jones, B. 1999. "Bounded Rationality." *Annual Review of Political Science* 2: 297–321.

Jones, C. 2008. "Chief Nursing Officer Retention and Turnover: A Crisis Brewing? Results of a National Survey." *Journal of Healthcare Management* 53 (2): 89–106.

Kane, K. 2010. "Physicians' Top 20 Ethical Dilemmas—Survey Results Slideshow." Medscape Multispecialty. Accessed December 8, 2014. www.medscape.com/features/slideshow/public/ethical-dilemmas.

Kanigel, R. 2005. *The One Best Way: Frederick Winslow Taylor and the Enigma of Efficiency*. Cambridge, MA: MIT Press.

Kaplan, R., and D. Norton 2006. *Alignment: Using the Balanced Scorecard to Create Corporate Synergies*. Boston: Harvard Business Review Press.

Kase, L. 2010. "Great Leaders Are Great Decision-Makers." *Graziadio Business Review* 13 (4): 1–5.

Kastelle, T. 2013. "Hierarchy Is Overrated." *Harvard Business Review*. Published November 20. https://hbr.org/2013/11/hierarchy-is-overrated/.

Katzenbach, J., and D. Smith. 2005. "The Discipline of Teams." *Harvard Business Review* 83 (7–8): 162–71.

Kelly, C. 2012. "O.K., Google, Take a Deep Breath." *New York Times*. Published April 28. www.nytimes.com/2012/04/29/technology/google-course-asks-employees-to-take-a-deep-breath.html.

Kim, W. C. and R. Mauborgne. 2014. "Blue Ocean Leadership." *Harvard Business Review* 92 (5): 60–72.

Kimberly, J., and M. Evanisko. 1981. "Organizational Innovation: The Influence of Individual, Organizational, and Contextual Factors on Hospital Adoption of Technological and Administrative Innovations." *Academy of Management Journal* 24 (4): 689–713.

King, D., and S. Demarie. 2014. "Tuning Up Organizational Culture." *Industrial Engineer* 46 (11): 26–30.

Knowlton, S. 2016. "The Positive Effects of Stress." Accessed May 14. www.healthguidance.org/entry/15537/1/The-Positive-Effects-of-Stress.html.

Kocken, M. 2014. "Seven Reasons Why Korea Has the Worst Productivity in the OECD." *BusinessKorea*. Published March 17. www.businesskorea.co.kr/article/3698/insider-perspective-seven-reasons-why-korea-has-worst-productivity-oecd.

Kohn, A. 1993. "Why Incentives Plans Cannot Work." *Harvard Business Review*. Published September–October. https://hbr.org/1993/09/why- incentive-plans-cannot-work.

Koonce, R. 2010. "Executive Coaching: Leadership Development in the Federal Government." *Public Manager* 39 (2): 44–51.

Koontz, H., and H. Weihrich. 2010. *Essentials of Management,* 8th ed. New York: McGraw-Hill.

Korea Times. 2015. "Thou Shalt Not Stretch During National Anthem! LG Cuts Leading Scorer in Middle of Playoffs." Published March 20. www.koreatimesus.com/thou-shalt-not-stretch-during-national-anthem-lg-cuts-leagues-top-scorer-in-middle-of-playoffs/.

Kotter, J., and H. Rathgeber. 2006. *Our Iceberg Is Melting: Changing and Succeeding Under Any Conditions*. New York: St. Martin's Press.

Kouzes, J., and B. Posner. 2006. *Leadership Legacy*. San Francisco: Jossey-Bass.

Kovner, A., and J. Knickman. 2011. *Health Care Delivery in the United States*. New York: Springer.

Kreitz, P. A. 2008. "Best Practices for Managing Organizational Diversity." *Journal of Academic Librarianship* 34 (2): 101–20.

Krivis, J. 2006. *Improvisational Negotiation: A Mediator's Story*. San Francisco: Jossey-Bass.

Kuhn, T. 2012. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

Kumar, K., A. Bakhshi, and E. Rani. 2009. "Organizational Justice Perceptions as a Predictor of Job Satisfaction and Organizational Commitment." *IUP Journal of Management Research* 8 (10): 24–37.

Kumar, R. 2010. *Basic Business Communication*. New Delhi: Excel.

LaCharity, L., C. Kumagai, and B. Bartz. 2014. *Prioritization, Delegation, and Assignment: Practice Exercises for the NCLEX Examination*. St. Louis, MO: Elsevier.

Lamoureux, K. 2007. "Changing the Way Top Talent Is Managed in Healthcare." Bersin & Associates. Published February 25. www.bersin.com/Practice/Detail.aspx?id=4978.

Lawrence, P., and J. Lorsch. 1967. "Differentiation and Integration in Complex Organizations." *Administrative Science Quarterly* 12 (1): 1–47.

Lazarus, I., and D. Fell. 2011. "Innovation or Stagnation? Crossing the Creativity Gap in Healthcare." *Journal of Healthcare Management* 56 (6): 363–67.

Leadership Paradigms. 2009. "Storytelling as Socializing." Accessed June 16, 2016. www.leadershipparadigms.com/docs/TELLME.PDF.

Leary, K., J. Pillemer, and M. Wheeler. 2013. "Negotiating with Emotion." *Harvard Business Review* 91 (1–2): 96–103.

Lee, E., and E. Emanuel. 2013. "Shared Decision Making to Improve Care and Reduce Costs." *New England Journal of Medicine* 368 (1): 6–8.

Lepsinger, R., and A. Lucia. 2009. *The Art and Science of 360 Degree Feedback*. San Francisco: Jossey-Bass.

Lester, P., S. Hannah, P. Harms, G. Vogelgesang, and B. Avolio. 2011. "Mentoring Impact on Leader Efficacy Development." *Academy of Management Learning & Education* 10 (3): 409–29.

Levi, D. 2011. *Group Dynamics for Teams*. Thousand Oaks, CA: Sage.

Lewis, E., D. Romanaggi, and A. Chapple. 2010. "Successfully Managing Change During Uncertain Times." *Strategic HR Review* 9 (2): 12–18.

Liedtke, M. 2009. "Tough Times Turning Newspaper Lenders into Owners." *Huffington Post*. Published November 29. www.huffingtonpost.com/2009/11/29/tough-times-turning-newsp_n_373166.html.

LifePoint Health. 2015. "Mission, Vision & Values." Accessed November 2. www.lifepointhealth.net/about-lifepoint/mission-vision-values.

Lindblom, C. E. 1994. "Modes of Inquiry." *Journal of Public Administration Research and Theory* 4 (3): 327–43.

Lipman, V. 2013. "The Secret to Effective Delegation." *Forbes*. Published June 3. www.forbes.com/sites/victorlipman/2013/06/03/the-secret-to-effective-delegation/.

———. 2012. "The Pros and Cons of Forced Rankings: A Manager's Perspective." *Forbes*. Published July 19. www.forbes.com/sites/victorlipman/2012/07/19/the-pros-and-cons-of-forced-rankings-a-managers-perspective/.

Lipsky, D., and A. Avgar. 2010. "The Conflict over Conflict Management." *Dispute Resolution Journal* 65 (2–3): 11–43.

Lobach, D., G. Sanders, T. Bright, A. Wong, R. Dhurjati, E. Bristow, L. Bastian, R. Coeytaux, G. Samsa, V. Hasselblad, J. Williams, L. Wing, M. Musty, and A. Kendrick. 2012. *Enabling Health Care Decision Making Through Clinical Decision Support and Knowledge Management*. Agency for Healthcare Research and Quality. Published April. www.ncbi.nlm.nih.gov/books/NBK97318/.

Locke, E. 1968. "Toward a Theory of Task Motivation and Incentives." *Organizational Behavior and Human Performance* 3 (2): 157–89.

Lorenzetti, L. 2015. "The 10 Biggest Health-Care Companies in the Fortune 500." *Fortune*. Published June 20. http://fortune.com/2015/06/20/ fortune-500-biggest-healthcare-companies/.

Luke, R., S. Walston, and P. Plummer. 2004. *Healthcare Strategy: In Pursuit of Competitive Advantage*. Chicago: Health Administration Press.

Lundy, O., and A. Cowling. 1996. *Strategic Human Resource Management*. London: Routledge.

Lunenburg, F. 2010. "Communication: The Process, Barriers and Improving Effectiveness." *Schooling* 1 (1): 1–11.

Lussier, R. 2012. *Management Fundamentals: Concepts, Applications, Skill Development*. Mason, OH: Cengage Learning South-Western.

Lutz, A. 2014. "Costco's Simple Strategy for Outperforming Walmart and Target." *Business Insider*. Published September 30. www.businessinsider.com/costcos-simple-strategy-2014-9.

Madden, M. 2015. "Soft-Leadership Competencies for Today's Healthcare Finance Executives." *Healthcare Financial Management* 69 (5): 42–45.

"madwife2002." 2011. "Micro-management = Poor Morale and Feelings of Negativity." Allnurses. Published September 25. http://allnurses.com/general-nursing-discussion/micro-management-poor-621187.html.

Malhotra, Y. 1996. "Organizational Learning and Learning Organizations: An Overview." Accessed March 29, 2016. www.brint.com/papers/orglrng.htm.

Managed Care Outlook. 2014. "Report Shows Dramatic Increase in Hospital CEO Turnover Rate in 2013." *Managed Care Outlook* 27 (7): 1–9.

Mancino, D. M. 2012. *Taxation of Hospitals and Health Care Organizations,* 2nd ed. Albany, NY: Matthew Bender.

Mandy, A., C. Milton, and P. Mandy. 2004. "Professional Stereotyping and Interpersonal Education." *Learning in Health and Social Care* 3 (3): 154–70.

Mannion, L. 2004. *Employee Assistance Programs: What Works and What Doesn't*. Westport, CT: Praeger.

Marcus, L. J. 1995. *Renegotiating Health Care*. San Francisco: Jossey-Bass.

Markey, D. W., and R. J. Brown. 2002. "An Interdisciplinary Approach to Addressing Patient Activity and Mobility in the Medical-Surgical Patient." *Journal of Nursing Care Quality* 16 (4): 1–12.

Marrone, S. 2007. "Understanding Barriers to Healthcare: A Review of Disparities in Health Care Services Among Indigenous Populations." *International Journal of Circumpolar Health* 66 (3): 188–98.

Maruthappu, M., R. Ologunde, and A. Gunarajasingam. 2013. "Is Health Care a Right? Health Reforms in the USA and Their Impact upon the Concept of Care." *Annals of Medicine and Surgery* 2 (1): 15–17.

Massachusetts Institute of Technology (MIT). 2010. "Collective Intelligence: Number of Women in Group Linked to Effectiveness in Solving Difficult Problems." *ScienceDaily*. Published October 2. www.sciencedaily.com/releases/2010/09/100930143339.htm.

Mathis, R., J. Jackson, and S. Valentine. 2014. *Human Resource Management,* 14th ed. Boston: Cengage Learning.

Maurer, R. 2009. "What's Happening These Days with Change?" *Journal for Quality and Participation* 32 (2): 56–66.

Maxfield, D., J. Grenny, R. Lavandero, and L. Groah. 2015. "The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives." Accessed July 23. www.aacn.org/wd/hwe/docs/the-silent-treatment.pdf.

Maylett, T., and J. Riboldi. 2007. "Using 360 Feedback to Predict Performance." *T & D* 61 (9): 48–52.

Mayo Clinic. 2015. "Mayo Clinic Mission and Values." Accessed October 29. www.mayoclinic.org/about-mayo-clinic/mission-values.

McAlearney, A. 2008. "Using Leadership Development Programs to Improve Quality and Efficiency in Healthcare." *Journal of Healthcare Management* 55 (5): 319–32.

McCain, J. 2005. "The Future of Gene Therapy." Published June. www.ncbi.nlm.nih.gov/pmc/articles/PMC3564347/.

McGregor, J. 2016. "This Big Change Was Supposed to Make Performance Reviews Better. Could It Be Making Them Worse?" *Washington Post*. Published June 7. www.washingtonpost.com/news/on-leadership/wp/2016/06/07/this-big-change-was-supposed-to-make-performance-reviews-better-could-it-be-making-them-worse/.

———. 2015. "What If You Could Replace Performance Evaluations with Four Simple Questions?" *Washington Post*. Published March 17. www.washingtonpost.com/blogs/on-leadership/wp/2015/03/17/deloitte-ditches-performance-rankings-and-instead-will-ask-four-simple-questions/.

McKinsey & Company. 2014. "Moving Mind-Sets on Gender Diversity: McKinsey Global Survey Results." Published January. www.mckinsey.com/insights/organization/moving_mind-sets_on_gender_diversity_mckinsey_global_survey_results.

———. 2009. "Flaws in Strategic Decision Making: McKinsey Global Survey Results." Published January. www.mckinsey.com/insights/strategy/flaws_in_strategic_decision_making_mckinsey_global_survey_results.

Mellman, D., and E. Dauer. 2007. "Negotiation: The CMO's Indispensable Skill." *Physician Executive* 33 (4): 48–51.

Mercy Health. 2015. "Organisational Structure." Published April. www.mercyhealth.com.au/au/ourorganisation/Pages/Organisational%20Structure.aspx.

Merriam-Webster. 2016. "Negotiation." *Learner's Dictionary*. Accessed June 7. www.learnersdictionary.com/definition/negotiation.

———. 2015a. "Conflict." Accessed September 21. www.merriam-webster.com/dictionary/conflict.

———. 2015b. "Delegation." Accessed April 8. www.merriam-webster.com/dictionary/delegation.

Meyer, J., and L. Herscovitch. 2001. "Commitment in the Workplace: Toward a General Model." *Human Resource Management Review* 11 (3): 299–326.

MHA Keystone Center. 2015. "A Road Map to Patient and Family Engagement: Recommended Policies & Practices for Hospitals." Revised August. www.mha.org/keystone_center/docs/pfe_roadmap.pdf.

Mihm, J. C. 2003. "Human Capital—Success Planning and Management Is Critical Driver of Organizational Transformation." Testimony before the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform. Washington, DC: US Government Accountability Office.

Mind Tools. 2016. "How Good Are Your Communication Skills? Speaking, Listening, Writing, and Reading Effectively." Accessed June 6. www.mindtools.com/pages/article/newCS_99.htm.

Mintzberg, H. 1979. *The Structuring of Organizations*. Englewood Cliffs, NJ: Prentice-Hall.

———. 1973. *The Nature of Managerial Work*. New York: Harper & Row.

Mooney, J., and A. Reiley. 1939. *The Principles of Organization*. New York: Harper & Brothers.

Morgan, G. 1996. *Images of Organization,* 2nd ed. Thousand Oaks, CA: Sage.

Mullen, J. 2014. "Korean Air Executive to Quit Remaining Posts After Nuts Scandal." CNN. Published December 12. http://edition.cnn.com/2014/12/12/world/asia/korean-air-nuts-scandal/.

Myatt, M. 2012a. "5 Keys of Dealing with Workplace Conflict." *Forbes*. Published February 22. www.forbes.com/sites/mikemyatt/2012/ 02/22/5-keys-to-dealing-with-workplace-conflict/.

———. 2012b. "6 Tips for Making Better Decisions." *Forbes*. Published March 28. www.forbes.com/sites/mikemyatt/2012/03/28/6-tips-for-making- better-decisions/

———. 2012c. "10 Communication Secrets of Great Leaders." *Forbes*. Published April 4. www.forbes.com/sites/mikemyatt/2012/04/04/10-communication-secrets-of-great-leaders/.

Nelson, D., and J. Campbell. 2012. *Organizational Behavior: Science, the Real World and You,* 8th ed. Mason, OH: South-Western.

Nelson, W., and P. Gardent. 2011. "Organizational Values Statements." *Healthcare Executive* 26 (2): 56–59.

Nembhard, I., and A. Edmondson. 2006. "Making It Safe: The Effects of Leader Inclusiveness and Professional Status on Psychological Safety and Improvement Efforts in Health Care Teams." *Journal of Organizational Behavior* 27 (7): 941–66.

News-Medical.net. 2011. "Study on 'Health Halo Effect.'" Published April 11. www.news-medical.net/news/20110411/Study-on-health-halo-effect.aspx.

Nitin, N., B. Groysberg, and L. Lee. 2008. "Employee Motivation: A Powerful New Model." *Harvard Business Review*. Published July/August. https://hbr.org/2008/07/employee-motivation-a-powerful-new-model.

North, M., and C. Coors. 2010. "Avoiding Death by the Dotted Line." *Healthcare Financial Management* 65 (1): 120–21.

Northeast Institute for Quality Community Action (NIQCA). 2016. "Draft Nepotism Policy." Accessed June 15. www.niqca.org/documents/Draft_Nepotism_Policy.pdf.

Northouse, P. 2007. *Leadership Theory and Practice,* 4th ed. Thousand Oaks, CA: Sage.

Novartis. 2015. "Our Mission and Vision." Accessed October 30. www.novartis.com/about-us/who-we-are/our-mission.

Nursing Times. 2011. "What's Your Negotiation Style?" Published August 31. www.nursingtimes.net/quiz-yourself-whats-your-negotiation-style/5032100.fullarticle.

O'Connor, K., J. Arnold, and A. Maurizio. 2010. "The Prospect of Negotiating: Stress, Cognitive Appraisal, and Performance." *Journal of Experimental Social Psychology* 46 (5): 729–35.

Oertig, M., and T. Buergi. 2006. "The Challenges of Managing Cross-Cultural Virtual Project Teams." *Team Performance Management* 12 (1–2): 23–30.

Office of Inspector General (OIG), US Department of Health and Human Services. 2016. "Compliance 101." Accessed May 12. http://oig.hhs.gov/compliance/101/.

Office of Inspector General (OIG), US Department of Veterans Affairs. 2015. "Major Management Challenges." Accessed June 8, 2016. www.va.gov/oig/pubs/VAOIG-2015-MMC.pdf.

Office of Minority Health, US Department of Health and Human Services. 2016. "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care." Accessed June 7. www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf.

O'Hara, C. 2015. "How to Negotiate Nicely Without Being a Pushover." *Harvard Business Review*. Published April 9. https://hbr.org/2015/04/how-to-negotiate-nicely-without-being-a-pushover.

Omachonu, V., and N. Einspruch. 2010. "Innovation in Healthcare Delivery Systems: A Conceptual Framework." *Public Sector Innovation Journal* 15 (1): 1–20.

Orentlicher, D. 2012. "Rights to Healthcare in the United States: Inherently Unstable." *American Journal of Law & Medicine* 38 (2–3): 326–47.

Osland, J., D. Kolb, I. Rubin, and M. Turner. 2007. *Organizational Behavior: An Experiential Approach*. Upper Saddle River, NJ: Prentice-Hall.

Overvold, G. 1987. "The Imperative of Organizational Harmony: A Critique of Contemporary Human Relations Theory." *Journal of Business Ethics* 6 (7): 559–65.

Paetz, P. 2014. *Disruption by Design*. New York: Apress.

Pal, N. 2008. *From Strategy to Execution: Turning Accelerated Global Change into Opportunity*. New York: Springer.

Pant, J., and V. Vijaya. 2015. "Challenges in Diversity Management: A Case Study of MediHealth Systems." *South Asian Journal of Management* 22 (1): 159–86.

Parameswaran, L., and J. Raijmakers. 2010. "People-Focused Innovation in Healthcare." Accessed August 3, 2015. www.design.philips.com/philips/shared/assets/design_assets/pdf/nvbD/july2010/people_focused_innovation_in_healthcare.pdf.

Park Scholarships. 2015. "Why People Don't Delegate." Accessed April 10. www.ncsu.edu/project/parkprgrd/PSTrainingModules/delegating/del12frame.htm. Parker, S. 2014. "Beyond Motivation: Job and Work Design for Development, Health, Ambidexterity, and More." *Annual Review of Psychology* 65 (1): 661–91.

Parsons, H. M. 1974. "What Happened at Hawthorne?" *Science* 183 (4128): 922–32.

Patnaik, J. 2011. "Role of Work Culture in Improving Organizational Health." *Amity Journal of Applied Psychology* 2 (1): 40–48.

Patrick, H., and V. Kumar. 2012. "Managing Workplace Diversity: Issues and Challenges." *SAGE Open* (April–June): 1–15.

Patterson, K., J. Grenny, R. McMillan, and A. Switzler. 2012. *Crucial Conversations: Tools for Talking When the Stakes Are High,* 2nd ed. New York: McGraw-Hill.

Patton, C. M. 2014. "Conflict in Health Care: A Literature Review." *Internet Journal of Healthcare Administration* 9 (1). http://ispub.com/UHCA/9/1/20081.

Pauly, M. V. 2011. "The Trade-Off Among Quality, Quantity, and Cost: How to Make It—If We Must." *Health Affairs* 30 (4): 574–80.

Pearce, C. 2006. "Ten Steps to Effective Delegation." *Nursing Management* 13 (8): 19.

Pearce, C. L., Y. Yoo, and M. Alavi. 2004. "Leadership, Social Work, and Virtual Teams: The Relative Influence of Vertical Versus Shared Leadership in the Nonprofit Sector." In *Improving Leadership in Nonprofit Organizations*, edited by R. E. Riggio and S. S. Orr, 180–203. San Francisco: Jossey-Bass.

Pearson, M. 2014. "The VA's Troubled History." Published May 30. www.cnn.com/2014/05/23/politics/va-scandals-timeline/.

Pedersen, P., K. Miloch, and P. Laucella. 2007. *Strategic Sport Communication*. Champaign, IL: Sheridan.

Pentland, A. 2012. "The New Science of Building Great Teams." *Harvard Business Review* 90 (4): 60–70.

Persily, C. 2013. *Team Leadership and Partnering in Nursing and Health Care*. New York: Springer.

Peters, T., and R. Waterman. 1982. *In Search of Excellence: Lessons from America's Best Run Companies*. New York: Harper & Row.

Petersen, D., J. Finnegan, and H. Spencer. 2015. "Anticipating Change, Sparking Innovation: Framing the Future." *American Journal of Public Health* 105 (Suppl. 1): S46–S49.

Pfeffer, J. 1997. *New Directions for Organization Theory: Problems and Prospects*. Oxford, UK: Oxford University Press.

———. 1982. *Organizations and Organization Theory*. Marshfield, MA: Pitman.

Phelan, P. 2001. "Improving the Quality of Health-Care: Personal Reflections on Some Opportunities and Impediments." *Journal of Quality in Clinical Practice* 21 (1–2): 34–36.

Pinder, C. 2008. *Work Motivation in Organizational Behavior*, 2nd ed. New York: Psychology Press.

Pingdom. 2012. "The iPad Halo Effect—a Coming Boost for Apple." Published August 3. http://royal.pingdom.com/2012/08/03/ipad-halo-effect/.

Piper, C. 2016. *Healthcare Fraud Investigation Guidebook*. Boca Raton, FL: CRC Press.

Porter, R., and J. Kaplan. 2011. *The Merck Manual of Diagnosis and Therapy*. Whitehouse Station, NJ: Merck Sharp & Dohme.

Porter-O'Grady, T., and K. Malloch. 2016. *Leadership in Nursing Practice: Changing the Landscape of Health Care*. Burlington, MA: Jones & Bartlett Learning.

Prenestini, L. 2013. "Do Senior Management Cultures Affect Performance?" *Journal of Healthcare Management* 58 (5): 336–51.

PRNewswire. 2006. "HCA Reports Fourth Quarter and 2005 Results." Published February 1. http://phx.corporate-ir.net/phoenix.zhtml?c=63489&p= irol-newsArticle&ID=811155.

Pugh, D., and D. Hickson. 1993. *Great Writers on Organizations*. Aldershot, UK: Dartmouth.

Pulakos, E. 2004. *Performance Management: A Roadmap for Developing, Implementing, and Evaluating Performance Management Systems*. SHRM Foundation. Accessed April 14, 2015. www.shrm.org/india/hr-topics-and-strategy/performance-management/creating-high-performance-culture/Documents/Performance%20Management.pdf.

Putre, L. 2013. "Generations in the Workplace: Who Will Lead Your Hospital?" *Hospitals & Health Networks*. Published May 5. www.hhnmag.com/articles/5922-generations-in-the-workplace-who-will-lead-your-hospital.

Quednau, R. 2015. "The Other Problem with Walmart." Strong Towns. Published February 25. www.strongtowns.org/journal/2015/2/23/the-other-problem-with-walmart.

Quester, P., R. McGuiggan, W. Perreault, and J. McCarthy. 2007. *Marketing: Creating and Delivering Value,* 5th ed. North Ryde, Australia: McGraw-Hill/Irwin.

Rahim, M. A. 2011. *Managing Conflict in Organizations*, 4th ed. New Brunswick, NJ: Transaction.

Ramos, A. 1978. "Misplacement of Concepts and Administrative Theory." *Public Administration Review* 38 (6): 550–57.

Raps, A. 2004. "Implementing Strategy." *Strategic Finance* 85 (12): 49–53.

Ratnapalan, S., and E. Uleryk. 2014. "Organizational Learning in Health Care Organizations." *Systems* 2 (1): 24–33.

Redd, S., and A. Mintz. 2013. "Policy Perspectives on National Security and Foreign Policy Decision Making." *Policy Studies Journal* 41 (Suppl. 1): S11–S37.

Reilly, M., and D. Markenson. 2010. *Health Care Emergency Management: Principles and Practice*. Burlington, MA: Jones & Bartlett Learning.

Remland, M. 1981. "Developing Leadership Skills in Nonverbal Communication." *Journal of Business Communication* 18 (3): 17–29.

Richardson, B. 2015. "IG Probes Uncover More Problems at VA Hospitals." *The Hill*. Published October 30. http://thehill.com/policy/defense/258652-ig-probes-uncover-more-problems-at-va-hospitals.

Richman, J., K. Rospenda, S. Nawyn, J. Flaherty, M. Fendrich, M. Drum, and T. Johnson. 1999. "Sexual Harassment and Generalized Workplace Abuse Among University Employees: Prevalence and Mental Health Correlates." *American Journal of Public Health* 89 (3): 358–63.

Richter, P., J. Peiro, and W. Schaufeli (eds.). 2007. *Psychosocial Resources in Health Care Systems*. Munich, Germany: Rainer Hampp Verlag.

Ricks, T. E. 2013. *The Generals: American Military Command from World War II to Today*. New York: Penguin.

Roan, D., and M. Slater. 2015. "Lance Armstrong: I'd Change the Man, Not the Decision to Cheat." BBC Sports. Published January 26. www.bbc.com/sport/0/cycling/30981609.

Robbins, S., R. Bergman, I. Staff, and M. Coulter. 2014. *Management*. New York: Pearson Education.

Robeznieks, A. 2014. "Team Training Takes Off as Providers Prepare for Coordinated Care." *Modern Healthcare* 44 (20): 8–9.

Roesch, S., B. Weiner, and A. Vaughn. 2002. "Cognitive Approaches to Stress and Coping." *Current Opinion in Psychiatry* 15 (6): 627–32.

Ronning, P. 2010. "ACOs: Preparing for Medicare's Shared Savings Program." *Healthcare Financial Management* 64 (8): 46–51.

Rosen, C., P. Levy, and R. Hall. 2006. "Placing Perceptions of Politics in the Context of the Feedback Environment, Employee Attitudes, and Job Performance." *Journal of Applied Psychology* 91 (1): 211–20.

Rosenthal, A. J. 2012. "4 Consumer-Focused Revolutions That Will Change Health Care." Fast Company. Published April 24. www.fastcoexist.com/1679724/4-consumer-focused-revolutions-that-will-change-health-care.

Rosenthal, N. 2012. "10 Ways to Enhance Your Emotional Intelligence." *Psychology Today*. Published January 5. www.psychologytoday.com/blog/your-mind-your-body/201201/10-ways-enhance-your-emotional-intelligence.

Rowe, G. 2001. "Creating Wealth in Organizations: The Role of Strategic Leadership." *Academy of Management Executive* 15 (1): 81–94.

Rowe, G., and M. Nejad. 2009. "Strategic Leadership: Short-Term Stability and Long-Term Viability." *Ivey Business Journal*. Published September/October. http://iveybusinessjournal.com/publication/strategic-leadership-short-term-stability-and-long-term-viability/.

Rowe, M. 2001. "Two Dollar Game." Accessed June 7, 2016. http://ocw.mit.edu/courses/sloan-school-of-management/15-667-negotiation-and-conflict-management-spring-2001/lecture-notes/about_game.pdf.

Rozanski, A., J. Blumenthal, and J. Kaplan. 1999. "Impact of Psychological Factors on the Pathogenesis of Cardiovascular Disease and Implications for Therapy." *Circulation* 99 (16): 2192–217.

Rue, L. W., and L. Byars. 2009. *Management Skills and Application*. New York: McGraw-Hill/Irwin.

Runde, C., and T. Flanagan. 2013. *Becoming a Conflict Competent Leader*. San Francisco: Jossey-Bass.

Russell, R., and A. G. Stone. 2002. "A Review of Servant Leadership Attributes: Developing a Practical Model." *Leadership & Organization Development Journal* 23 (3): 145–57.

Rust, G., D. Satcher, G. Fryer, R. Levine, and D. Blumenthal. 2010. "Triangulating on Success: Innovation, Public Health, Medical Care, and Cause-Specific US Mortality Rates over a Half Century." *American Journal of Public Health* 100 (51): S95–S104.

Ryan, R., and E. Deci. 2000. "Intrinsic and Extrinsic Motivations: Classic Definitions and New Directions." *Contemporary Educational Psychology* 25 (1): 54–67.

Sahni, P., and E. Vayunandan. 2010. *Administrative Theory*. New Delhi, India: PHI Learning.

Saint Louis University. 2016. "Staff Job Composite: Staff Nurse." Accessed May 12. www.slu.edu/jobs/job_description.php?d=858jd.

Salas, E., and K. Frush. 2013. *Improving Patient Safety Through Teamwork and Team Training*. New York: Oxford University Press.

Salin, D. 2009. "Organizational Responses to Workplace Harassment: An Exploratory Study." *Personnel Review* 38 (1): 26–44.

Sanderson, R., and M. Pugliese. 2012. *Beyond Naivete: Ethics, Economics, and Values*. Lanham, MD: University Press of America.

Santamour, B. 2011. "Meet Our New CEO. Oops, Too Late." *Hospitals & Health Networks Daily*. Published April 26. www.hhnmag.com/articles/4905-meet-our-new-ceo-oops-too-late.

Saporito, B. 2013. "The Trouble Lurking on Walmart's Empty Shelves." *Time*. Published April 9. http://business.time.com/2013/04/09/the-trouble-lurking-on-walmarts-empty-shelves/.

Sapru, R. 2010. *Administrative Theories and Management Thought*. New Delhi, India: PHI Learning.

Sarfraz, J. 2011. "Five Contributing Disciplines to the Organizational Behavior." Management Sea. Accessed July 28, 2014. www.managementsea.com/five-contributing-disciplines-to-the-organizational-behavior/#.U9cXwfldU7c.

Sashkin, M. 2004. "Transformational Leadership Approaches." In *The Nature of Leadership,* edited by J. Antonakis, A. Cianciolo, and R. Sternberg, 171–96. Thousand Oaks, CA: Sage.

Schein, E. H. 2010. *Organizational Culture and Leadership,* 4th ed. San Francisco: Jossey-Bass.

———. 1984. "Coming to a New Awareness of Organizational Culture." *Sloan Management Review* 25 (2): 3–16.

Schilling, J., and A. Kluge. 2009. "Barriers to Organizational Learning: An Integration of Theory and Research." *International Journal of Management Reviews* 11 (3): 337–60.

Scholtes, P., B. Joiner, and B. Streibel. 2000. *The Team Handbook*. Madison, WI: Oriel.

Schraeder, M., and M. Jordan. 2011. "Managing Performance: A Practical Perspective on Managing Employee Performance." *Journal for Quality and Participation* 34 (2): 4–10.

Schriesheim, C., and S. Kerr. 1976. "Theories and Measures of Leadership: A Critical Appraisal of Current and Future Directions." In *Leadership: The Cutting Edge*, edited by J. G. Hunt and L. L. Larson, 9–56. Carbondale, IL: Southern Illinois University Press.

Schyve, P. M. 2009. "Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards." The Governance Institute. Accessed May 19, 2016. www.jointcommission.org/assets/1/18/wp_leadership_standards.pdf.

Scivicque, C. 2012. "Are You a Team Player?" Eat Your Career. Published August 31. www.eatyourcareer.com/2012/08/quiz-are-you-a-team-player.

Scott, W. R. 2002. *Organizations: Rational, Natural, and Open Systems*. Upper Saddle River, NJ: Prentice-Hall.

Seaward, B. 2014. *Essentials of Managing Stress*. Burlington, MA: Jones & Bartlett Learning.

See, K., E. Morrison, N. Rothman, and J. Soll. 2011. "The Detrimental Effects of Power on Confidence, Advice Taking, and Accuracy." *Organizational Behavior and Human Decision Processes* 116 (2): 272–85.

Seidman, D. 2012. "(Almost) Everything We Think About Employee Engagement Is Wrong." *Forbes*. Published September 20. www.forbes.com/sites/dovseidman/2012/09/20/everything-we-think-about-employee-engagement-is-wrong/.

Senge, P. 2006. *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday.

Sexton, D., C. Lemak, and J. Wainio. 2014. "Career Inflection Points of Women Who Successfully Achieved the Hospital CEO Position." *Journal of Healthcare Management* 59 (5): 367–83.

Shamir, B., R. J. House, and M. B. Arthur. 1993. "The Motivational Effects of Charismatic Leadership: A Self-Concept Based Theory." *Organizational Science* 4 (4): 577–94.

Shanafelt, T., S. Boone, L. Tan, L. Dyrbye, W. Sotile, D. Satele, C. West, J. Sloan, and M. Oreskovich. 2012. "Burnout and Satisfaction with Work–Life Balance Among US Physicians Relative to the General US Population." *JAMA Internal Medicine* 172 (18): 1377–85.

Shaver, P., J. Schwartz, D. Kirson, and C. O'Connor. 2001. "Emotional Knowledge: Further Exploration of a Prototype Approach." In *Emotions in Social Psychology: Essential Readings,* edited by G. Parrott, 26–56. Philadelphia, PA: Psychology Press.

Sherman, A. 2014. "Rick Scott 'Oversaw the Largest Medicare Fraud' in U.S. History, Florida Democratic Party Says." PolitiFact. Published March 3. www.politifact.com/florida/statements/2014/mar/03/florida-democratic-party/rick-scott-rick-scott-oversaw-largest-medicare-fra/.

Sherman, E. 2010. "Blockbuster's Plight Exposes a Broader Corporate Creativity Problem." *CBS Money Watch*. Published September 23. www.cbsnews.com/8301-505124_162-43445681/blockbusters-plight-exposes-a-broader-corporate-creativity-problem-update/.

Sherwood, R. 2013. "Employee Engagement Drives Health Care Quality and Financial Returns." *Harvard Business Review*. Published October 30. https://hbr.org/2013/10/employee-engagement-drives-health-care-quality-and-financial-returns.

Shin, D., and R. Strausz. 2014. "Delegation and Dynamic Incentives." *Rand Journal of Economics* 45 (3): 495–520.

Shook, J. 2010. "How to Change a Culture: Lessons from NUMMI." *MIT Sloan Management Review* 51 (2): 63–68.

Shteingart, H., T. Neiman, and Y. Loewenstein. 2013. "The Role of First Impression in Operant Learning." *Journal of Experimental Psychology* 142 (2): 476–88.

Shultz, K., M. Wang, and D. Olson. 2009. "Role Overload and Underload in Relation to Occupational Stress and Health." *Stress and Health* 28 (2): 99–111.

Sias, P. M. 2008. "Peer Coworker Relationships." In *Organizing Relationships: Traditional and Emerging Perspectives on Workplace Relationships*. Thousand Oaks, CA: Sage.

Silverthorne, C., and T. Wang. 2001. "Situational Leadership Style as a Predictor of Success and Productivity Among Taiwanese Business Organizations." *Journal of Psychology* 135 (4): 399–412.

Simon, H. A. 1976. *Administrative Behavior*. New York: Free Press.

Simons, D. 2011. "Seeing the World as It Isn't." Posted March 19. http://tedxtalks.ted.com/video/TEDxUIUC-Daniel-Simons-Seeing-T.

Simons, J., S. Dewitte, and W. Lens. 2004. "The Role of Different Types of Instrumentality in Motivation, Study Strategies, and Performance." *British Journal of Educational Psychology* 74: 343–60.

Sloan, S., and R. Fralicx. 2011. "Is There a Leader in the House?" *Hospitals & Health Networks*. Published August 11. www.hhnmag.com/articles/4860-is-there-a-leader-in-the-house.

Sperling, J., C. Marcati, and M. Rennie. 2014. *GCC Women in Leadership—from the First to the Norm*. McKinsey & Company. Published July. www.mckinsey.com/global-locations/europe-and-middleeast/middle-east/en/gcc-women-in-leadership.

Spiegelman, P., and B. Berrett. 2013. *Patients Come Second: Leading Change by Changing the Way You Lead*. New York: An Inc. Original.

Stefl, M. E. 2008. "Common Competencies for All Healthcare Managers: The Healthcare Leadership Alliance Model." *Journal of Healthcare Management* 53 (6): 360–73.

Sterbenz, C. 2015. "Here's Who Comes After Generation Z—and They'll Be the Most Transformative Age Group Ever." *Business Insider*. Published December 5. www.businessinsider.com/generation-alpha-2014-7-2.

Stevens, G., and G. Frazer. 2005. "Coaching: The Missing Ingredient in Blended Learning Strategy." *Performance Improvement* 44 (8): 8–13.

Stogdill, R. M. 1948. "Personal Factors Associated with Leadership: A Survey of the Literature." *Journal of Psychology* 25: 35–71.

Stoner, C., and R. Hartman. 1993. "Team Building: Answering the Tough Questions." *Business Horizons* 36 (5): 70–78.

Stout-Rostron, S. 2014. *Business Coaching International: Transforming Individuals and Organizations,* 2nd ed. London: Karmac.

Strickler, J. 2006. "What Really Motivates People?" *Journal for Quality and Participation* 29 (1): 26–28.

Strong Memorial Hospital. 2014. "Mission & Vision." Accessed October 16. www.urmc.rochester.edu/strong-memorial/about-us/mission-vision.aspx.

Sullivan, J. 2011. "The Top 50 Problems with Performance Appraisals." ERE Media. Published January 31. www.eremedia.com/tlnt/the-top-50-problems-with-performance-appraisals/.

Sullivan, J. J. 1989. "Self Theories and Employee Motivation." *Journal of Management* 15 (2): 345–63.

Sussman, A. J., J. R. Otten, R. C. Goldszer, M. Hanson, D. J. Trull, K. Paulus, M. Brown, V. Dzau, and T. A. Brennan. 2005. "Integration of an Academic Medical Center and a Community Hospital: The Brigham and Women's/Faulkner Hospital Experience." *Academic Medicine.* Published March. http://journals.lww.com/academicmedicine/documents/sussman.pdf.

Syptak, J., D. Marsland, and D. Ulmer. 1999. "Job Satisfaction: Putting Theory into Practice." *Family Practice Management* 6 (9): 26–30.

Taie, E. 2011. "Coaching as an Approach to Enhanced Performance." *Journal for Quality and Participation* 34 (1): 34–38.

Taylor, S. 2011. "Assess Pros and Cons of 360-Degree Performance Appraisals." Society for Human Resource Management. Published July 12. www.shrm.org/hrdisciplines/employeerelations/articles/pages/360degreeperformance.aspx.

Teng, C. 2011. "Who Are Likely to Experience Flow? Impact of Temperament and Character on Flow." *Personality and Individual Differences* 50 (6): 863–68.

Thach, L., and T. Heinselman. 1999. "Executive Coaching Defined." *Training & Development* 53 (3): 35–39.

Thakur, R., S. Hsu, and G. Fontenot. 2012. "Innovation in Healthcare: Issues and Future Trends." *Journal of Business Research* 65 (4): 562–69.

Thompson, G. 2013. *Verbal Judo: The Gentle Art of Persuasion*. New York: HarperCollins.

Thompson, J. 1967. *Organizations in Action*. New York: McGraw-Hill.

Thye, S. R., and E. Lawler. 2010. *Advances in Group Processes*. Bingley, UK: Emerald Group.

Timmins, N., and C. Ham. 2013. *The Quest for Integrated Health and Social Care: A Case Study in Canterbury, New Zealand*. King's Fund. Accessed November 6, 2015. www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf.

Timothy, H. 2015. "Conflict in the Workplace: Resolving the Nurse–Physician Clash." *Sentinel Watch: Nursing*. Published October 6. www.americansentinel.edu/blog/2015/10/06/conflict-in-the-workplace-resolving-the-nurse-physician-clash/.

Tinsley, C. 2001. "How Negotiators Get to Yes: Predicting the Constellation of Strategies Used Across Cultures to Negotiate Conflict." *Journal of Applied Psychology* 86 (4): 583–93.

Totten, M. K. 2015. "Best Governance Practices: Not Just for Goliaths." *Great Boards*. Published Summer. www.greatboards.org/newsletter/2015/greatboards-newsletter-summer-2015.pdf.

Trahan, K. 2014. "Texas Is Not Special for Planning to Pay Athletes $10,000." SB Nation. Published October 22. www.sbnation.com/college-football/2014/10/22/7041515/texas-college-athletes-paid-10000-dollars.

Trastek, V., N. W. Hamilton, and E. Niles. 2014. "Leadership Models in Health Care—A Case for Servant Leadership." *Mayo Clinic Proceedings* 89 (3): 374–81.

Tucker, A., and A. Edmondson. 2003. "Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics That Inhibit System Change." *California Management Review* 45 (2): 55–72.

Tuckman, B. 1965. "Development Sequence in Small Groups." *Psychological Bulletin* 63 (6): 384–99.

Tuna, C. 2008. "Micromanagers Miss Bull's-Eye: Dealing with Every Detail Robs Subordinates of the Freedom to Solve Problems." *Wall Street Journal*. Published November 3. www.wsj.com/articles/SB122566866580091589.

Tversky, A., and D. Kahneman. 1981. "The Framing of Decisions and the Psychology of Choice." *Science* 211 (4481): 453–58.

———. 1974. "Judgement Under Uncertainty: Heuristics and Biases." *Science* 185 (4157): 1124–31.

Ungson, G., and Y. Wong. 2008. *Global Strategic Management*. Armonk, NY: M.E. Sharpe.

University of Maryland School of Medicine (UMM). 2015. "360-Degree Evaluation Form: Rater Assessment." Accessed November 6. https://umm.edu/~/media/umm/office-docs/for-health-professionals/graduate-medical-education/360_allied_health_professional.doc.

University of Texas at Dallas (UT Dallas). 2015. "Performance Management." Accessed April 24. www.utdallas.edu/hr/er/performance/.

University of Utah Health Sciences Center. 2016. "About Us." Accessed June 17. http://healthcare.utah.edu/about/mission.htm.

US Bureau of Labor Statistics. 2010. "2010 SOC Definitions." Published February. www.bls.gov/soc/soc_2010_definitions.pdf.

US Census Bureau. 2015. "2014 National Population Projections." Revised March 4. www.census.gov/population/projections/data/national/2014.html.

US Department of Health and Human Services (HHS). 2015. "About the Law." Reviewed August 13. www.hhs.gov/healthcare/rights/.

US Equal Employment Opportunity Commission (EEOC). 2009. "29 CFR 1604.11—Sexual Harassment." Published July 1. www.gpo.gov/fdsys/granule/CFR-2009-title29-vol4/CFR-2009-title29-vol4-sec1604-11.

US Government Printing Office. 2011. "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." Published June 14. https://veterans.house.gov/sites/republicans.veterans.house.gov/files/documents/112-18transcriptFC6-14-11.htm.

Utrecht Faculty of Education. 2015. "The Indigenous People of Mindanao." Accessed August 21. www.philippines.hvu.nl/mindanao2.htm.

Valle, M., and P. L. Perrewé. 2000. "Do Politics Perceptions Relate to Political Behaviors? Test of an Implicit Assumption and Expanded Model." *Human Relations* 53 (3): 359–86.

Van Kleef, G., and S. Cote. 2007. "Expressing Anger in Conflict: When It Helps and When It Hurts." *Journal of Applied Psychology* 92 (6): 1557–69.

Van Maurik, J. 2001. *Writers on Leadership*. London: Penguin Group.

Van Scotter, J. 2000. "Relationships of Task Performance and Contextual Performance with Turnover, Job Satisfaction and Affective Commitment." *Human Resource Management Review* 10 (1): 79–95.

VanWart, M. 2005. *Dynamics of Leadership in Public Service*. Armonk, NY: M.E. Sharpe.

Velasquez, M., C. Andre, T. Shanks, and M. J. Meyer. 2015. "Thinking Ethically." Published August 1. www.scu.edu/ethics/ethics-resources/ethical-decision-making/thinking-ethically/.

Villarica, H. 2011. "Maslow 2.0: A New and Improved Recipe for Happiness." *The Atlantic*. Published August 17. www.theatlantic.com/health/archive/2011/08/maslow-20-a-new-and-improved-recipe-for-happiness/243486/.

Wagner-McGough, S. 2015. "2015 US Open Prize Money: What Every Golfer Will Earn from $10M Pool." CBS Sports. Published June 21. www.cbssports.com/golf/eye-on-golf/25221327/us-open-prize-money-what-every-golfer-will-earn-from-10m-pool.

Walston, S. 2014. *Strategic Healthcare Management: Planning and Execution*. Chicago: Health Administration Press.

Walston, S., C. Bennett, and A. Al-Harbi. 2014. "Understanding the Factors Affecting Employees' Perceived Benefits of Healthcare Information Technology." *International Journal of Healthcare Management* 7 (1): 35–44.

Walston, S., and A. Chou. 2011. "CEO Perceptions of Organizational Consensus and Its Impact on Hospital Restructuring Outcomes." *Journal of Health Organization and Management* 25 (32): 176–94.

Walston, S., and A. Khaliq. 2012. "Factors Affecting the Value of Professional Association Affiliation." *Health Care Management Review* 37 (2): 122–31.

Walston, S., P. Lazes, and P. Sullivan. 2004. "Improving Hospital Restructuring: Lessons Learned." *Health Care Management Review* 29 (4): 309–19.

Walumbwa, F. O., B. J. Avolio, W. L. Gardner, T. S. Wernsing, and S. J. Peterson. 2008. "Authentic Leadership: Development and Validation of a Theory-Based Measure." *Journal of Management* 34 (1): 89–126.

Weber, M. 1958. *From Max Weber: Essays in Sociology*. Oxford, UK: Oxford University Press.

WebFinance. 2015. "Rational Decision Making." Accessed May 6. www.businessdictionary.com/definition/rational-decision-making.html.

Webley, S., and A. Werner. 2008. "Corporate Codes of Ethics: Necessary but Not Sufficient." *Business Ethics: A European Review* 17 (4): 405–15.

Wheat, H. 2003. "Negotiation Details Made Public as Hospitals and Health Plans Seek Support." *Managed Care Outlook* 16 (4): 1.

White, E. 2007. "Making Mentorships Work: Building Trust, Setting Guidelines Are Key to Successful Programs." *Wall Street Journal*. Published October 23. http://www.wsj.com/articles/SB119310906855868119.

Whitman, E. 2015. "Gulf Countries' Migrant Workers: Health Care Providers Are Mostly Foreigners in Saudi Arabia and Neighboring Countries." *International Business Times*. February 12. www.ibtimes.com/gulf-countries-migrant-workers-health-care-providers-are-mostly-foreigners-saudi-1814550.

Whitten, S. 2015. "Facebook Unfriending Considered in Office Harassment Case." CNBC. Published September 28. www.cnbc.com/2015/09/28/facebook-unfriending-considered-in-office-harassment-case.html.

WHO Collaborating Centre for Patient Safety Solutions. 2007. "Patient Identification." Published May. www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf.

Williamson, O. 1975. *Markets and Hierarchies*. New York: Free Press.

Wilson, J. 2014. "Managing Change Successfully." *Journal of Accountancy* 217 (4): 38–41.

Wilson, J. Q. 1989. *Bureaucracy*. New York: Basic.

Wilson-Stronks, A., K. Lee, C. Cordero, A. Kopp, and E. Galvez. 2008. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*. Oakbrook Terrace, IL: Joint Commission.

Wokuch, R. 2001. "Nike and Its Critic: Beginning a Dialogue." *Organization and Environment* 14 (2): 207–37.

Wolf, J. A. 2008. "Health Care, Heal Thyself! An Exploration of What Drives (and Sustains) High Performance in Organizations Today." *Performance Improvement* 47 (5): 38–45.

Wolff, M. 1999. "In the Organization of the Future, Competitive Advantage Will Be Inspired." *Research Technology Management* 42 (4): 2–4.

Woodward, J. 1958. *Management and Technology*. London: Her Majesty's Stationary Office.

Woodward, N., and D. Saini. 2006. "Diversity Management Issues in the USA and India: Some Emerging Perspectives." In *Future of Work: Mastering Change*, edited by P. Singh, J. Bhatnagar, and A. Bhandarker, 149–64. New Delhi, India: Excel Books.

World Health Organization (WHO). 2015. "WHO 7 Day Mother Baby mCheck Tool." Accessed August 4. www.who.int/patientsafety/patients_for_patient/mother_baby/tool/en/.

World Innovation Summit for Health (WISH). 2016. "Innovation Catalogue." Accessed June 17. www.wish-qatar.org/research/innovation-catalogue.

———. 2015a. "Global Diffusion of Healthcare Innovation." Accessed August 14. www.wish-qatar.org/summit/2015-summit/global-diffusion-of-healthcare-innovation.

———. 2015b. "7 Day Mother Baby mCheck Tool." Accessed August 4. www.wish-qatar.org/research/innovation-catalogue/catalogue-item&innovationID=55.

Wren, J. T., and M. Swatez. 1995. "The Historical and Contemporary Contexts of Leadership: A Conceptual Model." In *The Leader's Companion: Insights on Leadership Through the Ages*, edited by J. T. Wren, 245–52. New York: Free Press.

Wulf, J. 2012. "The Flattened Firm—Not as Advertised." Harvard Business School Working Knowledge. Published May 10. http://hbswk.hbs.edu/item/7000.html.

Your Dictionary. 2015. "Stereotype Examples." Accessed February 26. http://examples.yourdictionary.com/stereotype-examples.html.

Yukl, G. 2002. *Leadership in Organizations,* 5th ed. Englewood Cliffs, NJ: Prentice-Hall.

———. 1981. *Leadership in Organizations*. Englewood Cliffs, NJ: Prentice-Hall.

Zaccaro, S., C. Kemp, and P. Bader. 2004. "Leader Traits and Attributes." In *The Nature of Leadership*, edited by J. Antonakis, A. Cianciolo, and R. Sternberg, 101–24. Thousand Oaks, CA: Sage.

Zelman, W., G. Pink, and C. Matthias. 2003. "Use of the Balanced Scorecard in Health Care." *Journal of Healthcare Finance* 29 (4): 1–16.

Zipes, J. 2012. *The Irresistible Fairy Tale: The Cultural and Social History of a Genre*. Princeton, NJ: Princeton University Press.

INDEX

Note: Italicized page locators refer to exhibits.

Abuse of power: sexual harassment and, 121–24
ACA. *See* Affordable Care Act
Academic medical center/private hospital integration (case), 12–14
AcademyHealth, 246
Academy of Nutrition and Dietetics: code of ethics and behavior for, *51*
Accenture, 196
Accountability: delegation and, 178, 179, 184; enforcement of, 190; Herzberg's two-factor theory and, 64
Accountable care organizations (ACOs), 360; definition of, 336; future organizational structures and, 337, 341; matrix arrangements and, 334
ACHE. *See* American College of Healthcare Executives
Achievement-oriented leadership style: path–goal theory and, 139
ACOs. *See* Accountable care organizations
Adams, J. Stacy, 66
Administrative management theory, 18–20; coordinative principle, 20; functional principle, 19–20; scalar principle, 19; staff principle, 20
Advancement on basis of achievement: in Weber's efficient bureaucracy, 18
Affective commitment, 103
Affirmative action: diversity management and, 289–93, 294
Affordable Care Act (ACA), 9; future structures in healthcare and, 336; shared decision making and, 218
African Americans, 285
Age diversity, 287–88, 294
Agency for Healthcare Research and Quality (AHRQ), 104; Comprehensive Unit-based Safety Program toolkit modules, *359,* 359–60; Health Care Innovations Exchange, 235; on racial and ethnic disparities in healthcare, 288
Agendas: components of, 220–21; effective meeting coordination and, 220
AHRQ. *See* Agency for Healthcare Research and Quality
Alaska Natives, 285
Alderfer, Clayton: ERG theory of motivation, 61–63, *62,* 69
Allhealthcare, 84
Alzheimer's Association: vision statement of, 355
AMA. *See* American Medical Association
Amazon: vision statement of, 355
Ambiguity: conflict in healthcare and, 305, 311
American Academy of Ophthalmology: code of ethics and behavior for, *51*
American Cancer Society, 246; code of ethics and behavior for, *51*
American College of Cardiology, 329

American College of Healthcare Executives (ACHE), 246, 247; code of ethics for members of, 49–50; Healthcare Executive Competencies Assessment Tool, 145, 202–3
American College of Nurse-Midwives: code of ethics and behavior for, *51*
American Dental Association: code of ethics and behavior for, *51*
American Heart Association, 246
American Hospital Association, 246
American Indians, 285
American Medical Association (AMA), 246; Principles of Medical Ethics preamble of, 56–57
American Nurses Association (ANA): Nursing Code of Ethics provisions, 56–57
American Occupational Therapy Association: code of ethics and behavior for, *51*
American Physical Therapy Association (APTA): code of ethics, preamble, 50; eight principles for ethical conduct and related core values, 50–51
American Psychological Association, 80
American Public Health Association, 246; code of ethics and behavior for, *51*
American Veterinary Medical Association: code of ethics and behavior for, *51*
America's Essential Hospitals, 246
ANA. *See* American Nurses Association
Anchoring bias, 216, 222
Anger, *75,* 84
Anxiety, 74, 82
AOL–Time Warner merger, failure of, 164
Applicability: emotional intelligence and, 76
APTA. *See* American Physical Therapy Association
Armstrong, Lance, 303
Arora, Sanjeev, 8
Arthur Anderson, 46
Ascension Health: primary ethics goals of, 49
Asia: collective cultures in, 286; power distance and fairness in, 163
Asians, 285
Asking questions: negotiating and, 310, 312
Assembly line: division of labor and, 322
Association for Coaching, *175*
Association for Professional Executive Coaching and Supervision, *175*
Association of Coach Training Organizations, *175*
Association of Corporate Executive Coaches, *175*
Association of State and Territorial Health Officials, 246
Athletes: cheating by, 303
Athletics: equity in, 66
AT&T, 337
Authentic leadership, *147,* 148, 149, 151
Authoritarian leaders: in Blake and Mouton's managerial grid, *137*
Authority: delegation and, 178, 183, 184; formal, 115; power and, 115
Authority and responsibility: Fayol's principle of, 5
Authority influence strategy, *119,* 125
Autonomous decision making: rights model and, 43
Autonomy, 44–45, 53
Awards: as incentives, 61

Baby boom generation: characteristics of, 287, 294
Backup plans, 219
Balanced scorecards, 193–94, 203; measures related to, 193; metrics' relationship to mission and vision, *193*
BATNA (best alternative to a negotiated agreement): understanding, 308–9

Baxter, 331
Behavioral assessment: performance rating numerical scale, *199*
Behavioral influences on stress, 78, *79,* 85
Behavioral period: in contemporary leadership study, 135
Behavioral theory: Blake and Mouton's managerial grid, 136, *137,* 150
Behavior change: change agents and, 164–65
Behaviorist strategies: motivation and, 61
Behavior-related competencies: establishing criteria for, 201
Behavior theory, 134, 136–37, *147,* 150
Beneficence, 44, 45, 53
Bennis, Warren, 135
Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (Institute of Medicine), 38
BHAGs. *See* Big hairy audacious goals
Bias(es), 93; in decision making, 215–17, 222; improper perceptions and, 98; negotiating and, 310, 312
Big hairy audacious goals (BHAGs), 68, 70
Biochips, 242
Bionic enhancements, 242
Biotechnology: future of, 241–43
Black, Conrad, 47
Blacks (African Americans), 285
Blanchard, Ken, 138
Blind spots: leaders and, 225–26
Blockbuster, 238
BlueCross of Tennessee: negotiating in the press and, 308
Board of directors: corporate level and, 320
Board of trustees, 338
Body language: negotiating and, 310
Boeing, 333
Bon Secours Health System (Maryland): implementation of learning communities, 35
Bonuses: performance-based, 61
Bounded rationality model, 213–14, 222
Branson, Richard, 353
Brigham and Women's/Faulkner Hospital integration (Massachusetts), 12–14
Bristol-Myers: mission statement for, 353
Bullying: workplace, 121, 122
Bundled shared-savings payments: accountable care organizations and, 337
Burnout, *79,* 82; avoiding, 83; characteristics of, 77–78; definition of, 77
Burns, James MacGregor, 138
Bush, George W., 217
Business: ethical challenges in, 46–49
Business ethics: corporate social responsibility and, 42–43
Business model: definition of, 231
Business model innovations: healthcare innovations and, 230, 231, 239
Business unit level: in corporations, 320, *321,* 339

Carter, Jimmy, 66
Cases: allocating salary increases and effort, 224–25; bad boss, 153–55; bad driving—road rage, 86; believing theory Y but living theory X, 27–28; busy regional vice president, 278–81; CEO and physician, 315–16; CEO case of quantitative overload and qualitative underload, 88–90; CEO misuse of company funds?, 56; CEO's salary dilemma, 11–12; compare and contrast ethical statements, 56–57; culture of violence, 168–70; delegating operational-level decision making, 187; diversity efforts at Novant Health, 296–97; doctor and multidisciplinary team, 260–61; employee perceptions, 107–11; ER physician and ER nurse, 128–29; flat

structure but centralized control, 346–47; fragmented university healthcare venture, 342–46; frustrated new employee, 11; future of biotechnology, gene therapy, and computer-assisted diagnostics, 241–43; healing hospital conflict, 87–88; HealthT seeks healthier employees, 54–56; inspiring employees: the turkey entitlement, 152–53; integration of academic medical center and private hospital, 12–14; it's all about the title—but it's not, 151–52; Korean Air executive motivates change with nuts, 71–72; lunch approval, 186; micromanaging and motivation: illusion or reality?, 71; mixed use of performance management system, 206–7; negotiating medical staff privileges, 313–14; nepotism, 26–27; NICU nurses, 367–68; night staffing and job commitment, 106–7; Pegasus Health's integration of care, 362–65; power of a contract, 129; problems in a diverse culture, 297–98; proposed metropolitan hospital restart, 126–28; role of information technology in healthcare learning, 38–40; seeing what we want to see, 225–26; setting medical office staff performance measures, 207–9; surprising performance evaluation, 205–6; take-care-of-it delegation, 185–86; UCLA Health's introduction to innovation, 240–41; unsafe patient care—poor communication, 281–82; values statement, 365–66
Causal relationships: perceptions and, 97
Center for Medicare & Medicaid Innovation, 234
Centers for Medicare & Medicaid Services (CMS), 104, 234, 336
Centralization: tensions between decentralization and, 328, 340; organizational structure, environment, and, 338, *339*
CEOs: as chief cultural officers, 290, 295; corporate level and, 320; salary dilemma (case), 11–12
Chain of command, *324, 325,* 326–27; description of, 324; fragmented university healthcare venture and, 343. *See also* Span of control
Challenges faced by consultant, 16
Champions: team building and, 251
Change: conflict in healthcare and, 305, 311; leadership and, 357–60; Pegasus Health's integration of care (case), 362–65; types of, and their interactions, 357, *357,* 360; vision-driven, 358. *See also* Organizational change
Change agenda: succession planning and, 147
Change agents: behavior change and, 164–65
Charisma: transformational leadership and, 142, 150
Charismatic leadership (or idealized influence), 142–43
Chief learning officer, 31
Chief Learning Officer magazine, 31
Children: skills needed by, to succeed in life, 266, *266*
China: major cultural values in, *286*
Christensen, Clayton, 231, 237
Christian Coaches Network International, *175*
Circuit City, 162, 163
Cisco, 333
Clarity: poor communication and lack of, 273–74, 277
Clinical ethics issues, 47–49
Cloning, 242
Closed systems: open systems *vs., 24*
CMS. *See* Centers for Medicare & Medicaid Services

Coaches: focus of, 175
Coaching, 183; areas of, 176; definition of, 174; effective leadership development and, 174; mentoring *vs.,* 184; professional associations for, *175*; psychosocial support for junior managers through, 177. *See also* Mentoring
Coalition, 117
Coca Cola Company: global diversity statement, 284
Codes of conduct, 45, 48, 52
Codes of ethics, 46, 49–51
Coercive power, 115, 124
Cognitive influences on stress, 78, *79,* 85
Collective cultures, 286, 294
Collectivism *vs.* individualism, 162
Columbia/HCA, 47
Command groups, 245
Commanding function: of Fayol, 5
Commitment: components of, 103, 105
Communication: culture and impact on, 274, 277; definition of, 266, 276; effective, barriers to, 272–74, 277; feedback in, 270–71, 277; noise in, 269–70, 276; nonverbal, 271–72, 274, 277; organizational change and, 358, 361; poor, unsafe patient care and, 281–82; process, 266–71, *267,* 276; receivers and, 266, *267,* 269, 276; senders and, 266, *267,* 269, 276; successful, 275–76, 277; verification and, 271; virtual, 275, 277; workable channels of, 268. *See also* Conflict management; Negotiation and negotiation skills
Communication channel: selection of, 268
Communication skills: for children to succeed in life, 266, *266*; paramount importance of, 265
Compassion, 53
Competence: delegation and, 178
Competency-based performance systems, 201–3, 204; advantages of, 201; constructing, 201–2; definition of, 201
Competition: conflict in healthcare and, 305, 311; zero-sum games and, 303–4, 311
Complexity: conflict in healthcare and, 305, 311; organizational structure, environment, and, 338, *339,* 341–42
Comprehensive Unit-based Safety Program (CUSP): Kotter's eight-step change model and, *359,* 359–60
Computer-assisted diagnostics: future of, 241–43
Confirming-evidence bias, 216–17, 222, 225
Conflict: amount of and organizational impact, *302,* 302–3, 311; definitions of, 300; dysfunctional outcomes of, 301; elements of, 300; intergroup, 304, *304,* 311; interpersonal, 304, *304,* 311; intragroup, 304, *304,* 311; intrapersonal, 304, *304,* 311; levels of, *304*; nontask organizational, 301; polarization and, 302; positive outcomes of, 300–301; process, 301; reasons for, in workplace, 304–5, 311; relationship, 301; structural problems and escalation in, 302, 311; task, 301; team building and, 253; teams and, 256–58, 259; work-related stress and, 81
Conflict management, 305–7; CEO and physician (case), 315–16; definition of, 306; effective managers and, 305; healthcare managers and, 301; at Maimonides Medical Center, 306–7; organizational mission and, 299; policies and procedures, 306–7; training in, 306, 312. *See*

also Negotiation and negotiation skills
Consequential theory, 44
Consistency and commitment influence strategy, *119,* 125
Consultation, 117
Consumer-focused innovations: healthcare innovations and, 230–31, 239
Content coaching, 176
Contingency approach, 23–24, 25
Contingency or situational period: in contemporary leadership study, 135
Contingency theory, 18, 134, 137–38, *147,* 150
Continuance commitment, 103
Controlling function: of Fayol, 5; performance management and, 189
Conversation starters team-building exercise, 255–56
Cook County Health & Hospitals System: standing committees of, 246
Coordinating function: of Fayol, 5
Coordination: lack of, in healthcare, 323, 340
Coordinative principle, 20
Coping strategies: locus of control and, 80
Core values: ethics, mission, vision, and, 42
Corporate citizenship, 42
Corporate level: in corporations, 320, *321,* 339
Corporate social responsibility: business ethics and, 42–43; definition of, 42
Corporate structure, 320, 339
Corporation(s): definition of, 320; structural levels in, 320, 339–40. *See also* Organizations Cost–benefit analysis, 219
Costco, 163
Country club leaders: in Blake and Mouton's managerial grid, *137*
Courage: in decision making, 220
Creativity, 227; definition of, 228, 238; encouraging and discouraging activities and, *233*; global healthcare system and, 228; healthcare, diffusion of, 234–37; increasing, strategies for, 232–34; link between innovation and, 228–30, *229*
Critical teams: team-building process for, 253
Cross-disciplinary teams: in healthcare industry, 7
Crossing the Quality Chasm (Institute of Medicine), 327
Cultural assessments, 162, 167
Cultural change: effective leaders and, 165, 167–68; primary and secondary approaches to, 166–67
Cultural competence: building, 290
Cultural differences, 161–62, 167; encoding errors and, 268; individualism *vs.* collectivism, 162, 167; masculinity *vs.* femininity, 162, 167; perceptions and attitudes and, 101–2, 105; power distance, 161, 167; time orientation, 162, 167; uncertainty avoidance, 161, 167. *See also* Diversity
Cultural diversity, 284–86, 294
Cultural values and biases: negotiating and, 310, 312
Culture(s): collective, 286, 294; communication barriers and, 273, 277; definition of, 158; impact on communication, 274, 277; individualistic, 285–86, 294
CUSP. *See* Comprehensive Unit-based Safety Program
CVS Health: organizational levels in, 320, *321*

Daimler-Chrysler merger: failure of, 164
DDI. *See* Development Dimensions International
Decentralization: organizational structure, environment, and, *339*;

tensions between centralization and, 328, 340
Decent work concept, 65
Decision making, 211–26; biases in, 215–17, 222; in centralized organizations, 328; courage in, 220; in decentralized organizations, 328; ethical or unethical, testing, 52; groupthink and, 217, 222; in healthcare, 218, 222; importance of, 211, 222; improving, 218–21; irrationality in, 213; in meetings, 219–21, 223; in organizational context, 214; organizational politics and, 121, *121*; perceptual problems, bias, and, 98
Decision-making models: bounded rationality model, 213–14, 222; garbage can model, *214,* 214–15, 222; rational decision making, 212–13, 222
Decision tree example, 212, *212*
Decoding: communication barriers and individual differences in, 273, 277; in communication process, 266, *267,* 269, 276
Defensiveness: poor communication and, 273, 277
Deficiency needs: Maslow's hierarchy of needs and, 21, *21*
Delegation, 183; accountability and, 178, 179, 184; authority and, 178, 183, 184; benefits of, 177; clear communication and, 182, 184; definition of, 178; dump-and-run, 182, 183; effective, ten steps to, 182–83; levels of, by empowerment, reporting time, and focus on outcomes, *180,* 180–81; managerial key points on, 181–83; reasons for avoiding, 177–78; responsibility and, 178, 183–84; trust and, 178–79, 181–84
Deloitte, 195
Democratic decision making: political behavior augmented by, 121
Depression, 74, 82
Development Dimensions International (DDI), 146
Dialogue: successful communication and, 276, 277
Dietitians: cross-disciplinary teams and, 7
Differentiation (decentralization), 328
Diffusion, 238; definition of, 236; of healthcare creativity and innovation, 234–37, 239
Digital technology, 231
Directive leadership style: path–goal theory and, 139
Discipline: Fayol's principle of, 5
Disengaged healthcare workers: diminished quality of care and, 16
Disparities in healthcare: decision-making biases and, 218
Disruptive innovation: gene therapy and, 241–42; sustaining innovation *vs.,* 237–38
Dissatisfiers, 63, *63,* 69
Distress, 78, 79, *79,* 85
Distributive justice, 43, 163
Diverse viewpoints: decision making and, 219
Diversity: barriers to, 292–93; benefits of, 289; communication and, 274; cultural, racial, and ethnic, 284–86, 294; gender and age, 286–88, 294; workplace, characteristics of, 283. *See also* Cultural differences
Diversity management: affirmative action and, 289–93, 294; cases, 296–98; federal, state, and private resources and, 293; human resources systems and, 292–93; National Standards for Culturally and Linguistically Appropriate Services and, *290–91*
Diversity needs: succession planning and, 146, 147
Divisional leaders: in multidivisional organizations, 330
Division of labor: advantages and disadvantages of, 323; definition of,

322; healthcare and principle of, 323; scientific management and, 322, 340; specialized, in Weber's efficient bureaucracy, 18
Division of work: Fayol's principle of, 5. *See also* Division of labor
Doctor–patient miscommunication, 267–68
Double-loop learning, 31, 36
Dump-and-run delegation, 182, 183

EAPs. *See* Employee assistance programs
Earnings before interest, taxes, depreciation, and amortization (EBITDA): high-performing facilities and, 144
Ebbers, Bernard, 46
EBITDA. *See* Earnings before interest, taxes, depreciation, and amortization
Economies of scale, 326
Efficiency: in Weber's efficient bureaucracy, 18
Efficient bureaucracy (Weber): characteristics of, 17–18
Egoist model, 43, 44, 52, 53
EI. *See* Emotional intelligence
Eisner, Michael, 66
Eli Lilly, 82
Emotional control: lack of (vignette), 76
Emotional influences on stress, 78, *79,* 85
Emotional intelligence (EI), 76–77, 84; improving, suggestions for, 76–77; physicians', 360-degree system, and, 200; self-regulation and, 83; skills related to, 76
Emotions, 73, 84; choice of behaviors and actions and, 79; conceptualizing, 74; moods *vs.,* 74; primary, 75, *75,* 84; secondary, 75, *75,* 84, 86; stress and, 77, 85; in the workplace, 74–77
Employee assistance programs (EAPs), 84, 85
Employee-oriented leadership, 136
Employee performance: Hawthorne studies and, 17
Employee recognition programs, 61
Employees: commitment and, enhancing, 103, 105; engaged, 144, 359; healthier, case, 54–56; high-performing, succession planning and, 146; learning organizations and, 31; motivating and engaging, 60; organizational mission and objectives and, 8; organizational politics and, 120; perceptions of (case), 107–11; stress, interpersonal conflict, and, 302, 311; stress management for, 82–84, 85
Employee satisfaction and commitment: Herzberg's two-factor theory and, 63–64; internal and external controls and, 61, *62*
Encoding: communication barriers and individual differences in, 273, 277; in communication process, 266–67, *267,* 268
Engaged employees: Gallup definition of, 144, 359
Enron, 46
Environment: nonverbal communication and, 272, 277; organizational structures and, 338, *339,* 342
Equity: in athletics, 66; Fayol's principle of, 5
Equity equilibrium, 66–67, *67*
Equity theory, 66–67, 70, 139, 141
ERG theory of motivation (Alderfer), 61–63, *62,* 69
Esprit de corps: Fayol's principle of, 5
Esteem: Maslow's hierarchy of needs and, 21, *21*
Ethical behavior: cultural effects and, 45–46; leaders and, 45; newspaper test for, 52, 53
Ethical challenges: in business and healthcare, 46–49
Ethical leadership, *147,* 151; definition and characteristics of, 148–49

Ethical models, 43–44; egoist model, 43, 44, 53; fairness, or justice, model, 43–44, 53; rights model, 43, 53; utilitarianism, 43, 52
Ethical principles, 44–45, 53; autonomy, 44–45, 53; beneficence, 45, 53; justice, 45, 53; nonmaleficence, 45, 53
Ethical relativism, 53
Ethical violations, 46–47
Ethics: clinical, 47–49; core values, mission, vision, and, 42; cultural effects and, 45–46; definition of, 41, 52; in healthcare, 42–43; professional, 49–52; teaching, 45
Ethnic disparities: in healthcare, 288–89
Ethnic diversity, 284–86, 294
Ethnocentrism, 285, 294
Eustress, 78, *79,* 85
Evaluation: delegation and, 183
Exchange, 117
Executive coaching: leadership performance and, 175; popularity of, 184
Executive leadership programs, 145
Exhaustion: stress, burnout, and, 78
Existence needs: in Alderfer's ERG theory of motivation, 62, *62*
Expatriate workers: diversity and, 284, 293
Expectancy: motivation and, 67, *67*
Expectancy theory, *67,* 67–68, 70, 141
Expert power, 116, 124
External controls: employee satisfaction and commitment and, 61, *62*
External environment: organizational structures and, 338
External locus of control, 80
External motivators: overreliance on, 60
External stimuli, 60–61
Extrinsic motivation, 33
Eye contact: culture and, 274, 277

Facebook: unfriending on, 122
Facial expressions: culture and, 277
Factories, 4
Fairness: organizational culture and, 163, 167
Fairness, or justice, model, 43–44, 53
Faust, Drew Gilpin, 227
Fayol, Henri, 4, 5, 6, 10, 18, 212
Fear, *75,* 84
Feedback: in communication, 270–71, 277; delegation and, 179; frequency of, 197–98; lack of, poor communication and, 273–74; performance, guidelines for, 197–98
Feedback coaching, 176
Female healthcare executives: mentoring and, 176
Femininity *vs.* masculinity: cultural differences in, 162
Fiedler's contingency theory, 139
Financial capital: multidivisional organizations and allocation of, 331
First jobs team-building exercise, 255
Flat organizations, 326, 340
Followers: charismatic leaders and, 143; individualized consideration and, 144–45; influence tactics and, 118; inspirational motivation and, 143; intellectual stimulation and, 143–44; transformational leaders and, 141. *See also* Subordinates
Forced distribution systems, 195–96, 203
Formal authority, 115
Formal groups, 245, 258
Forming stage: in team building, 254, *254,* 259
For-profit organizations, 321, 340
Framing bias, 217, 222
Fraud, 46, 47, 304, 351; ethics violations and, 46–47; toxic culture at HealthSouth and, 158–59
Frustrated new employee (case), 11
Frustration–regression, 63
Functional organizations, 328–30, 340; advantages of, 328–29, 341; differing professional tenets in, 329; disadvantages of, 329, 341

Functional principle, 19–20
Functional structure: advantages and disadvantages of, 335–36, *336,* 341; environment and, *339*
Functional unit level: in corporations, 320, *321,* 339
Fundamental attribution error, 98–99, *99,* 104
Fund for Innovation in Healthcare Leadership, 236

Gallup, 104
Gamesmanship, 120
Gantt charts, 191, *192,* 203
Gap analysis, 162; developing, 355–56; from values, mission, and vision, *356,* 360
Garbage can model, *214,* 214–15, 222
Gender: communication barriers and, 273
Gender diversity, 286–87, 294
General Electric, 196, 337
Generalists: transfer of care from specialists to, 231–32
Generational differences, 287–88, 294
Generation X: characteristics of, 287, 294; turnover rates and, 175
Generation Y: *See* Millennial generation
Generation Z. *See* Postmillennial generation
Gene therapy, 238, 241–43
Genetic revolution, 242
Genetics, 34
Genomics, 238, 239
Gestures: culture and, 274; nonverbal communication and, 272, 277
Globalization: communication and, 274; diverse workforce and, 284
Goals: metrics for gauging progress on, 190; SMART, 68, 70; team building and, 251; values and, 351
Goal-setting theory, 68
Gofer delegation: definition of, 179–80, 184; micromanaging and, 182
Google, 83
Governing boards, 338–39; increasing role and proper functioning of, 339; successful organizations and, 338, 342
Great man theory, 135, 150
Greenleaf, Robert, 148
Ground rules: for negotiation, 308; team building and, 251–52
Group identity: group commitment and, 246
Group/interpersonal level: of organizational behavior, *3*
Groups: command, 245; competition within, 303; definition of, 245; formal, 245, 258; informal, 245, 258; professional organizations, 246–47; task, 245–46; teams *vs., 247,* 247–48, 259; ubiquity of, 245. *See also* Teams
Groupthink, 217, 222, 226
Growing from within: continuity of management and, 146
Growth needs: in Alderfer's ERG theory of motivation, 62, *62*; Maslow's hierarchy of needs and, 21, *21*
Guantanamo Bay prison (Cuba): medical ethical violations at, 351
Gulick, Luther, 18

Hall, Edward, 274
Halo effect, 8, 100, 104, 105
Harassment: psychological, 121; sexual, 121–24. *See also* Sexual harassment
Harbaugh, Jim, 66
Hardiness, 80
Hawthorne experiment, 6, 17, 22
HCA. *See* Hospital Corporation of America
HCAHPS. *See* Hospital Consumer Assessment of Healthcare Providers and Systems
Healthcare: competition in, 303, 304; conflict triggers in, 305; cycle of

service in, 323; decision making in, 218, 222; disruptive innovation and, 238; division leadership in, 331, 332; division of labor in, 23; ethical challenges in, 46–49; ethics in, 42–43; interdisciplinary nature of, 250; lack of coordination in, 323, 340; mission statements in, 354; negotiation in, 307–10; racial and ethnic disparities in, 288–89; transformational leaders and, 145. *See also* Learning in healthcare
Healthcare associations: codes of ethics and behavior for, *51*
Healthcare corporations: importance to US economy, 320
Healthcare disparities: decision-making biases and, 218
Healthcare Executive Competencies Assessment Tool (American College of Healthcare Executives), 202–3
Healthcare Financial Management Association, 246
Healthcare industry: need for good leaders in, 134; organizational behavior study and organizational theory and, 6–10
Healthcare innovation and diffusion: enablers that promote phases of, *236,* 236–37, 239
Healthcare innovations: types of, 230–32
Healthcare organizations: clear ethics guidelines for, 42; coordination across specialized positions in, 323; ethical violations and, 48; implementing positive, sustainable change in, 357, 360; by percentage of ownership, *321,* 321–22
Healthcare professionals: "pecking orders" and, 7
Healthcare system boards: average number of members on, 338–39
Healthcare systems: continuously learning, characteristics of, *34*; motivation and success of, 59
Healthcare technology: Project ECHO, hepatitis C, and, 8
Healthcare work: stress and, 77
Health insurance: consumer choice and, 231
Health insurance companies: percentage of ownership for, *321*
Health problems: poorly managed conflict and, 301
Health professionals: stress-related injuries and, 77
HealthSouth: ethics violations at, 47; toxic culture at, 157, 158–59
HealthStream, 104
HealthTrust Inc.: regional structure for, 326, *326*
Hepatitis C: changes in healthcare and, 8
Herzberg, Frederick: two-factor theory of, *63,* 63–64, 69
Heuristics, 215, 222
Hewlett Packard–Compaq merger: failure of, 164
Hierarchy of command: in Weber's efficient bureaucracy, 18
Hierarchy of needs (Maslow), 20–21, *21,* 25, 60; ERG theory of motivation and, 61, 62, 63, 69; Herzberg's two-factor theory and, 63, 69
High-context cultures, 273
High Five! (Blanchard), 138
High-performing facilities: Hospital Corporation of America study, 143–44
High-performing work environments: transformational leadership in, 141
High-richness channels of communication, 269
Hippocratic Oath, 351
Hiring: diversity promotion and, 292
Hispanics, 285

Hofstede Centre, 162
Hollinger International, 47
Home health agencies: percentage of ownership for, *321*
Honesty, 53
Horizontal structures, 341; description of, 337; environment and, *339*
Hospices: percentage of ownership for, *321*
Hospital boards: average number of members on, 338
Hospital compensation: patient satisfaction and, 104
Hospital conflict: healing of (case), 87–88
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), 104; scores, employee engagement and, 359
Hospital Corporation of America (HCA): ethics and compliance program tenets of, 48–49; high-performing facilities study, 143–44; negotiating in the press and, 308
Hospital Employees' Union: on stress prevention policies, 83
Hospital of the University of Pennsylvania: mandated actions relative to harassment, 123–24; sexual harassment policy, 122–23, *123*
Hospitals: accountable care organization creation and, 337; competency-based appraisal systems and, 201; employee engagement in, 359; functional structure in, 328; matrix structure in clinical care areas, 333; multidivisional organization in, 331; percentage of ownership for, *321*; top-performing, visionary leaders and, 142, 143–44; values in, 351
Hostile work environment: harassment and, 122, 125
House's path–goal leader behaviors, *140*
Human capital challenges: succession planning and, 146–47
Human Relations Movement, 6, 22
Human relations theory, 22–24, 25; contingency approach, 23–24; open systems theory, 24; theory X, 22, *23*; theory Y, 22, *23*
Human resources systems: diversity promotion and, 292–93
Humor: tension resolution and, 258
Hygiene factors, 63, 69

IBM, 333
If I were at my job right now: team-building exercise, 256
iGen. *See* Millennial generation
ILO. *See* International Labour Organization
Immigrants: diversity and, 284, 293
Impersonality: in Weber's efficient bureaucracy, 18
Impoverished leaders: in Blake and Mouton's managerial grid, 136, *137*
Incentives: external, types of, 61; reward power and, 115
In-depth development coaching, 176
India: major cultural values in, *286*
Individualism *vs.* collectivism, 162, 167
Individualistic cultures, 285–86, 294
Individualized consideration: transformational leaders and, 144–45, 150
Individual level: of organizational behavior, 2–3, *3*
Industrial Revolution, 322, 340
Influence: definition of, 114; negative connotations tied to, 113; power *vs.*, 114, *114,* 124
Influence strategies: definitions and examples of, *119,* 125
Influence tactics: choosing, 117–18, 125; negative, 117, 118, 125; positive, 117, 118, 125
Informal groups, 245, 258
Information overload: functional structure and, 330
Information richness: communication channels and, 268, *269,* 276; videoconferencing and, 275

Information technology: decision making in healthcare and, 218, 222; healthcare learning and (case), 38–40; innovation in healthcare and, 238
Informed consent: rights model and, 43
Ingham, Sir Bernard, 136
Ingratiation, 117
Initiative: Fayol's principle of, 5
Innovation, 227; definition of, 228, 238–39; disruptive, 237, 238, 239, 241–42; encouraging and discouraging activities and, *233*; global healthcare system and, 228; healthcare, diffusion of, 234–37; healthcare, types of, 230–32, 239; increasing, strategies for, 232–34; link between creativity and, 228–30, *229*; matrix structures and, 333–34; sustaining, 238; UCLA Health's introduction to (case), 240–41
Innovation centers, 234
Inspirational appeals, 117
Inspirational motivation: transformational leaders and, 143, 150
Institute for Diversity in Health Management, 293
Institute of Medicine (IOM): *Crossing the Quality Chasm,* 327; healthcare aims articulated by, 228; healthcare recommendations, 38–39; interdisciplinary team defined by, 247; on racial and ethnic disparities in healthcare, 288–89; *Unequal Treatment* report, 293
Institutionalizing: learning in an organization and, 30, *30*
Instrumentality: motivation and, 67, *67*
Integrating: learning in an organization and, 30, *30*
Integration (centralization), 328
Intellectual stimulation: transformational leaders and, 143–44, 150
Intelligence quotient (IQ), 76
Interactional justice, 44, 163
Interdependence: types of, 248–49, *249*
Interdisciplinary education, 248
Interdisciplinary teams: definition of, 247, 250
Interests: positions *vs.,* 307–8
Intergroup conflict, 304, *304,* 311
Internal controls: employee satisfaction and commitment and, 61, *62*
Internal environment: organizational structures and, 338
Internal locus of control, 80
International Accreditation Body for Coaching & Mentoring, *175*
International Association of Coaching, *175*
International Coach Federation, *175*
International Coaching Community, *175*
International Labour Organization (ILO), 65
Internet, 238
Interpersonal conflict, 304, *304,* 311
Interpreting: learning in an organization and, 30, *30*
Interprofessional teams: composition of, 247–48
Interview practices: performance feedback and, 197
Intragroup conflict, 304, *304*
Intrapersonal conflict, 304, *304,* 311
Intrinsic motivation, 33, 34
Intrinsic stimuli, 61
IOM. *See* Institute of Medicine
IQ. *See* Intelligence quotient

JCI. *See* Joint Commission International
Jefferson, Davon, 164
Job characteristics model, 65
Job commitment: night staffing and (case), 106–7; perceptions and attitudes and, 102–3, 105
Job descriptions: functional principle and, 19–20

Job design, 64–65, 69, 233
Job enlargement, 65
Job enrichment, 65–66
Job responsibilities: performance rating scales and, 198
Job rotation, 65
Job satisfaction: organizational justice and, 44
Job security: change and, 358, 359
Johnson, Lyndon B., 33
Johnson & Johnson, 331; diversity statement, 292, *292*
Joint Commission, 201, 271, 290, 295
Joint Commission Center for Transforming Healthcare, 7
Joint Commission International (JCI), 271
Joint problem solving: negotiation and, 310, 312
Joy, *75,* 84
Junior leaders: mentoring, 175
Justice, 44, 45, 53
Justice model, 52; distributive justice and, 43; interactional justice and, 44; procedural justice and, 44

Katz, Jose, 351
Kennedy, John F., 217
Key performance indicators (KPIs), 191, 203
King, Martin Luther, Jr., 148
Kodak: digital photography and, 229, 238
Korean culture: stifling of productivity in, 161
Kotter's eight-step model of change: Agency for Healthcare Research and Quality's Comprehensive Unit-based Safety Program toolkit modules and, *359,* 360
KPIs. *See* Key performance indicators

Lao-Tzu, 148
LASIK machines, 232
Latinos, 285
Leader–member exchange theory, 139, 140–41
Leader(s): blind spots in, 225–26; conflict management and, 305; dynamic, need for, 134; emotional intelligence and, 76–77; ethics and, 45; good communication skills and, 265–66; influence tactics of, 117–18; managers *vs.,* Mintzberg on, 137; organizational change and, 164–65, 167–68; power and, 114, 124; successful communication and, 275–76, 277; usage of term, throughout history, 134, 150
Leadership, 149; change and, 357–60; charismatic, 142–43; defining, 134–38; diversity promotion and, 290; female representation in, 286–87; participative, 136; transactional, 138, 141, 142, *147,* 150; transformative, 141–47, 150, 357, 360–61. *See also* Leadership theories
Leadership development: challenge of, in today's healthcare environment, 173. *See also* Coaching; Mentoring; Training
Leadership direction: cultural change and, 167
Leadership performance: executive coaching and, 175
Leadership study: contemporary, five overlapping periods in, 135
Leadership style: informal indicator of, 138
Leadership theories: behavior theory, 136–37, *147,* 150; contingency theory, 137–38, *147,* 150; five major schools of thought in, 134, 150; path–goal theory, 139–40, *140*; situational leadership theories, 138–39, *147,* 150; summary of theories and models, *147*; trait

theory, 135–36, *147,* 150; transactional leadership theory, 138, *147,* 150; transformational leadership theory, 141–47, *147,* 150
Lean approach, 36, 37
Learning: barriers to, 33; cycle of, *30,* 30–31, 36; definition of, 29; double-loop, 31, 36; in healthcare, challenges of, 34–36, 37; motivation in, role of, 33–34; organizational, 29, 30, 36; single-loop, 31, 36
Learning communities: best practices across systems and, 35; definition of, 35–36
Learning in healthcare: challenges of, 34–36; as continuing function, 30
Learning management systems, 35, 37
Learning organizations, 37; characteristics of, 31–32; components of, 32, *32*; definition of, 32; group and organizational barriers in, 33; personal barriers in, 33
Legitimacy appeals, 117
LifePoint Health: vision statement of, 355
Liking influence strategy, *119,* 125
Limited information: perceptions and, 97, *98*
Lincoln, Abraham, 148
Line-staff principle, 20
Listening: negotiating and, 310, 312
Locus of control, 80–84; definition of, 80; sources of stress and, 80–82; stress management and, 82–84
Love, *75,* 84
Low-context cultures, 273
Low-richness channels of communication, 269
Loyalty, 53

Madoff, Bernard, 47
Mahatma Gandhi, 148
Maimonides Medical Center: Code of Mutual Respect at, 306–7
Maintenance factors, 63, 69
Major depression, 74
Managed care contracts: negotiating, 308
Management: poor, impact on US economy, 16
Management by objectives (MBO), 68
Management theories, 15–24; administrative management theory, 18–20, 25; contingency approach, 23–24, 25; contributors to, 4–6; human relations theory, 22–24, 25; Maslow's hierarchy of needs, 20–21, 25; open systems theory, 24, 25; overview, 15–17; theory X and theory Y, 22, 25; Weber's efficient bureaucracy, 17–18, 25
Managers: conflict management skills and, 305; leaders *vs.,* Mintzberg on, 137; resistance to change and role of, 358. *See also* Leader(s)
Mandela, Nelson, 148
Marital partners: bounded rationality and choice in, 213
Masculinity *vs.* femininity: cultural differences in, 162, 167
Maslow, Abraham, 60, 61; hierarchy of needs, 20–21, *21,* 25
Massachusetts General Hospital, 262; Center for Innovations in Care Delivery, 234
Matrix organizations, 328, 332–35, *333,* 340; advantages of, 333–34, 341; disadvantages of, 334, 341; examples of, 333; project or service line managers in, 334–35; two-boss challenge and, 334, 341
Matrix structure: advantages and disadvantages of, 335, *336,* 341; environment and, *339*
Mayo, Elton, 17
Mayo Clinic: values of, 352
Mayo Clinic for Innovation, 234
MBO. *See* Management by objectives
McGregor, Douglas, 22, 60

McKiernan, David, 272
Meaningful work: delegation and, 177
Measles epidemics, 94
Mechanistic organizations, 327, *327*
Medical errors, 7; burnout and, 78; miscommunication and, 267–68, 276
Medical ethical violations: at Guantanamo Bay prison, 351
Medical ethics: autonomy in, 44
Medical Group Management Association: code of ethics and behavior for, *51*
Medical homes, 360
Medical professional training programs: focus of, 35
Medical tourism, 232
Meditation, 83
Meeting cycle, 221, *221*
Meetings: decision making in, 219–21, 223
Mental Health America, 246
Mental models: in learning organizations, 32
Mentoring, 183; coaching *vs.,* 184; definition of, 174; effective leadership development and, 174; ground rules for, 176–77; objectives in, 176; psychosocial support for junior managers through, 177. *See also* Coaching
Merck Manual, 218
Mercy Health (Australia): as functional organization, 328; organizational chart for, 324, *324*
Mergers: failed, differing cultures, and, 164, 167
Messages: in communication process, 266, *267*; erroneous encoding of, 267; information richness and complexity of, 268, *269*
Metrics: performance management and, 190
Micromanagement: case, 71; gofer delegation and, 182; job enrichment *vs.,* 66
Microsoft, 196
Middle East: collective cultures in, 286; expatriate healthcare professionals in, 284
Midlevel providers, 238, 239
Millennial generation: characteristics of, 288; turnover rates and, 175
Ming, Yao, 216
Minneapolis Star Tribune, 238
Mintzberg, Henry: leadership roles defined by, 136–37
Miscommunication: doctor–patient, 267–68; medical errors and, 7, 276
Mission: balanced scorecard metrics' relationship to, *193*; coordinative principle and, 20; core values, ethics, vision, and, 42; definition of, 350, 360; gap analysis from, *356,* 360; interrelationship among values, vision, and, *350*; organizational culture and, 157; organizational structure and, 319–20. *See also* Values; Vision
Mission statements, 353–54; organizational purpose and, 349, 353; recommendations for, 354, 360
Modular (or virtual) organizations, 337–38
Molecular biology, 34
Money stressors, 80
Monitoring: balanced scorecards and, 193; performance management and, 190
Montefiore Hospital (New York), 262
Moods: emotions *vs.,* 74
Mooney, James, 18
Morale: poorly managed conflict and, 301, 311
Motivation: Alderfer's ERG theory and, 61–63, *62,* 69; behaviorist strategies and, 61; definition of, 59; delegation and, 177; equity theory, 66–67, 70; expectancy theory and, 67–68, 70; external stimuli and, 60–61, 69; focus of theories in, 59; goal-setting theory

and, 68, 70; Hawthorne studies and, 17; Herzberg's two-factor theory and, *63,* 63–64, 69; inspirational, 143; intrinsic stimuli and, 61, 69; job design and, 64–65, 69; job enrichment and, 65–66; in learning, role of, 33–34; multifaceted, complex approach to, 70; myths of, 68–69; performance management systems and, 194; power and, 116; strong moral values and, 352, 360; transformational leadership and, 141, 145, 150
MRI (magnetic resonance imaging) scanners, 231
Multidisciplinary teams, 249–50, 259
Multidivisional organizations, 328, *330,* 330–32, 340; advantages of, 331, 341; decentralization of functions in, 331–32, 341; popularity of, 330; transfer pricing and, 332, 341
Multidivisional structure: advantages and disadvantages of, 335, 336, *336,* 341; environment and, *339*
Multigenerational workforce, 287, 294
Mutual purpose: successful communication and, 276, 278

National Association of County and City Health Officials, 246
National Association of State Mental Health Program Directors, 246
National Environment Health Association, 246
National Standards for Culturally and Linguistically Appropriate Services, *290–91*
Negative emotions, 74, 79, 309, 312
Negative influence tactics, 117, 118, 125
Negotiation and negotiation skills, 299, 307–10; BATNA (best alternative to a negotiated agreement) and, 308–9, 312; CEO and physician (case), 315–16; deceptive emotions in negotiating, 309, 310; definition of, 306; ensuring solidified relationships and, 310; ground rules for, 308; medical staff privileges (case), 313–14. *See also* Conflict management
Nepotism policy (case), 26
Network structures, 341; description of, 337–38; environment and, *339*
Newspaper test for ethical behavior, 52, 53
NICU (neonatal intensive care unit) nurses (case), 367–68
Night staffing: job commitment and (case), 106–7
Nike, 338
Noise, 269–70, 276
Nokia, 333
Nonmaleficence, 44, 45, 53
Nontask organizational conflict, 301
Nonverbal communication, 274, 277; forms of, 271–72; misinterpretation of, 273, 277
Normative commitment, 103
Norming stage: in team building, *254,* 255, 259
Not-for-profit organizations, 321, 340
Novartis: mission statement of, 354
Novell-WordPerfect merger, failure of, 164
National Research Corporation, 104
Numbers: cultural differences and, 102
Numerical rating systems, 195, 203
Nurses: competition and, 303; conflicts between physicians and, 87; cross-disciplinary teams and, 7; stress-related injuries and, 77
Nursing context: delegation in, defined, 178
Nursing homes: percentage of ownership for, *321*

Objective criteria: negotiation and, 308

Obligatory cooperation: conflict in healthcare and, 305, 311
Office of Minority Health, 293
One Minute Manager (Blanchard), 138
One-way communication, 270, 277
Open systems: closed systems *vs., 24*
Open systems theory, 24, 25
Operant conditioning, 60–61
Operating rooms: division of labor in, 323
Order: Fayol's principle of, 5
Organic organizations, 327, *327*
Organizational behavior, 2–3; interactive nature of three levels of, 2–3, *3*; topics related to levels of, *9,* 9–10; understanding dynamics of, 3
Organizational behavior study, 10; history and development of, 4–6; relevance of, to healthcare industry, 6–10
Organizational change: challenges related to, 356–57, 360; transformational leaders and, 141, 357, 360–61. *See also* Change
Organizational culture, 157–70; changing, 164–67; components of, *160*; definition of, 158; development of, 159; fairness and, 163, 167; importance of, 157, 167; primary levers applied to, 166; rituals and routines in, 159, *160,* 167; stories and, 159–60, *160,* 167; structures in, *160,* 160–61; symbols in, 160, *160,* 167; values and, 350
Organizational design, 319–47. *See also* Organizational structure(s)
Organizational diversity statement: creating, 291–92
Organizational goals: positive outcomes of conflict and, 300–301
Organizational justice, 164, 167
Organizational learning, 29, 36, 37; definition of, 29; ongoing process in, 30–31; tenets for embedding learning, 36
Organizational politics, 119–24, 125; definition of, 119, 125; individual and organizational factors leading to, 120; negative, 120; sustainable, 120
Organizational/structural level: of organizational behavior, *3*
Organizational structure(s): advantages and disadvantages with types of, 335–36, *336*; chain of command and, 324, 326–27; corporate, 320; definition of, 322; division of labor and, 322–23; environment and, 338, *339,* 342; flat organizations, 326; functional organizations, 328–30, 340; horizontal structures, 337, 341; integration and differentiation and, 328; matrix organizations, 332–35, *333,* 340; mechanistic organizations, 327; mission and, 319–20; multidivisional organizations, *330,* 330–32, 340; network, 337–38, 341; organic organizations, 327; possible future structures in healthcare, 336–38, 341; role and scope of duties and, 322, 340; span of control and, 323, 340; types of, 328–35, 340–41
Organizational theory, 10; focus of, 4; history and development of, 4–6; organizational behavior study and, *4*; relevance of, to healthcare industry, 6–10
Organizational values: performance rating scales and, 198
Organizations: centralized, 328; decentralized, 328; definition and central aspect of, 2; flat, 326, 340; for-profit, 321, 340; functional, 328–30; governing boards of, 338–39; instilling purposeful direction for, 349; matrix, 332–35, *333*; mechanistic, 327, *327*;

multidivisional, *330,* 330–32; not-for-profit, 321, 340; organic, 327, *327*; ubiquity of, 1; values-based, 350. *See also* Corporation(s)
Organizing function: of Fayol, 5
Other-awareness: emotional intelligence and, 76
Overconfidence, 74
Ownership: healthcare organizations by percentage of, *321,* 321–22

Paradigms: definition of, 94, 104; established, decision making and, 94–95; of expected restaurant service, 94; interactions of stimuli, perceptions, and, 95–96, *96*
Paradigm shift, 95
Participative leadership, 136, 151
Participative leadership style: path–goal theory and, 139
Partners HealthCare (Massachusetts), 13
Path–goal theory of leadership, 139–40, *140*
Patient safety: feedback and, 270, 277; poor communication and, 281–82
Patient satisfaction, 103–4
Patient's Bill of Rights, 351
Penicillin, 231
Perceptions, 93; cause-and-effect patterns and, 97; communication and, 273; cultural determination of, 102; definition of, 95, 104; extrapolating from limited information and, 97, *98*; generating, 96; improper, 98; interaction of stimuli, paradigms, and, 95–96, *96,* 104; patient, 95; patient satisfaction and, 103–4; personal characteristics and, 96
Perceptual problems, 98–103; cultural differences and, 101–2, 105; fundamental attribution error, 98–99, *99,* 104; halo effect, 98, 100, 104; job commitment and, 102–3; primacy effect, 98, 101, 104; recency effect, 98, 101, 104; similar-to-me effect, 98, 100–101, 104; stereotypes, 98, 99–100, 105
Performance: stress and, 78, *79*
Performance appraisals, 195; complaints about, 194; feedback and, 197–98
Performance evaluations: case, 205–6; organizational politics and, 121, *121*; problems with, 194–95, 203
Performance feedback: effectively providing, guidelines for, 197–98, 204
Performance management, 189–209; benefits of, 191; description of, 189; individual, 194–203; levels of occurrence, 189, *190*; monitoring activities and, 190; optimal system of, 190
Performance management tools: balanced scorecards, 193–94, 203; Gantt charts, 191, *192,* 203; key performance indicators, 191, 203
Performance monitoring: delegation and, 183
Performance rating scales, 198, *199*
Performing stage: in team building, *254,* 255, 259
Personal appeal, 117
Personalized medicine, 232
Personal mastery: in learning organizations, 31
Pew Charitable Trust, 266
Pfeffer, Jeffrey, 4
Pharmacists: cross-disciplinary teams and, 7
Pharmacogenomics, 232
Philippines: ethnic groups in, 284
Philips: healthcare innovations and, 231
Physical characteristics: nonverbal communication and, 272, 277
Physician–hospital partnership arrangement, 331
Physicians: bad behavior by, 258; burnout experienced by, 77–78; competition and, 303; conflict

resolution training for, 306; conflicts between nurses and, 87; cross-disciplinary teams and, 7; professional culture of, 163; stress-related injuries and, 77; 360-degree appraisals for, 200; top ethical dilemmas of, *48*
Physiological influences on stress, 78, *79,* 85
Physiological needs: in Maslow's hierarchy of needs, *21*
Planning function: of Fayol, 5
Polarization: conflict and, 302
Polaroid, 238
Political behavior, 120
Pooled interdependence, 248, 249, *249*
Positions: interests *vs.,* 307–8
Positive emotions, 74, 309
Positive influence tactics, 117, 118, 125
Postmillennial generation: characteristics of, 288
Posttraumatic stress, 74
Power: abuse of, sexual harassment and, 121–24; authority and, 115; coercive, 115, 124; definition of, 114; expert, 116, 124; influence *vs.,* 114, *114,* 124; negative connotations of, 113; referent, 115–16, 124; reward, 115, 124; zone of indifference and, 116–17
Power distance, 161, 163, 167
Pre-performance preparation, 197
Press Ganey, 104
Pressure, 117
Primacy effect, 98, 101, 104–5
Primary care teams: brief history of, 261–62
Primary emotions, 75, *75,* 84
Procedural justice, 44, 163
Process conflict, 301
Process failures: in healthcare, 34
Process structures, 337
Procter & Gamble, 333
Production-oriented leadership, 136
Productivity: Korean culture and stifling of, 161
Professional ethics, 49–52
Professional groups: competition within, 303; high-functioning teams, conflict resolution, and, 258; interdisciplinary nature of healthcare and, 250; team building among, 252
Professionalism: negotiation and, 310, 312
Professional organizations: groups formed through, 246–47
Profit maximization: values and, 352
Project ECHO (Extension for Community Healthcare Outcomes), 8
Project or service line managers: in matrix organizations, 334–35
Promotion(s), 61; diversity and, 292; organizational politics and, 120, *121*
Proteomics, 34
Punishments and threats: work performance and, limitations with, 60, 61
Purpose of organization: expressing, 349–50

Qualitative overload, 82, 85, 88
Qualitative underload, 82, 85
Quality improvement programs: functional structure in hospitals and, 329; promoting learning and, 36, 37
Quantitative overload, 82, 85, 88
Quantitative underload, 82, 85

Racial disparities: in healthcare, 288–89
Racial diversity, 284–86, 294
Rapport: negotiation and, 310, 312
"Rater inflation," 196
Rational decision making, 212–13, 222
Rational persuasion, 117
Receiver: in communication process, 266, *267*

Recency effect, 98, 101, 105
Reciprocal interdependence, 248, 249, *249*
Reciprocation influence strategy, *119,* 125
Referent power, 115, 124
Regulation: emotional intelligence and, 76
Reiley, Alan, 18
Relatedness needs: in Alderfer's ERG theory of motivation, 62, *62*
Relational power, 115–16
Relationships: conflicts in, 301; damaged, poor communication and, 273, 277; strengthening, team building and, 253
Relaxation space: in workplace, 84
Remuneration: Fayol's principle of, 5
Reporting relationships: organizational design and, 322
Resignations, 191
Resistance: to change efforts, 358, 361
Resource allocation: multidivisional organizations and, 331
Resources: definition of, 114; types of, 115
Respect: successful communication and, 276, 278; teams and, 254
Respiratory therapists: cross-disciplinary teams and, 7
Responsibility: delegation and, 178, 183, 184
Results assessment: performance rating numerical scale, *199*
Retail clinics, 232, 238, 239
Retention: poorly handled conflict and, 302; succession planning and, 146, 147
Retirement: of CEOs, in next decade, 174–75
Reward power, 115, 124
Rewards: expectancy theory and, 67, 68, 70; work performance and, limitations of, 60
Ridgeview Medical Center (Minnesota): service line divisions at, 332
Rights model, 43, 52, 53
Rituals and routines, 159, *160,* 167
Road rage (case), 86
Robotic medicine, 34
Roethlishberger, Fritz, 17
Role ambiguity, 80, 85, 120, *121*
Role conflict, 80, 85
Rules of conduct: written, in Weber's efficient bureaucracy, 18
Rumsfeld, Donald, 272

Sadness, *75,* 84
Safety and security needs: in Maslow's hierarchy of needs, 21, *21*
Salary increases: equity issues and, 67
Sarbanes-Oxley Act of 2002, 47, 53
Satisfiers, *63,* 64, 69
SBUs. *See* Strategic business units
Scalar chain: Fayol's principle of, 5
Scalar principle, 19, *19*
Scarcity influence strategy, *119,* 125
Scarcity of resources: organizational politics and, 120, *121*
Scientific management theory, 6, 22, 23, 60; division of labor and, 322, 340; job enrichment *vs.,* 65
Scrushy, Richard, 157, 158, 159
Secondary emotions, 75, *75,* 84, 86
Second Industrial Revolution, 4, 10
Selective memory, 225
Self-actualization: job design and, 64; in Maslow's hierarchy of needs, 21, *21,* 25
Self-awareness: emotional intelligence and, 76
Self-evaluations, 200
Self-knowledge: stories and, 160
Self-serving behaviors, 119
Self-worth: stories and, 160
Sender: in communication process, 266, *267*
Senge, Peter, 31
Senior executives: as coaches, 175
September 11, 2001 terrorist attacks: groupthink and events of, 217
Sequential interdependence, 248, *249*

"Servant as Leader" (Greenleaf), 148
Servant leadership, *147,* 148, 151
Service lines: divisions created around, 331
7 Day Mother Baby mCheck Tool (World Health Organization), 235
Sexual harassment, 125; definition of, 122; Hospital of the University of Pennsylvania policy, 122–23, *123*; prohibiting, written policies for, 122, 125
Shared vision: in learning organizations, 32
Silence: communication barriers and, 273, 277
Silos: NICU nurses and (case), 367–68
Similar-to-me effect, 98, 100–101, 104, 105
Simon, Herbert, 213
Single-loop learning, 31, 36
Single-organ-focused hospitals, 232
Situational leadership, 138–39, *147,* 150
Situation analysis, 219
Skinner, B. F., 61
Small talk: negotiating and, 310, 312
"Smart" drug-infusion pumps: at Massachusetts General Hospital, 234
SMART goals, 68, 70
Social needs: in Maslow's hierarchy of needs, *21*
Social media: harassment and, 122
Social validation influence strategy, *119,* 125
Southweatern Vermont Health Care (Bennington, Vermont), 35
Space: nonverbal communication and, 272, 277
Span of control, 323, 340. *See also* Chain of command
Specialists: transfer of care to generalists from, 231–32
Specialization: division of labor and, 322, 323, 340; functional organizations and, 328–29
Specialized division of labor: in Weber's efficient bureaucracy, 18
Spieth, Jordan, 303
Sponsors: team building and, 251
Sports: teams *vs.* groups in, 248
Sprint-Nextel merger: failure of, 164
Stability of tenure of personnel: Fayol's principle of, 5
Stacked or forced ranking appraisal systems, 195–96, 203
Staff principle, 20
Stakeholders: learning organizations and, 31
Standing committees, 246, 343–46
State of the American Workplace: Employee Engagement Insights for U.S. Business Leaders (Gallup), 361
Status quo bias, 216, 222
Stereotypes, 98, 99–100; danger of, 100, 105; helpful aspects of, 100, 105
Stewardship delegation, 180, 184
Stimuli: interaction of perceptions, paradigms, and, 95–96, *96*
Storming stage: in team building, 254, *254,* 259
Story telling: organizational culture and, 159–60, *160,* 167
Strains: stress and, 82
Strategic business units (SBUs), 320
Strategic options: gap analysis and, 355–56
Strategic planning: succession planning linked to, 146
Stress, 73, 77–80; choice of behaviors and actions and, 79; emotions and, 77, 85; influences on, *79*; managing, 82–84, 85; performance and, 78, *79*; physical symptoms of, *81*; poorly managed conflict and, 301; prevention policies, 83; sources of, 80–82, *81,* 85; work overload or underload and, 82; work-related factors in, 78
Stress-free zones, 84
Stress management: successful negotiation and, 309

Stress-related injuries: health professionals and, 77
"Stretch" assignments: succession planning and, 146
Structural contingency theory, 24
Structures: organizational culture and, *160,* 160–61
Subordinates: delegation and, 177, 178; influence tactics and, 118; span of control and, 323; transformational leaders and, 145, 150. *See also* Followers
Subordination: Fayol's principle of, 5
Successful communication, 275–76, 277
Succession planning: effective, practices tied to, 146–47; transformational leadership and, 146–47, 150; value of, 146
Sunk cost bias, 216, 222
Superlatives team-building exercise, 255
Supervisors: delegation and, 178, 179, 184; span of control and, 323
Supportive leadership style: path–goal theory and, 139
Surgical robots, 232
Surgical time-outs, 271
Surprise, *75,* 84
Surveys: patient satisfaction, 104
Sustainable organizational politics, 120
Sustaining innovation: disruptive innovation *vs.,* 238
Symbols: cultural differences and, 102; organizational culture and, 160, *160,* 167
System thinking: in learning organizations, 31

Task conflict, 301
Task groups, 245–46
Taylor, Frederick W., 6, 10, 23, 60, 65, 322, 340
Team building: components of, 252; early-stage exercises in, 255–56; guidelines for, 250–52; stages of, *254,* 254–55, 259; strengthening relationships and, 253
Team identity: personal interactions and, 275, 277; strengthening, approaches to, 253–54
Team leaders: in Blake and Mouton's managerial grid, *137*
Team learning: in learning organizations, 32
Team members: effective delegation and, 182
Team relationship: interdependence and need for, 249, *249*
Teams: assessment tool for, *257*; conflict and, 256–58, 259; definition of, 247; effective, signs of, 256; groups *vs., 247,* 247–48, 259; high-performing, 250, *251,* 259; interdependent, 248–49, *249*; interdisciplinary, 250; multidisciplinary, 249–50, 259; primary care, brief history of, 261–62; ubiquity of, 245; virtual, 275, 277. *See also* Groups
Technological breakthroughs: disruptive innovation and, 238
Technology innovations: healthcare innovations and, 230, 231, 239
TEDMED, 236
Telemedicine, 34, 232
Tenet Healthcare, 46
Texas Health Resources: 360-degree evaluations at, 200
Thatcher, Margaret, 136
Theory of Social and Economic Organization (Weber), 17
Theory X, 22, *23,* 25, 60
Theory Y, 22, *23,* 25, 60
360-degree feedback appraisal systems, 198, 200–201, 204; disadvantages with, 200; successful, criteria for, 200–201
Time orientation: cultural differences in, 162, 167
Time perception: nonverbal communication and, 272, 277

Time pressures: conflict in healthcare and, 305, 311
Tone of speech: nonverbal communication and, 272, 277
Touching: nonverbal communication and, 271, 277
Toyota Motor Corporation: merger with General Motors plant (Fremont, California), 164
Toyota Production System, 36
Training: for collaborative and coordinated care, 248; in conflict management, 306, 312; division of labor and, 323; effective leadership development and, 174; team building and, 252–53. *See also* Coaching; Mentoring
Trait period: in contemporary leadership study, 135
Trait theory, 134, 135–36, *147,* 150
Transactional leadership, 138, *147,* 150; dynamics of, 141; transformational leadership *vs.,* 142
Transactional period: in contemporary leadership study, 135
Transactional theory, 134
Transfer pricing: multidivisional structures and, 332, 341
Transformational leadership, 141–47, *147,* 150; change and, 357, 360–61; charisma in, 142, 150; components of, 142–45, 150; servant leadership and, 148, 151; succession planning and, 146–47, 150; transactional leadership *vs.,* 142; vision in, 141–42
Transformational period: in contemporary leadership study, 135
Transformational theory, 134, *147. See also* Transformational leadership
Transparency: ethical behavior and, 52, 53
Tribune Media Company, 238
Trust, 53; delegation and, 178, 179, 181, 182, 183, 184; micromanagement and lack of, 182; successful communication and, 276, 277, 278; teams and, 254; zone of indifference and, 116, *116,* 124
Turf battles, 303
Turnover: interpersonal conflict and, 302, 311; rates for generation Xers and millennials, 175
Two-boss challenge: matrix organizations and, 334, 341
Two-factor theory (Herzberg), *63,* 63–64, 70
Two truths and a lie team-building exercise, 255
Two-way communication, 270, 277

UCLA Health: introduction to innovation (case), 240–41
Uncertainty: organizational structure, environment, and, 338, *339,* 341
Uncertainty avoidance, 161, 167
Understanding: learning in an organization and, 30, *30*
Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Institute of Medicine), 293
Unfriending on Facebook, 122
Unilever, 333
United States: competition in, 303, 311; individualism in, 286; major cultural values in, *286*; minority population in, 284; stress in, reasons for and symptoms of, *81*
Unity of command: Fayol's principle of, 5
Unity of direction: Fayol's principle of, 5
Universal Declaration of Human Rights, 351
University of Maryland School of Medicine: 360-degree assessment of residents and students at, 201

University of Texas at Dallas: performance appraisal process at, 198
University of Utah Health Sciences Center: mission statement of, 353
Upward appeals, 117
US Department of Health and Human Services: diverse workforce guidelines, 290, 295
US Department of Justice, 47
US Department of Veterans Affairs (VA): organizational chart for, 324, *325*; work culture of, 165
US Equal Employment Opportunity Commission, 122
US Government Accountability Office, 146, 293
US Joint Chiefs of Staff, 33
Utilitarianism (or utilitarian model), 43, 52

VA. *See* US Department of Veterans Affairs
Vaccinations: paradigms, anti-vaxxer movement, and, 94–95
Valence: motivation and, 67, *67*
Values, 165, 350–52; definition of, 350, 360; gap analysis from, *356,* 360; goals and, 351; interrelationship among mission, vision, and, *350*; motivation and, 352, 360; organizational, 159, *160*; organizational culture and, 157; stories and, 159–60; successful organizations and, 350. *See also* Mission; Vision
Values statements: disregard for, 351–52; purpose of organization and, 349
Verification: communication and, 271
Victimization, 121
Videoconferencing, 275
Vietnam War, 33
Virtual communication, 275, 277
Virtual organizations, 337–38
Vision: balanced scorecard metrics' relationship to, *193*; coordinative principle and, 20; core values, ethics, mission, and, 42; definition of, 141–42, 350, 360; gap analysis from, *356,* 360; interrelationship among values, mission, and, *350*; transformational leadership and, 141–42. *See also* Mission; Values
Visionary leaders: top-performing hospitals and, 142, 143–44
Vision statements: guidelines for, 354–55; purpose of organization and, 349, 360
Vroom, Victor, 67

Walmart, 162, 163
Watson Wyatt, 194
Weber, Max, 4, 6, 10, 17–18, 23, 25, 142, 212
Western Electric Company (Chicago): Hawthorne experiment at, 6, 17
Whale Done! (Blanchard), 138
Whites (Caucasians), 285
WHO. *See* World Health Organization
Win–win solutions: negotiation and, 308
WISH. *See* World Innovation Summit for Health
W. L. Gore, 326
Woodward, Joan, 23
Work: five core characteristics for, 65
Work environment: conflict triggers in, 305, 311
Worker disengagement: scope of, 16
Worker productivity: Hawthorne studies and, 17
Work groups: virtual, 275, 277
Work inputs: equity equilibrium and, *67*; equity theory and, 66 Work–life balance: company vignette, 165; stress and, 77
Work outputs: equity equilibrium and, *67*; equity theory and, 66
Workplace: emotions in, 74–77
Workplace performance: emotional intelligence and, 76–77

Work-related conflict: types of, 301–3. *See also* Conflict management
Work-related stressors, 80, 81. *See also* Stress
WorldCom, 46
World Health Organization (WHO), 271; 7 Day Mother Baby mCheck Tool, 235
World Innovation Summit for Health (WISH), 235
Worldwide Association of Business Coaches, *175*
Written rules of conduct: in Weber's efficient bureaucracy, 18

Yahoo, 196

Zero-sum games: competition and, 303–4, 311
Zone of indifference: power and, 116–17; trust and, 116, *116,* 124

Stephen L. Walston, PhD, has worked as both a professor and a healthcare administrator. Currently, he is a professor in the David Eccles School of Business at the University of Utah in Salt Lake City. Previously, he served as the vice president for academic affairs at the University of Utah's Asia Campus, located at the Incheon Global Campus in Songdo, Korea, and concurrently as a professor on the faculty of the Division of Public Health in the Department of Family and Preventive Medicine at the University of Utah School of Medicine.

Prior to that, Dr. Walston worked for 10 years as a professor and associate dean for academic affairs at the University of Oklahoma School of Public Health in the Department of Health Administration and Policy. He also served as an MHA program director at Indiana University and a faculty member at Cornell University. Earlier in his career, he served as an executive for 14 years in hospitals in the western United States. For 10 of those years, he was a CEO.

Dr. Walston has worked in many Middle Eastern and Central American countries, helping organizations improve their strategic direction and leadership capabilities. He has published articles in numerous journals in the United States and Europe. He has a PhD from the University of Pennsylvania's Wharton School and specializes in healthcare strategy, organizational development, and leadership. He earned a bachelor's and master's degree from Brigham Young University.

In his free time, Dr. Walston enjoys woodworking, beekeeping, reading, bicycling, gardening, and helping his six children and six grandchildren.

ABOUT THE AUTHOR

Britt R. Berrett, PhD, FACHE, is program director and professor of healthcare administration at the University of Texas at Dallas. Previously, he served as president of Texas Health Presbyterian Hospital of Dallas and executive vice president of Texas Health Resources. Dr. Berrett has more than 20 years of experience as a leader in healthcare administration for both not-for-profit and investor-owned hospitals. He is a Fellow of the American College of Healthcare Executives (ACHE) and has served as a Regent of ACHE and as a member of numerous healthcare and civic boards. He holds a doctoral degree in public affairs from the University of Texas at Dallas, a master's degree in health administration from Washington University School of Medicine in St. Louis, and a bachelor's degree in finance from Brigham Young University in Provo, Utah.

Benjamin Whisenant, JD, teaches communications at Brigham Young University in Provo, Utah, and at the University of Utah in Salt Lake City. Before and during his time in academia, he worked in media law for several organizations, including the Media Law Resource Center, Time Warner Cable, Basic Research, and Candlelight Media Group. After earning a degree in comparative literature from Brigham Young University, Professor Whisenant began working for US Senator Orrin G. Hatch in Washington, DC. He then spent several years working as a business journalist. Returning to school, he received a master's degree in journalism from Northwestern University in Evanston, Illinois, and a law degree from the University of Utah. Professor Whisenant currently teaches at the University of Utah's Asia Campus.

ABOUT THE CONTRIBUTORS