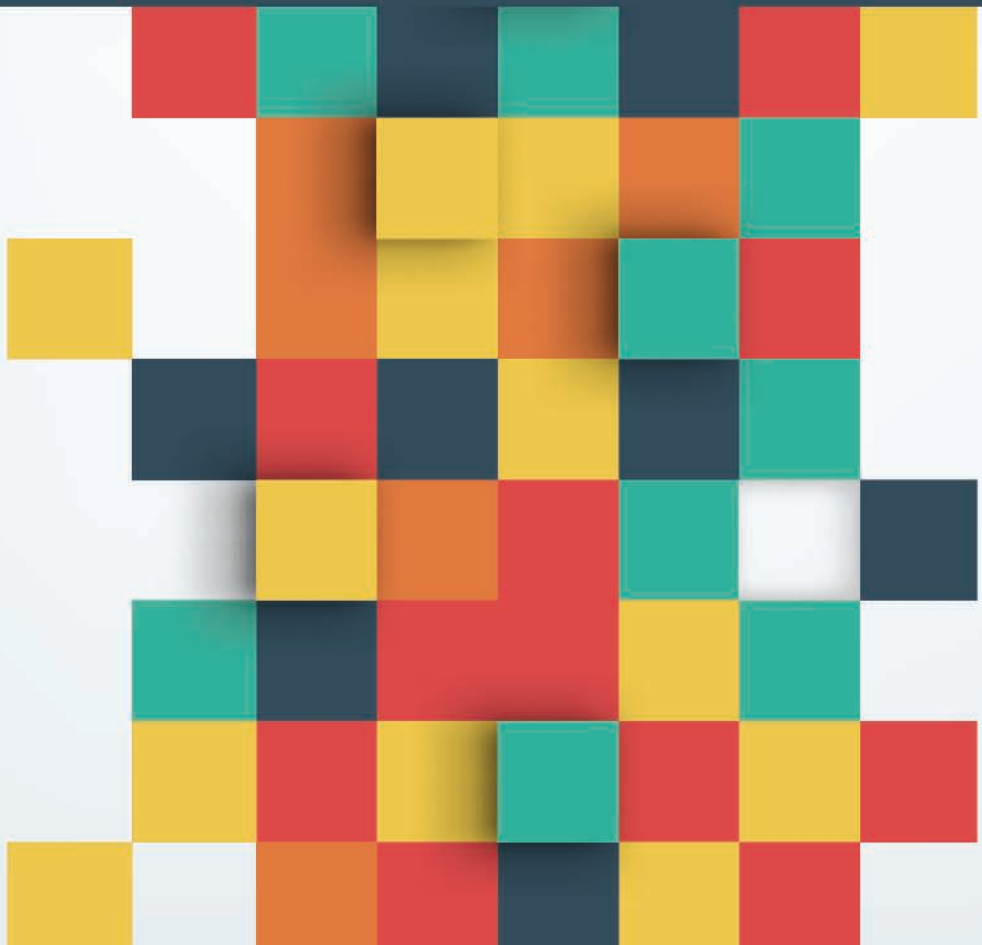
FOURTH EDITION

Organizational Behavior in HEALTH CARE

Nancy Borkowski
Katherine A. Meese



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Printing and Binding: Sheridan Books

Library of Congress Cataloging-in-Publication Data
Library of Congress Control Number: 2020933339

6048

Printed in the United States of America
24 23 22 21 20 10 9 8 7 6 5 4 3 2 1

Brief Contents

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Preface

In the first edition of this book, Chapter 1 stated that "the U.S. health care industry has grown and changed dramatically over the past twenty-five years." That was an understatement! Since that time, the industry has experienced some of the most dynamic changes that health care managers have seen. In the coming years, more system-wide changes will occur as we continue our push forward to achieve patient-centered, value-based health care. Health care managers are quickly learning that what worked in the past might not work in the future. This was the compelling reason to write an organizational behavior book specifically for health care managers who are on the front lines every day, motivating and leading others in a constantly changing, complex environment. This is not an easy task, as we know firsthand!

The purpose of this book is to provide health care managers and other professionals with an in-depth analysis of the theories and concepts of organizational behavior while embracing the uniqueness and complexity of the industry. Although health care is similar to other industries, it is also very different. As the nation's largest industry, health care employs more than 16 million people in numerous interrelated and interdependent segments.

Using an applied focus, this book provides a clear and concise overview of the essential topics in organizational behavior from the health care manager's perspective. It is our goal to give you a greater understanding of why and how people and groups behave as they do in the workplace. With this knowledge, you will be able to predict and effectively influence the behavior of the people you lead. Please let me know if we accomplish our goal! You can reach us at nborkows@uab.edu or kameese@uab.edu.

We have tried to ensure that we referenced all the individuals whose work contributed to the development of this book. However, if by chance we failed to give credit to someone along the way, please contact us so that we can make the necessary correction.

At this time, we wish to thank our families for their patience, understanding, and support over the years. Finally, we wish to thank the many wonderful and caring people employed throughout the health care industry with whom we have had and will continue to have the opportunity to work with. Our lives continue to be blessed by these dedicated individuals!

Thank you for purchasing (and reading) our book. We welcome your comments and suggestions, and we wish you the best on your health care management and leadership journey.

With personal regards,

Nancy Borkowski, DBA, FACHE, FHFMA
Katherine A. Meese, PhD

About the Authors

Nancy Borkowski, DBA, FACHE, FHFMA, is Professor in the Department of Health Services Administration at the University of Alabama at Birmingham. She received her DBA with specializations in health services administration and accounting from Nova Southeastern University. Dr. Borkowski has over 25 years' experience in the health care industry and is a two-time past recipient of the American College of Healthcare Executives' (ACHE) Southern Florida Senior Career Healthcare Executive Award, which recognizes individuals who have made significant contributions to the advancement of health management excellence.

A nationally recognized author, Dr. Borkowski is also board certified in health management and is a Fellow of both the American College of Healthcare Executives and the Healthcare Financial Management Association. The first edition of her book, *Organizational Behavior in Health Care,* referred to as "one of the most significant advances in the field of health services administration," was honored with the *American Journal of Nursing*'s 2005 Book of the Year Award for nursing leadership and management. Dr. Borkowski is the author of three textbooks that are widely used in graduate and undergraduate health administration and nursing programs both nationally and internationally.

Dr. Borkowski's work has been published in the *Journal of Ambulatory Care Management*, *Leadership in Health Services*, *Group & Organization Management*, *Organizational Behavior and Human Decision Processes*, *Health Care Management Review*, *Journal of Health Administration Education*, *Journal of Health and Human Services Administration*, *International Journal of Public Administration*, and various other journals.

Her teaching interests are leadership, organizational behavior, and strategic management. Dr. Borkowski is a past recipient of the ACHE's Excellence in Teaching Award, which is given to faculty who engage in furthering academic excellence and the professional development of health management students.

Over the past three decades, Dr. Borkowski has served in various leadership roles for the Association of University Programs in Health Administration, Academy of Management's Health Care Management Division, the American College of Healthcare Executives' Southern Florida Regent's Advisory Council, the South Florida Healthcare Executive Forum, the Alabama Healthcare Executive Forum, and various other health-related organizations. In 2013, Dr. Borkowski received the Jessie Trice Hero Award for her leadership and commitment to improving the lives of underserved and minority populations. She has also been honored with the Exemplary Service Award from the American College of Healthcare Executives (2012) and the Frederick T. Muncie Gold Award from the Healthcare Financial Management Association (2017).

Katherine A. Meese, PhD, is an Assistant Professor in the Department of Health Services Administration at the University of Alabama at Birmingham. She earned her PhD in Health

Services Administration with a specialization in strategic management from the University of Alabama at Birmingham in 2019. Dr. Meese has seven years of industry experience, encompassing work in ten countries on four continents, including management positions for a large academic medical center. Her work has been published in *Anesthesia & Analgesia, Health Services Management Research, Journal of Health Administration Education*, and various other journals. Her research interests are in wellness, burnout, quality and safety, and delivery models that enhance organizational learning.

PART I

Introduction

Part I includes four different but related topics. In Chapter 1, the history of organizational behavior and its importance to today's health care managers are discussed. Chapter 2 describes the changing environment in which health care managers find themselves. The chapter examines the numerous issues that have emerged within the health care industry because of the nation's changing demographics. Chapter 3 focuses specifically on cultural competency and the skills that managers need to adapt to the changing environment explored in Chapter 2. Chapter 4 deals with attitudes and perceptions, which are the foundation for understanding organizational behavior. You will find the terms "attitude" and "perception" frequently referred to in the various organizational behavior theories. Finally, Chapter 5 discusses the importance of communication. Recent surveys have revealed that 70% of small- to medium-sized businesses claim that ineffective communication is their primary problem. Sentinel event data from The Joint Commission estimated that communication failure was the root cause for patient harm 70% of the time in 2400 reported negative outcomes studied. No wonder the ability to communicate effectively is considered an essential job skill for today's health care managers and leaders.

CHAPTER 1

Overview and History of Organizational Behavior

LEARNING OUTCOMES

After completing this chapter, the student should understand:

- The definition of organizational behavior.
- The major challenges facing today's and tomorrow's health care organizations and health care managers.
- The importance of the Hawthorne Studies to the study of organizational behavior.
- The importance of McGregor's Theory X and Theory Y to the study of organizational behavior.
- The differences between organizational behavior, organization theory, organizational development, and human resources management.

Overview

Organizational behavior (OB) is an applied behavioral science that emerged from the disciplines of psychology, sociology, anthropology, political science, and economics. OB is the study of individual and group dynamics in an organizational setting. Whenever people work together, numerous and complex factors interact. The discipline of OB attempts to understand these interactions so that managers can predict behavioral responses and, as a result, manage the resulting outcomes.

According to Ott (1996, p. 1), OB asks the following questions:

1. Why do people behave the way they do when they are in organizations?
2. Under what circumstances will people's behavior in organizations change?
3. What impacts do organizations have on the behavior of individuals, formal groups (such as departments), and informal groups (such as people from several departments who have lunch together regularly)?
4. Why do different groups in the same organization develop different behavior norms?

From Ott. *Classic Readings in Organizational Behavior*, 2E. © 1996 South-Western, a part of Cengage Learning, Inc.

OB has three goals. First, OB attempts to explain why individuals and groups behave the way they do in organizational settings. Second, OB tries to predict how individuals and groups will behave on the basis of internal and external factors. Third, OB provides managers with tools to assist in the management of individuals' and groups' behaviors so that they willingly put forth their best effort to accomplish organizational goals. In the health care industry, OB has become more important because people with diverse backgrounds and cultural values have to work together effectively and efficiently.

Why Study Organizational Behavior in Health Care?

The largest U.S. industry is health care, which currently employs over 20 million individuals. The industry will account for almost a third of the nation's projected job growth through 2026, adding over 2 million jobs. The projected 1.9% per year growth rate is the fastest among all industry sectors (Bureau of Labor Statistics, 2019).

Each segment of the health care industry (e.g., hospitals, home health, rehabilitation facilities) comprises a different mix of health-related occupations, ranging from highly skilled licensed professionals, such as physicians and nurses, to those with on-the-job training. Furthermore, each segment of the industry has various economic structures (e.g., for-profit, not-for-profit, governmental). Therefore, today's health care managers need to have the skills to communicate effectively with, motivate, and lead diverse groups of people within a large, dynamic, and complex industry. Communication, motivation, and leadership are all concepts in the discipline of OB. Furthermore, managers need to understand the causes of workplace problems, such as low performance, turnover, conflict, and stress, so that they may be proactive and minimize these unnecessary negative outcomes. With a greater understanding of OB, managers are better able to predict and therefore influence the behavior of employees to achieve organizational goals.

Given the service-related intensity of the health care industry, understanding individuals' behavior and group dynamics within health service organizations is critical to a health care manager's success. Research indicates that the primary reasons why managers fail stem from difficulty in handling change, not being able to work well in teams, and having poor interpersonal relations. There is a saying that employees don't leave organizations, they leave managers!

The Health Care Industry

Changes within the health care industry over the past 30 years have been powerful, far reaching, and continuous. Because readers are probably familiar with most of these changes either from their own experiences or from a previous health care delivery system course, the discussion will address some of the trends or future concerns that will affect tomorrow's health care industry.

Past changes and future trends are interrelated forces that have shaped or will shape tomorrow's health care organizations at both the system level and the organizational level. Declining reimbursement and changes in payment schemes for services have had, and will continue to have, two of the deepest impacts on the industry. Technology has also caused significant changes within the industry. Biomedical and genetic research, advances in information technology, and use of "big data" are producing rapid changes in clinical treatments. In addition, the industry has experienced

more government mandates and substantial legislative changes, such as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; the American Recovery and Reinvestment Act of 2009; the Patient Protection and Affordable Care Act of 2010 (ACA) and subsequent legislation to repeal portions of the act; and the Medicare Access & Chip Reauthorization Act of 2015 (MACRA). With an increased focus on chronic disease management, patients are living longer, and requiring more long-term and home health care services now and in the future. Patients' and health care workers' characteristics are also changing. Both populations are becoming older and more diverse. Patients are better informed and have increasingly high expectations of health care professionals. This trend has changed the way in which health care services are delivered, with a focus on patient satisfaction and safety as well as on the quality and value of services provided. Physician–patient relationships have changed because patients are beginning to understand that much of the responsibility for wellness lies with them and have easy access to health-related information. A growth in high-deductible insurance plans places a larger financial responsibility on patients to manage their own health and reduce unnecessary health spending. The economics of health care are in a state of flux. For example, reimbursements are moving toward value-based payments; therefore, we see an increase in the use of evidence-based medicine. There are continuing shortages of staff, especially in the areas of primary care physicians, nurses, imaging technicians, and pharmacists, leading to competition for well-qualified people. Changes are also taking place in the disease environment. Many factors of modern life are contributing to the emergence of new diseases, reemergence of old ones, and evolution of pathogens that are immune to many of today's medications. In addition, because of potential terrorism attacks, health care providers are concerned with biodisaster preparedness. Finally, even with some states' Medicaid expansion programs and the ACA, there continues to be the issue of caring for the uninsured which can contribute to the overuse and misuse of hospital emergency departments.

To deal with these changes, a number of health care organizations have adapted their organizational forms by restructuring themselves into integrated delivery networks, which may be part of a local, regional, or national system. We have seen increased vertical, horizontal, and virtual integration. Vertical integration focuses on the development of a continuum of care services to meet the patient's full range of health care needs. This integration model, in which a single entity owns and operates all the segments providing care, may include preventive services, specialized and primary ambulatory care, acute care, subacute care, long-term care, and home health care, as well as a health plan. Recently, we have seen the creation of accountable care organizations (ACOs), in which groups of doctors, hospitals, and other health care providers have joined together to provide coordinated care to predetermined patient populations. Horizontal integration usually occurs through mergers, acquisitions, and/or consolidation within one segment of the industry. For example, during the 1990s, numerous hospitals were acquired by the large, for-profit, publicly held hospital chains of Hospital Corporation of America (HCA), Tenet Healthcare, and Health Management Associates (now part of Community Health Systems), and these acquisitions continue today. Consolidation in health care began to rise rapidly in 2009 and doubled between 2011 and 2015 (Health Care Financial Management Association, 2017). In addition, not-for-profit hospitals have merged with for-profit health systems as a result of competition and the need to reduce cost through economies of scale. Virtual integration, which emphasizes coordination of health care services through patient-management agreements, provider incentives, and/or information systems, has increased. This virtual integration has evolved to meet the need for better technology and information infrastructures that allow for information sharing, patient care management, and cost control.

Because of the dramatic changes and the future trends in the health care industry, most managers have had to change the ways in which they and other employees carry out their job responsibilities. These changes have been forced on the industry by the need to increase productivity, due to decreasing reimbursement and increasing competition. At the same time, health care providers must deliver patient-centered, value-based care. These are not easy tasks to balance. As a result, many health care providers are breaking down their traditional hierarchical structures and moving toward multidisciplinary team-managed environments. Employees are finding themselves in new roles with new responsibilities. All of these changes cause disruptions in the workplace. The study of OB will assist health care managers to minimize the negative effects (such as stress and conflict) related to this "new" environment and to maximize their ability to motivate staff and lead their organizations effectively.

History of Organizational Behavior

The beginnings of OB can be found in the human relations/behavioral management movement, which emerged during the 1920s as a response to the traditional or classic management approach. Beginning in the late 1700s, the Industrial Revolution was the driving force for the development of large factories employing many workers. Managers at that time were concerned "about how to design and manage work in order to increase productivity and help organizations attain maximum efficiency" (Daft, 2004, p. 24). This traditional approach included Frederick Taylor's (1911) well-known framework of scientific management, or "Taylorism," as it is now labeled. Taylor believed that efficiency was achieved by creating jobs that economized time, human energy, and other productive resources. Through his time-and-motion studies, Taylor scientifically divided manufacturing processes into small, efficient units of work. Through Taylor's work, productivity greatly increased. For example, Henry Ford developed his assembly line according to the principles of Taylorism and was able to churn out Model Ts at a remarkable and economical pace (Benjamin, 2003).

Although the classic approach to management focused on efficiency within organizations, Taylor did attempt to address a human relations aspect in the workplace. In his book *The Principles of Scientific Management*, Taylor stated that:

> in order to have any hope of obtaining the initiative (i.e., best endeavors, hard work, skills and knowledge, ingenuity, and good-will) of his workmen, the manager must give some special incentive to his men beyond that which is given to the average of the trade. This incentive can be given in several different ways, as, for example, the hope of rapid promotion or advancement; higher wages, either in the form of generous piecework prices or of a premium or bonus of some kind for good and rapid work; shorter hours of labor; better surroundings and working conditions than are ordinarily given, etc., and, above all, this special incentive should be accompanied by that personal consideration for, and friendly contact with, his workmen which comes only from a genuine and kindly interest in the welfare of those under him. It is only by giving a special inducement or incentive of this kind that the employer can hope even approximately to get the initiative of his workmen.

Although Taylor included a concern for workers in the scientific management approach, the human relations or behavioral movement of management did not begin until after the landmark Hawthorne Studies.

The Hawthorne Studies

Elton Mayo, Frederick Roethlisberger, and their colleagues from Harvard Business School conducted a number of experiments from 1924 to 1933 at the Hawthorne Plant of the Western Electric Company in Cicero, Illinois. The Hawthorne Studies were significant to the development of OB because the researchers demonstrated the important influence of human factors on worker productivity. It was through these experiments that the Hawthorne Effect was identified. The Hawthorne Effect is the bias that occurs when people know that they are being studied. Roethlisberger and Dickson (1939), in their book *Management and the Worker*, and Homans (1950), in his book *The Human Group*, provided a comprehensive account of the Hawthorne Studies. The Hawthorne Studies had four phases: the illumination experiments, the relay-assembly group experiments, the bank-wiring observation-room group studies, and the interviewing program. The intent of these studies was to determine the effect of working conditions on productivity.

The illumination experiments were conducted to determine whether increasing or decreasing lighting would lead to changes in productivity. The researchers were surprised to learn that productivity increased in both the control group (no change in lighting) and the experimental group (lighting alternated upward and downward). The researchers determined that it was not the lighting that caused the increased productivity; rather, the improvement resulted from the attention received by the group.

In the relay-assembly group experiments, productivity of a segregated group of workers was studied as they were subjected to different working conditions. The researchers and management observed the group closely for 5 years. During the first part of the experiment, the employees' working conditions were improved by extending their rest periods, decreasing the length of their workday, and providing them a free day and lunches. In addition, the workers were consulted before any changes were made, because their agreement had to be obtained before the change would be implemented. The workers of the group were given the freedom to interact with one another during the workday. Furthermore, one researcher also served as their supervisor, who, during the experiment, expressed concern about the workers' physical health and well-being. The researchers eagerly sought the employees' opinions, hopes, and fears during the experiment. During the improved-conditions period, the workers' productivity increased. In part two of the experiment, the original working conditions were restored. Surprisingly, the researchers found that the employees' productivity remained at the high level that had occurred under the improved working conditions. This result was attributed to group dynamics because the group was allowed to develop socially with a common purpose.

The bank-wiring observation-room experiment was similar to the relay-assembly experiment. A group of workers were segregated so that their productivity and group dynamics could be studied. The workers were paid at a piecework rate that reflected both group and individual efforts. The researchers found that the wage incentive did not work. The group had developed its own standard as to what constituted a "proper day's work." As a result, the group's level of productivity remained constant because they did not want management to know that they could produce at a higher level. If a member of the group produced more than the agreed-upon level, the other members influenced the "rate buster" to return their productivity level to the group's norm. In addition, if a member of the group failed to produce the required level of output, the other members traded jobs to ensure that the group's output level remained constant. The results of the bank-wiring experiment mirrored the relay-assembly experiment results. The researchers concluded that there

was no cause-and-effect relationship between working conditions and productivity and that any increase or decrease in productivity was attributed to group dynamics.

As a result of the bank-wiring experiment, researchers became very interested in exploring informal employee groups and the social functions that occur within the group and influence the behavior of the individual group members. As part of the Hawthorne Studies, the researchers conducted extensive interviews with the employees. Over 21,000 interviews were conducted to determine the employees' attitudes toward the company and their jobs. A major outcome of these interviews was that the researchers discovered that workers were not isolated, unrelated individuals; they were social beings and their attitudes toward change in the workplace were based on (1) the personal social conditioning (values, hopes, fears, expectations, etc.) that they brought to the workplace, formed from their previous family or group associations, and (2) the human satisfaction that the employees derived from their social participation with coworkers and supervisors. What the researchers learned was that an employee's expression of dissatisfaction may be a symptom of an underlying problem in the workplace, at home, or in the person's past.

Theories X and Y

Another significant impact in the development of OB came from Douglas McGregor (1957, 1960) when he proposed two theories by which managers view their employees: Theory X (negative/pessimistic) and Theory Y (positive/optimistic). Theories X and Y reflect polar positions and are ways of seeing and thinking about people, which, in turn, affect their behavior.

Theory X states that employees are unintelligent and lazy. They dislike work, avoiding it whenever possible. Employees should be closely controlled because they have little desire for responsibility, have little aptitude for creativity in solving organizational problems, and will resist change. In contrast, Theory Y states that employees are creative and competent; they want meaningful work; they want to contribute; and they want to participate in decision-making and leadership functions.

Borrowing from Maslow's Hierarchy of Needs, McGregor stated that the autocratic (Theory X) managers were no longer effective in the workplace because they relied on an employee's lower needs for motivation (physiological concerns and safety), which, in modern society, were mostly satisfied and therefore no longer acted as motivators for the employee. For example, managers would ask, "Why aren't people more productive? We pay good wages, provide good working conditions, have excellent fringe benefits, and provide steady employment. Yet people do not seem to be willing to put forth more than minimum efforts." The answers to these questions were embedded in Theory X's managerial assumptions about people. If managers believed that their employees had an inherent dislike for work and must be coerced, controlled, and directed to achieve organizational goals, the resulting employee behavior was nothing more than a self-fulfilling prophesy. The manager's assumptions caused the staff's "unmotivated" behavior.

At the opposite end of the spectrum from Theory X, McGregor proposed Theory Y, which suggested productivity increased when managers created opportunities, removed obstacles and encouraged growth and learning for their employees. McGregor stated that participative (Theory Y) managers supported decentralization and delegation of decision making, job enlargement, and participative management because these allowed employees some freedom to direct their own activities and to assume responsibility, thereby satisfying their higher-level needs (see **Figure 1-1**).

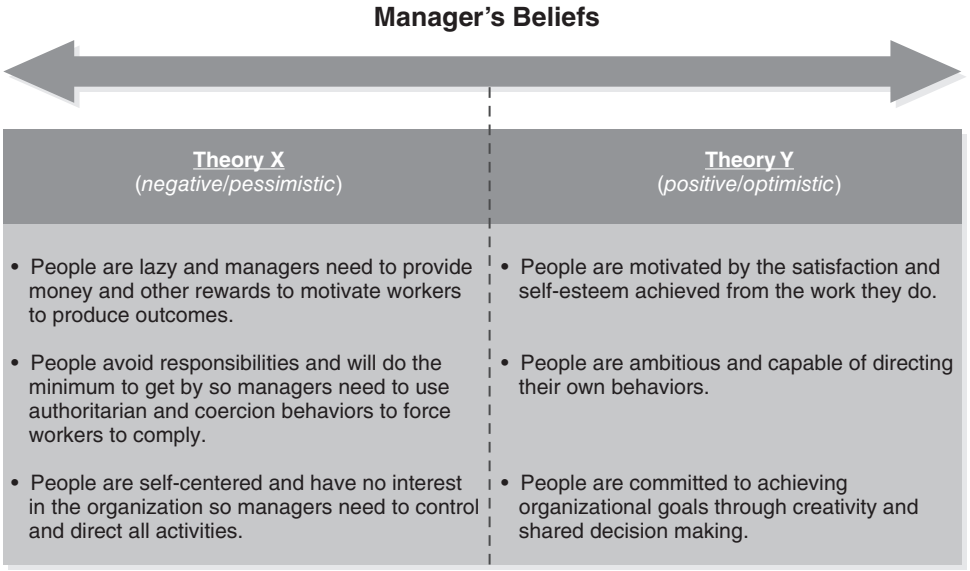

Figure 1-1 McGregor X–Y Theory Diagram

Related Disciplines

Before we conclude this chapter, we would like to explain the differences between OB and three other related fields: organization theory (OT), organizational development (OD), and human resources management (HRM). As was noted at the beginning of the chapter, OB is the study of individual and group dynamics within an organization setting and therefore is a micro approach. OT analyzes the entire organization and is a macro perspective, since the organization is the unit examined. The field of OD describes a planned process of change that is used throughout the organization with the goal of improving the effectiveness of the organization. Since, like OT, OD involves the entire organization, it is a macro examination. Finally, HRM can be viewed as a micro approach to managing people. The difference between HRM and OB is that the latter studies human behavior in various settings with an emphasis on explaining, predicting, and understanding behavior in organizations, whereas HRM emphasizes systems, processes, procedures, and the like for personnel management and is usually housed in a functional unit within an organization.

Since 1960, a wealth of information has emerged within the study of OB, which will be addressed in this textbook. In Part I, the issues of diversity, perceptions, attitudes, and communication are discussed. Part II addresses motivation and individual behaviors. Part III examines the subject of leadership from four approaches—power and influence, behavioral, contingency, and transformational. Part IV emphasizes the importance of intrapersonal and interpersonal issues within the context of stress and conflict management. Part V examines group dynamics, working in groups, and teams and team-building. Part VI provides an overview of managing organizational change within the context of organizational development.

Discussion Questions

1. Define organizational behavior.
2. What are some of the major challenges facing today's and tomorrow's health care organizations and health care managers? Why?
3. Why did the Hawthorne Studies have an impact on the study of organizational behavior?
4. Why did McGregor's Theory X and Theory Y have an impact on the study of organizational behavior?
5. Discuss the difference between organizational behavior, organization theory, organizational development, and human resources management.

What Do You Know About Organizational Behavior?

	Questions	True/False
1	OB is the study of individuals, groups, and organizations.	_____
2	Under Theory Y, managers create opportunities, remove obstacles, and encourage growth and learning for their employees.	_____
3	Attitudes are very individual and subjective; therefore, we do not currently have ways to measure employees' attitudes about their jobs.	_____
4	Extroverts do best in quiet, nonsocial jobs such as computer work, while introverts show the best job performance when they must work and present in front of large groups of people.	_____
5	Motivation is described as the conscious or unconscious stimulus, incentive, or motives for action toward a goal resulting from psychological or social factors, the factors giving the purpose or direction to behavior.	_____
6	Employee motivation has a direct impact on a health services organization's performance.	_____
7	Process theories of motivation assist managers in predicting employees' behavior so that the behavior may be influenced if necessary.	_____
8	An employee's degree of job satisfaction is proportional to the actual amount of rewards the employee is receiving.	_____
9	Power may be defined as the influence over the beliefs, emotions, and behaviors of people.	_____
10	A leader is a person who directs the work of employees and is responsible for results.	_____
11	Management and leadership are both necessary for an organization to achieve its goals.	_____
12	The leader who is able to respond to ever-increasing levels of environmental uncertainty through the utilization of more than one style of leadership will be most likely to increase motivation, satisfaction, and productivity of employees.	_____
13	Transactional leadership is all about change, innovation, improvement, and entrepreneurship through vision and inspiration.	_____

14	Transactional and transformational leader approaches are clearly in opposition.	_____
15	Because stress is a complex and highly personalized process, some individuals see a specific situation as a threat, whereas others see the same situation as a challenge or opportunity.	_____
16	Managers are under the constraints of limited time and resources, personal bias, and other factors, which make rational decision making unrealistic.	_____
17	Conflict is inevitable and unavoidable.	_____
18	Individuals join groups to satisfy their need for safety and social interaction.	_____
19	Barriers to effective teamwork fall within four categories: (1) lack of management support, (2) lack of resources, (3) lack of leadership, and (4) lack of training.	_____
20	The two primary forces influencing an individual's perception, attitude, and response toward change are cumulative life experiences and social (informal group) forces.	_____

Scoring

The correct answers to the above 20 questions are:

1. False
2. True
3. False
4. False
5. True
6. True
7. False
8. False
9. True
10. False
11. True
12. True
13. False
14. True
15. True
16. True
17. True
18. True
19. True
20. True

Interpretation

How much do you know about organizational behavior? If you scored well—good for you! However, the above questions represent only a very small part of organizational behavior. If you didn't score high, don't be concerned. You will learn the many theories and concepts of organizational behavior that will provide you with the necessary skill set to successfully manage and lead others.

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CHAPTER 2

Diversity, Equity, and Inclusion in Health Care*

LEARNING OUTCOMES

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

- Define diversity, equity, and inclusion.
- Understand major trends in U.S demographics.
- Understand why changes in U.S. demographics affect the health care industry.
- Understand the unique challenges facing different groups of people.

Overview

Demographics of the U.S. population have changed dramatically in the past three decades. These changes directly affect the health care industry in regard to the patients we serve and our workforce. Over the next 40 years, there is expected to be a fundamental shift in which demographic groups represent majority and minority percentages of the U.S. population. According to the U.S. Census Bureau, by midcentury the White, non-Hispanic population will make up less than 50% of the nation's population. The health care industry needs to change and adopt new ways to meet the diverse needs of our current and future patients and employees.

This chapter is presented in three parts. First, we define the terms "diversity," "equity," and "inclusion." Second, we discuss the changing demographics of the nation's population. Last, we examine how these changes are affecting the delivery of health services from both the patient's and the employee's perspectives. Because diversity challenges faced by the health care industry are not limited to quality-of-care and access-to-care issues, in part three of our discussions we explore

* We would like to thank Dr. Justin Lord for his contribution to this chapter. We wish to acknowledge and thank Dr. Jean Gordon, who was the contributing author of an earlier version of this chapter, which appeared in *Organizational Behavior in Health Care* (2014), Jones & Bartlett Learning.

how these changes will affect the health services workforce and, more specifically, the current and future leadership within the industry.

Diversity, Equity, and Inclusion Defined

The *American Heritage Dictionary of the English Language* (4th ed.) defines diversity as "(1) the fact or quality of being diverse; difference, and (2) a point in which things differ." Dreachslin (1998) provides a more specific definition of diversity as "the full range of human similarities and differences in group affiliation including gender, race/ethnicity, social class, role within an organization, age, religion, sexual orientation, physical ability, and other group identities" (p. 813). Therefore, diversity can mean a great many things, from differences in education, language, and background to race and gender identity. For our discussions, we will focus on the following characteristics: (1) race/ethnicity, (2) age, (3) biological sex at birth, and (4) sexual orientation, gender identity, and gender expression.

Equity is providing fair treatment, access, opportunity, and advancement for all people while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups. Improving equity involves increasing fairness of the procedures and processes within the organization as well as in their distribution of resources. Tackling equity issues requires an understanding of the root causes of outcome disparities within our society and organizations (Kapila, Hines, & Searby, 2016).

Inclusion refers to the act of creating environments in which any individual or group can feel welcomed, respected, and supported and can fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions to all people (Kapila et al., 2016). Inclusion allows people to have a sense of belonging.

A diverse environment with many different types of people might not be equitable or inclusive. Therefore, just increasing diversity is not enough. For example, if a manager does not offer the same mentorship and coaching to employees from underrepresented populations and therefore these employees do not get the same opportunities for promotion as nonminority employees do, that is not an equitable environment. An environment can be diverse and equitable but not inclusive. For example, maybe all employees have access to the same coaching and career development opportunities, but the manager plans a celebratory lunch during an important Jewish religious holiday. This lunch would not be inclusive because Jewish employees could not attend as a result of their religious obligations. One way to remember the differences between diversity, equity, and inclusion is by thinking about going to a dance. Diversity means that everyone is invited to the dance. Equity means that each person gets to contribute to the playlist. Inclusion means everyone gets asked to dance (Meyers, 2017; University of Michigan, 2018; see **Case 2-1**).

Unfortunately, we all have implicit or unconscious biases that can affect how we treat people of certain genders, gender identities, sexual orientations, races, ethnicities, and ages. Despite our best intentions, these implicit biases are often unknown even to ourselves, and they can lead us to create or accept environments in which certain people are treated poorly or are discriminated against. "Think of implicit bias as the thumbprint of the culture on our brain," says Harvard University social psychologist Mahzarin Banaji (Joplin & Kunitz, 2018). Harvard University's Project Implicit provides a series of free online implicit association tests to help people determine what implicit biases they hold. An analysis of almost 8000 participants found that people tend to demonstrate a moderate implicit preference for Whites over Blacks and for heterosexuals over homosexuals and

a strong implicit preference for young over old people. People also have a stronger implicit association with men and science than with women and science (Project Implicit, 2019; see **Case 2-2**). It is only by recognizing our unconscious and implicit biases that we can hope to change them. Instead of denying their existence—we *all* have them—we must actively work to eliminate our own blind spots that might be leading us to treat certain types of people differently.

CASE 2-1 Diverse but Not Inclusive

Jill, a young White female, was hired to work at a health care consulting firm. The team was very diverse, with people from all over the world who had a variety of educations and backgrounds. Jill's coworkers had different religious and cultural beliefs, races, languages, and countries of origin. Jill felt that she connected well with all of her colleagues and really appreciated the unique perspectives they all brought to the team. However, she started to notice that the senior vice president, Mark, had a small group of favorites. The only people whom he would invite to lunch or have coaching sessions with were the younger White employees. In fact, as individuals started to get promoted, the White employees were promoted much higher and more quickly than anyone else. Although these employees' promotions were usually deserved, other employees seemed to have a harder time gaining promotion even if they had performed equally well. When Jill had been at the company for almost a year, Mark scheduled a team lunch at an expensive restaurant to thank the entire team for surpassing productivity targets. The lunch was scheduled during Ramadan, which is an important religious time for Muslims, and involves fasting during the day. Jill overhead one of her Muslim coworkers whispering to another coworker, "Doesn't he know how insulting it is to invite us knowing that we can't eat anything? I mean if he had just waited one more week to schedule the lunch, we could all enjoy it." Jill thought that Mark might have been unaware of the poor timing, so she brought it to his attention at their next one-on-one meeting. When Jill raised the issue, Mark replied, "Well, I've got to keep the numbers down somehow if I want us to go somewhere expensive. They are invited. It's not my problem if they choose not to eat."

Was this environment diverse, equitable, and inclusive? Why or why not?

CASE 2-2 You Don't Look Like a Doctor

Tamika Cross, a young African American physician who worked in Houston, was flying home from a wedding in Detroit. When the flight attendants asked for any physicians on board to help a passenger who had become unresponsive, Dr. Cross raised her hand and offered to help. The flight attendant responded, "Sweetie, put [your] hand down. We are looking for actual physicians or nurses or some type of medical personnel, we don't have time to talk to you."

When Dr. Cross tried to inform the flight attendant that she was a physician, she was repeatedly dismissed and asked to show credentials. When she insisted that she was a doctor, the flight attendants responded with surprise and disbelief. The crew continued to ask any physicians on board to press their call buttons. A few moments later, a white male physician told the flight attendant that he was a physician, and Dr. Cross was sent back to her seat.

Dr. Cross posted the account to her Facebook page, which then went viral on a number of social media sites and news outlets, sparking the #WhataDoctorLooksLike movement.

What implicit biases do you think the flight attendant held about what a physician should look like?

Reproduced from https://twitter.com/hashtag/TamikaCross and https://twitter.com/hashtag/whatadoctorlookslike accessed September 2, 2019.

Changing U.S. Population

To better appreciate the need for more diverse, equitable, and inclusive environments, it is important to understand how our population is changing. The demographic profile of the U.S. population is projected to undergo significant alterations over the next 40 years in age, gender, and ethnicity (see **Table 2-1**).

In 2016, 323.1 million people resided in the United States, an increase of 41.7 million people, or 14.8%, between 2000 and 2016. The 2016 census data showed a decline in the White, non-Hispanic population for the first time in history since the first census in 1790. This decline was almost a decade ahead of earlier projections. Additionally, there are currently more non-White

Table 2-1 Projected Population of the United States by Age, Gender, and Race/Ethnicity[a] (in Millions)

	2016		2060		2016–2060 Change	
	Number	Percent	Number	Percent	Number	Percent
Total population	323.1	100	403.7	100	80.6	24.9
Under age 18	73.6	22.8	79.8	19.8	6.2	8.4
Ages 18–64	200.2	62.0	229.7	56.9	29.4	14.7
Ages 65 and over	49.2	15.2	94.7	23.5	45.4	92.3
Males	159.1	49.2	200.9	49.8	41.8	26.3
Females	164.0	50.8	203.6	50.4	39.6	24.1
One race	314.6	97.4	379.2	93.9	64.6	20.5
White	248.5	76.9	275.0	68.1	26.5	10.7
Non-Hispanic White	198.0	61.3	179.2	44.4	–18.8	–9.5
Black or African American	43.0	13.3	60.7	15.0	17.7	41.1
American Indian and Alaska Native	4.1	1.3	5.6	1.4	1.5	37.7
Asian	18.3	5.7	36.8	9.1	18.5	101.0
Native Hawaiian and Other Pacific Islander	0.8	0.2	1.1	0.3	0.4	45.9
Two or more races	8.5	2.6	25.3	6.3	16.8	197.8
Hispanic or Latino	57.5	17.8	111.2	27.5	53.7	93.5

[a]Data from U.S. Census Bureau. (2108) 2017 National Population Projections Tables. Available at: https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

Vespa, J., Armstrong, D. M., & Medina, L. (2018). Demographic turning points for the United States: Population projections for 2020 to 2060. US Department of Commerce, Economics and Statistics Administration, US Census Bureau.

children than White children under 10 years old for those born after 2007 (Frey, 2018). This means that as the youngest generation ages, we are on the verge of a fundamental shift in the diversity of both patients and workers in the United States. In addition to the changing ethnic and racial composition of America, another trend is the aging population. The percentage of the population over age 65 is projected to increase from 15% to 23% by the year 2060, an increase of 45.5 million people (see Table 2-1). Finally, by the year 2030, international migration is projected to outpace the natural increase (excess of births over deaths) as the main cause of population growth (Vespa, Armstrong, & Medina, 2018).

Males and females are almost evenly divided in the total population, representing 49.2% and 50.8%, respectively (see Table 2-1); however, in the population under age 25 years, males outnumber females. Among older adults, the male–female ratio reverses, with women outnumbering men, typically due to longer life spans (Vespa, Armstrong, & Medina, 2018). This imbalance is expected to persist through 2060 and beyond. However, the gap between males and females over age 65 is narrowing as men are living longer than men in previous generations.

Race/Ethnicity

The U.S. population continues to diversify racially as minority populations continue to increase at a faster rate than the White population. Although the non-Hispanic White population still represents the largest group (61.3%) of the U.S. population, this number is expected to decrease by almost 10% by 2060 (see Table 2-1).

In 2016, the Hispanic or Latino population represented the largest minority in the United States, at almost 18% of the population. By 2060, Hispanics are expected to make up over a quarter of the U.S. population (27.5%), almost doubling in number. The remaining population is composed of 13% Black or African American, 6% Asian and Pacific Islanders, 1% American Indians and Alaska Natives, and 3% people who identify themselves as belonging to another or more than one race (see Table 2-1).

The Asian population in the United States is increasing rapidly as a percentage of the total population. From 2000 to 2010, the population of people who identified themselves as being Asian (either alone or in combination with another race) grew 43.3%, while the total population grew only 9.7% (U.S. Census Bureau, 2010). After people identifying as more than one race, the Asian population is expected to be the fastest-growing segment, doubling in size by 2060 (see Table 2-1).

In addition to the resident population in the United States, health care organizations may encounter an even more diverse patient population, due to the strong reputation of U.S. health care and its popularity as a destination for medical travel and medical tourism. The United States is a highly desirable destination for health care for people around the world who might not be able to access various types of procedures or treatments in their home countries. Hundreds of thousands of visits from international patients from almost every country occur at U.S. hospitals every year (Johnson & Garman, 2010). As the middle class expands in countries such as China and India, this trend is expected to continue as more patients around the world are able to afford to travel for treatment. This means that health care workers will need additional skills and tools for dealing with a vastly more diverse population of patients coming from other countries in addition to the growing diversity in the domestic population.

Unfortunately, people from underrepresented racial and ethnic groups often face additional challenges when they interact with the U.S. health care system. A survey by the Commonwealth Fund (2002) found that Black non-Hispanics, Asian Americans, and Hispanics are more likely

than White non-Hispanics to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving health care, to experience barriers to access to care such as lack of insurance or not having a regular physician, and to feel that they would receive better care if they were of a different race or ethnicity. In addition, the survey found that Hispanics were more than twice as likely as White non-Hispanics (33% versus 16%) to cite one or more communication problems, such as not understanding the physician, not being listened to by the physician, or not asking questions they needed to ask. Twenty-seven percent of Asian Americans and 23% of Black non-Hispanics experience similar communication difficulties.

Age

The world's population is aging at unprecedented rates. Slow population growth brought about by reductions in fertility leads to population aging; that is, it produces populations in which the proportion of older persons increases while that of younger persons decreases. For the first time in history, in 2018 the number of people over age 65 in the world outnumbered the number of children under age 5. By 2050, the number of people over age 65 is projected to be double the number of people under age 5 (United Nations, 2019).

The United States is experiencing the same trend. Between 2016 and 2060, the U.S. population under age 18 is expected to grow by 8%, and the population aged 45–64 is expected to grow by almost 15%. In stark contrast, the country is experiencing substantially faster growth rates for older ages. For example, the population over age 65 is expected to almost double (U.S. Census Bureau, 2018, see Table 2-1). The large growth in this age group is primarily attributable to the aging of the Baby Boom population and longer life spans due to disease control and advances in medical technology.

One of the most striking characteristics of the older population is the change in the ratio of men to women as people age. As Howden and Meyer (2011, p. 3) point out, this is a result of differences in mortality rates for men and women, in that women tend to live longer than men. For example, life expectancy for men in the United States is 76.1 years, whereas women's life expectancy is 81.1 years.

While the elderly population is not as racially and ethnically diverse as younger generations, its racial and ethnical makeup is projected to diversify over the next four decades. As in the past, the largest proportion of the U.S. population age 65 and over is White. However, the racial composition of the older population is changing; the percentage of Whites is projected to decrease by 2060, and the percentages of all other race groups will increase (Vespa et al., 2018).

Technology and other medical advances have given us the ability to increase longevity. As our citizens grow older, more services are required for the treatment and management of both acute and chronic health conditions. Health care professionals must devise strategies to care for the growing elderly patient population. America's older citizens are often living on fixed incomes and have small or nonexistent support groups. Although this may be considered an infrastructure dilemma, the reality is that medical professionals must be able to understand and empathize with poor, sick, elderly people of all races, sexes, and creeds.

The term "ageism" was coined in 1968 by Robert N. Butler, MD, a pioneer in geriatric medicine and a founding director of the National Institute on Aging (NIA). Butler (1969) was among the first to identify the phenomenon of age prejudice, initially describing it as "a systematic stereotyping of and discrimination against people because they are old" (p. 12).

Ageism can be defined as "any attitude, action, or institutional structure, which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age"

(Traxler, 1980, p. 4). Health care professionals often make assumptions about their older patients on the basis of age rather than functional status (Bowling, 2007). This may be due to the limited training physicians receive in the care and management of geriatric patients. For example, Warshaw and colleagues (2002, 2006) related that medical residents have only limited training in geriatric medicine. Findings from Warshaw et al.'s 2006 study were compared with those from a similar 2002 survey to determine whether any changes had occurred. Of the participating 3-year residency training programs, only 9% required 6 weeks or more of training. As in 2002, the residency programs continue to depend on nursing home facilities, geriatric preceptors in non-geriatric clinical ambulatory settings, and outpatient geriatric assessment centers for the medical residents' geriatrics training. A report from the Alliance for Aging Research (2003) related that there continues to be shortcomings in medical training, prevention, screening, and treatment patterns that disadvantage older patients. The report outlined five domains of ageism in health care:

1. Health care professionals do not receive enough training in geriatrics to properly care for many older patients.
2. Older patients are less likely than younger people to receive preventive care.
3. Older patients are less likely to be tested or screened for diseases and other health problems.
4. Proven medical interventions for older patients are often ignored, leading to inappropriate or incomplete treatment.
5. Older people are consistently excluded from clinical trials, even though they are the largest users of approved drugs.

On a positive note, Perry (2012) relates that progress against systematic ageism in health care has begun, in part, as a result of the passing of the 2010 Affordable Care Act (ACA). He notes that the law's various provisions, such as Medicare's increased focus on chronic disease prevention, new models of care for reducing rehospitalizations, and improved care coordination, as well as annual screening for cognitive impairment, will assist in changing attitudes toward elderly patients.

Gender

As was previously noted, according to the U.S. Census Bureau, in 2016, 50.8% of the U.S. population was female and 49.2% was male—almost identical to percentages in the 2000 Census. That translates to 96 men for every 100 women. However, the ratio of men to women varies significantly by age group. There were about 105 males for every 100 females under age 25 in 2010 (U.S. Census Bureau, 2010), reflecting the fact that more boys than girls are born every year and that boys continue to outnumber girls through early childhood and young adulthood. However, the male–female ratio declines as people age. Among older adults, the male–female ratio falls as women increasingly outnumber and outlive men. When we look at education, it appears that females and males are somewhat equal. Among the population age 25 and older, 90% of both men and women were high school graduates, with 34% of men and 35% of women graduating from college (U.S. Census Bureau, 2017).

Sexual Orientation, Gender Identity, and Gender Expression

Another important aspect of diversity to consider in health care is sexual orientation, gender identity, and gender expression. The last decade has led to an increased focus on disparities that

exist in the lesbian, gay, bisexual, transgender, and questioning community (LGBTQ). Various surveys estimate that people over age 18 who identify as LGBT make up 2.8%–4.1% of the total population, or 5–10 million individuals in the United States, according to a Kaiser Family Foundation Report (Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2018). The term "LGBTQ" may encompass elements of sexual orientation, gender identity, and gender expression. Sexual orientation is defined by the Institute of Medicine report as "an enduring pattern of or disposition to experience sexual or romantic desires for, and relationships with, people of one's same sex, the other sex, or both sexes" (Graham et al., 2011, p. 27). For many people, sexual orientation does not fall neatly into any specific category and may be better described as belonging somewhere along a spectrum. Gender identity refers to one's internal sense of being male, female, or something else (Kates et al., 2018). Because gender identity is internal, it is not necessarily visible to others. Gender expression refers to the outward and external portrayal of gender. Gender expression may include clothing, hairstyles, mannerisms, and taking on gender roles that are defined by one's culture. Both gender identity and gender expression may be different from one's biological sex at birth.

These aspects of identity and orientation can span all ages, races, and biological genders. According to the Kaiser Family Foundation report, "while sexual orientation and gender identity are important aspects of an individual's identity, they interact with many other factors, including sex, race/ethnicity, and class. The intersection of these characteristics helps to shape an individual's health, access to care, and experience with the health care system" (Kates et al., 2018, p. 2).

Individuals who identify as LGBTQ may experience unique health challenges that cannot be explained by differences in race/ethnicity, age, or gender alone. Because of discrimination and a variety of other factors, research has shown that self-identified lesbian, gay, and bisexual individuals are more likely to rate their health as poor and have higher prevalence of many chronic diseases such as cancer and cardiovascular disease, as well as asthma, allergies, headaches, and disabilities. In addition to concerns about physical health, studies have found that people who identify as LGBT are at a higher risk for mental health conditions, often as a result of prejudice, discrimination, and stigma. Various studies show that LBGT individuals are 2.5 times more likely to suffer anxiety, depression, and substance misuse; are more likely to have experienced both sexual and physical violence; and have a substantially higher rate of suicidal ideation or attempts. In addition to stigma and discrimination, LGBTQ individuals may face additional health disparities resulting from practices that pose barriers to accessing health services. For example, some insurance companies will not pay for mental health services for transgender individuals. Additionally, between 6% and 15% of employers reported not offering same-sex spousal benefits to workers. Although these numbers are improving, there is still a substantial disparity in this area (Kates et al., 2018).

However, there has been some progress in this area. Since 2007, the Healthcare Equality Index (HEI) of the Human Rights Campaign (HRC) Foundation has been available for use by hospitals and other organizations. This survey is a resource for health care organizations that are seeking to provide equitable, inclusive care to LGBTQ Americans and for LGBTQ Americans who are seeking health care organizations that have a demonstrated commitment to their care (HRC, 2019). In 2018, 680 facilities across the country participated in the HEI survey, with 60% designated as leaders and 22% as top performers demonstrating that they have varying inclusive LGBT patient and employment policies. These nondiscrimination policies are required for Joint Commission accreditation. In addition, both The Joint Commission and the Centers for Medicare and Medicaid Services require that facilities allow visitation without regard to sexual orientation or

Table 2-2 Healthcare Equality Index's Core Four Leader Criteria

Criteria	
Non-discrimination and staff training	Patient non-discrimination Equal visitation Employment non-discrimination Staff training
Patient services and support	LGBTQ patient services & support Transgender services and support Patient self-identification Medical decision making
Employee benefits and policies	Equal benefits Additional support for LGBTQ employees Healthcare benefits impacting transgender employees
Patient and community engagement	LGBTQ community engagement and marketing Understand the needs of LGBTQ patients and community

gender identity. The HEI has two sections: (1) the core four leader criteria and (2) the additional best practices checklist. The core four leader criteria are reflected in **Table 2-2**. Additionally, patient forms should reflect diverse gender identities, allowing patients to identify both their biological sex at birth and their gender identity. The additional best practices checklist is designed to familiarize HEI participants with other expert recommendations for LGBT patient-centered care, to help identify and remedy gaps.

Implications for the Health Care Industry

The changing demographics of the U.S. population affect the healthcare industry significantly. Health care organizations need to work to reduce disparities in care and treatment provided to underrepresented populations as well as ensuring that our health care systems are diverse, equitable, and inclusive places for both patients and employees.

Consider the following:

> *Scenario One:* An insulin-dependent, indigent black non-Hispanic male was treated at a predominantly Hispanic border clinic. Later, he was brought back to the clinic in a diabetic coma. When he awoke, the nurse who had counseled him asked whether he had been following her instructions. "Exactly!" he replied. When the nurse asked him to show her, the monolingual Spanish-speaking nurse was startled when the patient proceeded to inject an orange and eat it.
>
> *Scenario Two:* As Maria (an elderly, monolingual Hispanic female) was being prepared for surgery, which was not why she had come to the hospital, her designated interpreter (a young female relative) was told by an English-speaking nurse to tell Maria that the surgeon was the best in his field and Maria would get through this fine. The young

interpreter told Maria, "The nurse says the doctor does best when he's in the field, and when it's over you'll have to pay a fine!"

At first glance, these might seem rather humorous misunderstandings, but there is nothing funny about a diabetic coma or the possibility of undergoing unneeded surgery, and real-life experiences such as these happen every day in the United States (Howard, Andrade, & Byrd, 2001). Cultural differences between providers and patients affect the provider–patient relationship. For example, Fadiman (1998) related a true and poignant story of cultural misunderstanding within the health care profession. Fadiman described the story of a young female epileptic Hmong immigrant whose parents believed that their daughter's condition was caused by spirits called "dabs," which had caught their daughter and made her fall down, hence the name of Fadiman's book *The Spirit Catches You and You Fall Down*. The patient's parents struggled to understand the prescribed medical care, which recognized only the scientific necessities but ignored the family's personal beliefs about the spirituality of one's soul in relationship to the universe. From a unique perspective, Fadiman examined the roles of the caregivers (physicians, nurses, and social workers) in the treatment of ill children. She studied the way in which the medical care system responded to its own perceptions that the family was refusing to comply with medical orders without understanding the meaning of those orders in the context of the Hmong culture, language, and beliefs. Health and health care disparities in the United States have been documented for many decades (see **Exhibit 2-1**). Kaiser Family Foundation and the Institute of Medicine both note that although many improvements in population health have occurred, numerous disparities have persisted and, in some cases, widened across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation (Orgera & Artiga, 2018; Weinstein, Geller, Negussie, & Baciu, 2017). As noted by Orgera and Artiga (2018), there is a complex and interrelated set of not only individual and provider factors, but also a broad array of social and environmental factors both inside and outside of the health care system that affect individuals' health and ability to engage in healthy behaviors, such as economic status, neighborhood/physical environment, educational levels, and access to healthy food.

Exhibit 2-1 Unequal Treatment

A 2002 study by the Institute of Medicine titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* found that a consistent body of research demonstrates significant variation in the rates of medical procedures by race even when insurance status, income, age, and severity of conditions are comparable. This research indicated that in the United States, members of underrepresented racial and ethnic groups receive fewer routine medical procedures and experience a lower quality of health services than the majority of the population. For example, members of minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery and are less likely to receive kidney dialysis or transplants. By contrast, they are more likely to be subjected to certain less desirable procedures, such as lower-limb amputations for diabetes. The study's recommendations for reducing racial and ethnic disparities in health care included increasing awareness about disparities among the general public, health care providers, insurance companies, and policy makers.

Modified from *Unequal treatment: Confronting racial and ethnic disparities in health care* (p. 3), by B. D. Smedley, A. Y. Stitch, and A. R. Nelson (Eds.), 2002, Washington, DC: National Academy of Sciences, Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.

Summary

Health care organizations need to build environments that are diverse, equitable, and inclusive for the well-being of their patients and employees. The slower growth of the younger population of the United States will have a direct effect on the health care industry's ability to recruit professionals to provide sufficient services in the future for a large elderly population. Young people of all races, ethnicities, and genders must be attracted to the health care industry as a career choice to meet the health care needs of the country's growing, aging, and increasingly diverse population.

Discussion Questions

1. Discuss what the terms "diversity," "equity," and "inclusion" mean.
2. Explain why and how changes in U.S. demographics affect the health care industry.
3. What are the differences between diversity, equity, and inclusion?
4. Describe a situation that is diverse but not equitable or inclusive.
5. Describe a situation that is diverse and equitable but not inclusive.

Exercise 2-1

In 2012, the Alliance of Aging Research established the Healthspan Campaign, a coalition of organizations committed to solving the challenges brought about by the aging of the American population. With each passing year, the percentage of people in the United States—and much of the world—over age 65 increases. This "Silver Tsunami" is expected to bring a flood of chronic disease and disabilities due to aging that could overwhelm the health care systems of many nations. Watch the films *The Healthspan Imperative* and *What Is the Silver Tsunami?* at www.healthspancampaign.org. Discuss the effect of the aging population on our health system, and present recommendations for how these challenges could be addressed.

Exercise 2-2

In December 2012, the American College of Healthcare Executives released its fifth report in a series of research surveys designed to compare the career attainments of male and female health care executives. View this report, titled *A Comparison of the Career Attainments of Men and Women Healthcare Executives: 2012,* at www.ache.org. In small groups, discuss the changes (if any) regarding women advancing to senior leadership positions that have occurred in the health care industry since the previous report in 2006.

Exercise 2-3

In 2019, *Modern Healthcare* published its biennial recognition of the Top 25 Women in Healthcare. The previous lists appeared in 2017 and 2015 and can be found by searching for the list on the website modernhealthcare.com. In small groups, discuss the changes (if any) over the past 9 years of the selected awardee population (i.e., employment in what sectors of the health industry, the positions they do or did hold, race/ethnicity groups, and so on).

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Information relating to Anne Fadiman's book *The Spirit Catches You and You Fall Down* may be viewed at www .spiritcatchesyou.com

CHAPTER 3

Diversity Management and Cultural Competency in Health Care

LEARNING OUTCOMES

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

- Define diversity management.
- Define cultural competency.
- Understand the importance of a culturally competent workforce in meeting the needs of patients.

The population of the United States is changing rapidly and is becoming increasingly diverse. In response to the growing diversity of the general population, health care organizations must be prepared to handle the unique needs of a changing population in two key ways. First, organizations must ensure that diversity management programs are in place to provide an environment where people of all demographic types have the opportunity to succeed within the organization and to feel a sense of belonging. Second, health care organizations must ensure that their workforce is equipped to handle the needs of an increasingly diverse patient population by developing cultural competency. Diversity management strategies and cultural competency are the focus of this chapter. Health care organizations need to be flexible to change and meet diversity challenges. The greatest barrier to the industry's success may be its inability to understand and appreciate the increasing diversity within our population, whether relating to patients or employees. As Kochan and colleagues (2003, p. 18) related,

> Diversity is a reality in labor markets and "customer" markets today. To be successful in working with and gaining value from this diversity requires a sustained, systemic approach and long-term commitment. Success is facilitated by a perspective that considers diversity to be an opportunity for everyone in an organization to learn from each other how better to accomplish their work and an occasion that requires a supportive

and cooperative organizational culture as well as group leadership and process skills that can facilitate effective group functioning. Organizations that invest their resources in taking advantage of the opportunities that diversity offers should outperform those that fail to make such investments.

Diversity Management

Diversity management is a challenge for all organizations. Diversity management is "a strategically driven process whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient population" (Svehla, 1994; Weech-Maldonado, Dreachslin, Dansky, DeSouza, & Gatto, 2002). In 2004, the National Urban League published its first study on employees' perceptions of the effectiveness of their companies' diversity programs. The results of the organization's 2009 follow-up survey showed progress in certain areas. However, leadership commitment to diversity and companies clearly communicating their platform on how they value diversity are still lagging (see **Figure 3-1**).

As reflected in Figure 3-1, organizations have improved in communicating effectively regarding their diversity platforms but need to focus on their (1) commitment to, (2) accountability for, (3) action on, and (4) measurement of these initiatives. The good news is the notable increases reflecting the intrinsic acceptance of diversity and inclusion by U.S. workers. As the National

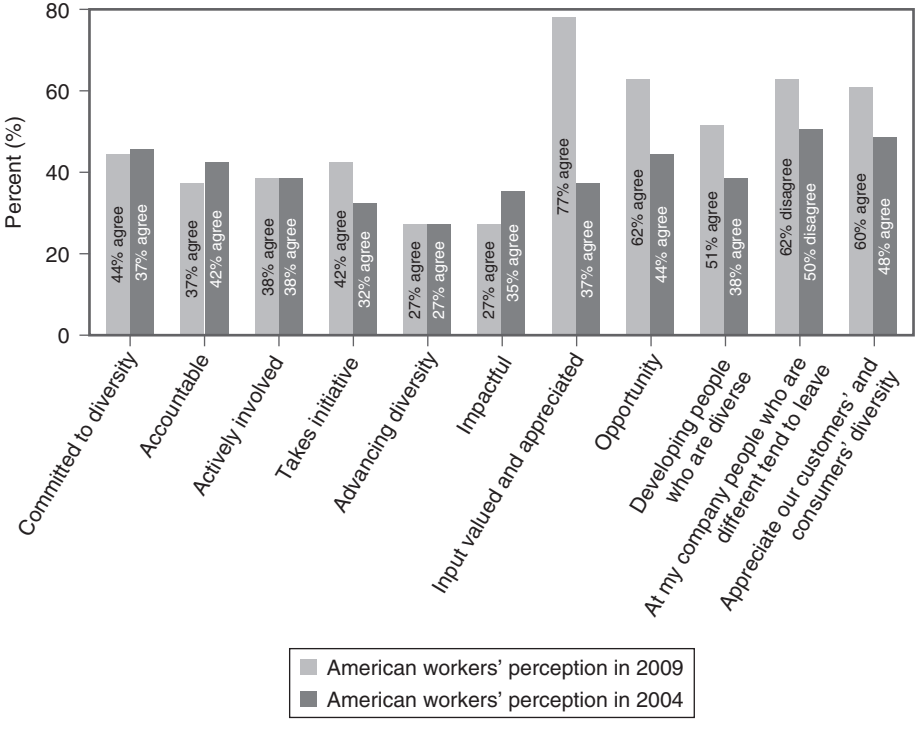

Figure 3-1 American Workers' Perceptions

Data from National Urban League. (2009). Diversity practices that work: The American worker speaks II.

Urban League (2009) reported, the playing field appears more level, diverse talent is being developed and retained, and customer/consumer diversity is being recognized.

While some gains have been made in increasing diversity in the field of health care management, recent studies suggest that there is still ample room for improvement. The Institute for Diversity in Health Management, an affiliate of the American Hospital Association, was formed in 1994 to address the problem, disclosed in a 1992 study, that minorities held fewer than 1% of top management positions in the industry. In addition, the study revealed that African American health care executives made less money, held lower positions, and had less job satisfaction than their White counterparts. A 1997 follow-up study, expanded to include Latinos and Asians, found that although the gap had narrowed in some areas, not much had changed. As examples, a study by Motwani, Hodge, and Crampton (1995) found that only 27.7% of health care workers in six Midwestern hospitals thought that their institutions had a program to improve employee skills in dealing with people of different cultures, and only 38.9% thought that management realized that cultural factors were sometimes the cause of conflicts among employees. Weech-Maldonado et al. (2002) found that hospitals in Pennsylvania had been relatively inactive in employing diversity management practices and that equal employment requirements were the main driver of diversity management policy. Five years later, Weech-Maldonado and colleagues (Weech-Maldonado et al., 2007; Weech-Maldonado, Elliott, Schiller, Hall, & Hays, 2007) continued to find low levels of diversity management activity in California hospitals. Since that time, the Institute for Diversity in Health Management, in collaboration with other organizations, has designed several initiatives to expand health care leadership opportunities for ethnically, culturally, and racially diverse individuals, thus increasing the number of these individuals entering and advancing in the field.

The Future Workforce

For the first time in modern history, the U.S. workforce consists of four separate generations working side by side, and the differences among generations are one of the greatest challenges facing managers today (Wasserman, 2007). Bonnie Clipper (2012, p. 45), author of *The Nurse Manager's Guide to an Intergenerational Workforce*, provides a humorous example for understanding the generations' differences.

> A nurse manager desperate for more staff, telephones four nurses to ask whether they will pull an extra shift:
>
> The first nurse says, "What time do you need me?"
>
> The second nurse says, "Call me back if you can't find anyone else."
>
> The third nurse says, "How much will you pay me?"
>
> The fourth nurse says, "Sorry, I have plans. Maybe next time."
>
> Stokowski, L. A. (2013). The 4-generation gap in nursing. Medscape. Available from www.medscape.com/viewarticle/781752.

These different responses are typical of the four generations of nurses currently working side by side at the bedside. The first response is from the traditionalist generational cohort. This generation, born between 1925 and 1942, is typically characterized as dedicated, hardworking, and loyal. The second response is from the Baby Boomer generation. Born between 1943 and 1960, Baby Boomers are viewed as optimistic, productive, and workaholics. The third response is from Generation X; this generation, born between 1961 and 1981, is typically referred to as cynical, independent, and informal. The fourth response is reflective of the Millennial generational cohort, born between 1982 and 2000. Millennials are viewed as confident, inpatient, and social. Becton,

Walker, and Jones-Farmer (2014) point out that although much has been written about their differences, there remains a gap in our understanding of each generational cohort's values and beliefs. Therefore, generational differences may best be explained by "age, life stage, or career stage effects" (Becton et al., 2014, p. 176).

As part of diversity management, health care managers need to devise strategies for attracting younger workers to the health care field while maintaining positive relationships with older workers. For example, Barney (2002, p. 83) points out that Generation X workers want "managers who listen, consider their ideas, and treat them as peers. They want to be part of the decision-making process and want flexibility in their work environment because they value their time and freedom."

What about the Millennials, sometimes referred to as Generation Y? Millennials make up the largest portion of today's workforce, comprising 35% of the U.S. labor force (Fry, 2018). Although it is impossible to generalize about the wants and needs of the millions of people in each generation, workplace experts tend to use the following characteristics to describe Millennials (Martin & Tulgan, 2006):

- High expectations of self: They aim to work faster and better than other workers.
- High expectations of employers: They want fair and direct managers who are highly engaged in their professional development.
- Ongoing learning: They seek out creative challenges and view colleagues as vast resources from whom to gain knowledge.
- Immediate responsibility: They want to make an important impact on day one.
- Goal oriented: They want small goals with tight deadlines so that they can build ownership of tasks.

Health care managers must also consider the needs of older workers. For example, in a Robert Wood Johnson Foundation study, Hatcher and colleagues (2006) suggested that hospitals that want to recruit and retain older nurses need to implement certain strategies, such as flexible work hours, increased benefits, newly created professional roles, and an atmosphere of respect for nurses.

Generational diversity poses challenges for today's and tomorrow's employers. Younger workers have a strong need for immediate feedback, workers now in their 30s and 40s demand greater work–life balance and flexibility, and older workers expect increased benefits and professionalism. With a multigenerational workforce, employers will need to develop age-diversity training programs for their managers so they can better understand the needs and expectations of each generation (Martin & Tulgan, 2006).

Diversity in Health Care Leadership

The American College of Healthcare Executives (ACHE), the National Association of Health Services Executives (NAHSE), the Institute for Diversity in Healthcare Management (IFD), the National Forum for Latino Healthcare Executives, and the Asian Health Care Leaders Association released a study in 2015 that measured the representation of Black non-Hispanics, Hispanics, women, and other minorities in health care executive leadership roles. This study was a follow-up to similar studies that were completed in 1992, 1997, 2002, and 2008. The study, completed in 2014, was based on a random-sample survey of 1409 health care executives. Respondents worked in a variety of settings: hospitals, health care provider organizations, government health agencies, and consulting and educational institutes (see **Table 3-1**).

Table 3-1 American College of Healthcare Executives 2014 Diversity Study

Position by race/ethnicity and gender[a]
For each ethnicity, percentage holding a specific position type

	Males				Females			
	Black	**White**	**Hispanic**	**Asian**	**Black**	**White**	**Hispanic**	**Asian**
CEO (%)	20	32	25	9	8	14	11	0
COO/senior vice president	16	19	19	17	11	18	19	13
Vice president	23	20	13	18	20	22	19	8
Department head	30	16	31	36	36	31	31	38
Manger/supervisor/ program director	2	3	1	5	7	4	6	7
Department staff/ consultant/other	9	10	10	16	18	11	14	24
Total %	100%	100%	99%	101%	100%	100%	100%	101%
N	219	182	158	153	224	218	108	132

[a]Responses may not total to 100 because of rounding.
Reproduced from American College of Healthcare Executives with permission.

Although there have been improvements since the initial 1992 survey, the health care industry did not do as well in promoting minorities and women to chief executive officer (CEO) and chief operating officer (COO)/senior vice president positions. In the 2014 ACHE study, reflected in Table 3-1, 32% of White men are CEOs, compared to 25% of Hispanic men, 20% of Black men, and 9% of Asian men. These disparities are not as apparent among women; roughly 8%–15% of women in each race hold CEO positions. Additionally, in 2014, members of minorities still reported the effects of discrimination in the workplace. Between 15% and 29% of minority respondents believed that they had not been hired for a position because of their race or ethnicity compared to 2% of White respondents.

In the 2015 Benchmarking Survey by the Institute of Diversity and Health Equity, the results highlighted that although there was some limited increase in the diversity of hospitals' leadership and governance, more positive movement is needed. The study reported that minorities composed:

- 14% of hospital board members (unchanged from 2013).
- 11% of executive leadership positions (decrease from 12% in 2013).
- 19% of first- and middle-level management positions (up from 15% in 2011).

Dreachslin and Curtis (2004) noted that career advancement of women and racially and ethnically diverse individuals in health care management was characterized by (1) underrepresentation, especially in senior-level management positions; (2) lower compensation, even controlling

for education and experience; and (3) more negative perceptions of equity and opportunity in the workplace. The researchers identified three areas that are key organization-specific factors for shaping career outcomes for women and racially and ethnically diverse individuals: (1) leadership and strategic orientation (i.e., senior management's commitment to successful implementation of diversity initiatives), (2) organizational culture and climate (i.e., the depth and breadth of the organization's strategic commitment to diversity leadership and cultural competency), and (3) human resources practices (i.e., establishing best practices in advancing the management careers of women and racially and ethnically diverse individuals, such as formal mentoring programs, professional development, work–life balances, and flexible benefits).

To best serve their patient base, health care organizations and providers must be willing to invest the time, money, and effort needed to educate all their employees. Educating senior staff is important, but so is educating the entire health care workforce. Wilson-Stronks and Murtha (2010), Cejka Search and Solucient (2005), and Kochan et al. (2003) have linked the effects of diversity to business performance. Kochan and colleagues (2003) concluded that the impact of diversity depends on organizational culture, human resource practices, and strategy. In other words, the impact of diversity is directly related to the organization's ability to successfully adapt to a diverse environment, and it can have negative effects if the adaptation is not done well. For example, Witt/Kieffer's 2011 national survey of 454 health care professionals, 54% of whom represented senior executives, provides a deeper understanding of how diversity is connected to measurable business benefits:

- Patient satisfaction: Nearly two-thirds (62%) believed that cultural differences improve patient satisfaction.
- Successful decision making: More than half (57%) believed that cultural differences support successful decision making.
- Strategic goals: More than half of these respondents (54%) acknowledged that diversity recruiting enables the organization to reach its strategic goals.
- Clinical outcomes: Nearly half (46%) believed that diversity improves clinical outcomes.

Dreachslin (2007) reinforces the need for mass customization of diversity practices to be inclusive of disparities that are represented in the communities that health care organizations serve. In order to actively support business strategy, organizations will need to provide employees with skills that are inclusive of conflict-management skills, self-awareness, understanding of cultural differences, validation of alternative points of view, and methods to manage bias through effective human resource training and development.

For health care managers to transform their organizations to provide an inclusive culture where all employees feel the opportunity to reach their full potential, Guillory (2004, pp. 25–30) recommended a 10-step process:

1. Development of a customized business case for diversity for your organization. In other words, how does diversity relate to the overall success of the organization?
2. Education and training for your staff to develop an understanding of diversity, its importance to your organization's success, and diversity skills to apply on a daily basis.
3. Establishment of a baseline by conducting a comprehensive cultural survey that integrates performance, inclusion, climate, and work/life balance.
4. Selection and prioritization of the issues that lead to the greatest breakthrough in transforming the culture.
5. Creation of a three- to five-year diversity strategic plan that is tied to organizational strategic business objectives.

6. Leadership's endorsement of and financial commitment to the plan.
7. Establishment of measurable leadership and management objectives to hold managers accountable to top leadership for achieving these objectives.
8. Implementation of the plan, recognizing that surprises and setbacks will occur along the way.
9. Continued training in concert with the skills and competencies necessary to successfully achieve the diversity action plan.
10. Survey one to one-and-a-half years after initiation of the plan to determine how inclusion has changed.

Reproduced from Guillory, W. A. (2004). The roadmap to diversity, inclusion, and high performance. *Healthcare Executive, 19*(4), 24–30.

Dreachslin (2007) stresses the need for organizations to manage diversity and invest in professional development so that team members have the tools needed to navigate their differences and effectively manage their bias. As Dreachslin notes, "[I]f left unmanaged, demographic diversity will interfere with team functioning."

Cultural Competency

In addition to supporting a diverse workforce, health care organizations must ensure that their employees can handle the diverse needs of their patient population. First, health care professionals and organizations need to have cultural and linguistic competence to provide effective and efficient health services to diverse patient populations. However, before we continue our discussion, we need to define what is meant by cultural and linguistic competence. Over the years, the term "cultural competency" has been defined in many ways, such as "ongoing commitment or institutionalism of appropriate practice and policies for diverse populations" (Brach & Fraser, 2000; Weech-Maldonado et al., 2002; see Hofstede's Cultural Dimensions, **Exhibit 3-1**). The term "linguistic competency" has been defined as "the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities" (Goode & Jones, 2004). For our discussions, we have adopted the definition used by the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services, which defines "cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and that enables effective work in cross-cultural situations." (U.S. Department of Health and Human Services, 2013).

Because of the changing demographics of the nation's population, the health care industry needs to ensure that the health care workforce mirrors the patient population that it serves, both clinically and managerially. As Weech-Maldonado et al. (2002) noted, health care organizations must develop policies and practices aimed at recruiting, retaining, and managing a diverse workforce in order to provide both culturally appropriate care and improved access to care for racial/ethnic minorities.

Because of our increasingly diverse population, health care professionals need to be concerned about their own cultural competency, which is more than just cultural awareness or sensitivity. Although formal cultural training has been found to improve the cultural competency of health care practitioners, Kundhal (2003) reported that only 8% of U.S. medical schools and no Canadian medical schools had formal courses on cultural issues. However, changes are occurring within the industry to assist health care practitioners in developing their cultural competency as they encounter more diverse patients. For example, in 2000, the Liaison Committee on Medical

Exhibit 3-1 Hofstede's Cultural Dimensions

One of the most extensive cross-cultural surveys ever conducted is Hofstede's (1983) study of the influence of national culture on organizational and managerial behaviors. National culture is deemed to be central to organizational studies, because national cultures incorporate political, sociological, and psychological components.

Hofstede's research was conducted over an 11-year period, with more than 116,000 respondents in more than 40 countries. The researcher collected data about "values" from the employees of a multinational corporation located in more than 50 countries. On the basis of his findings, Hofstede proposed that there are four dimensions of national culture within which countries could be positioned that are independent of one another. Hofstede's (1983, pp. 78–85) four dimensions of national culture were labeled and described as follows:

- *Individualism–collectivism*: Individualism–collectivism measures culture along a self-interest versus group-interest continuum. Individualism stands for a preference for a loosely knit social framework in society wherein individuals are supposed to take care of themselves and their immediate families only. Its opposite, collectivism, stands for a preference for a tightly knit social framework in which individuals can expect their relatives, clan, or other in-group to look after them in exchange for unquestioning loyalty. Hofstede (1983) suggested that self-interested cultures (e.g., individualism) are positively related to the wealth of a nation.
- *Power distance*: Power distance is the measure of how a society deals with physical and intellectual inequalities and how the culture applies power and wealth relative to its inequalities. People in societies with a large power distance accept a hierarchical order in which everybody has a place, which needs no further justification. People in societies with a small power distance strive for power equalization and demand justification for power inequalities. Hofstede (1983) indicated that group-interest cultures (e.g., collectivism) have large power distance.
- *Uncertainty avoidance*: Uncertainty avoidance reflects the degree to which members of a society feel uncomfortable with uncertainty and ambiguity. The scale runs from tolerance of different behaviors (i.e., a society in which there is a natural tendency to feel secure) to a society in which institutions create security and minimize risk. Societies with strong uncertainty avoidance maintain rigid codes of belief and behavior and are intolerant of deviant personalities and ideas. Societies with weak uncertainty avoidance maintain a more relaxed atmosphere in which practice counts more than principles and deviance is more easily tolerated.
- *Masculinity versus femininity*: Masculinity versus femininity measures the division of roles between the genders. The masculine side of the scale is a society in which the gender differences are maximized (e.g., need for achievement, heroism, assertiveness, and material success). Feminine societies are those in which there are preferences for relationships, modesty, caring for the weak, and the quality of life.

Hofstede proposed that the most important dimensions for organizational leadership are individualism–collectivism and power distance, and the most important for decision making are power distance and uncertainty avoidance. Uncertainty avoidance plays an integral part in a country's culture regarding change. For example, Nahavandi and Malekzadeh (1999, pp. 495–496) point out that countries such as Greece, Portugal, and Japan have national cultures that do not easily tolerate uncertainty and ambiguity. These cultures emphasize uncertainty avoidance and the importance of planned and well-managed activities. Other countries, such as Sweden, Canada, and the United States, have cultures that are willing to tolerate change because of the potential for new opportunities that may come with change.

A question that is frequently asked is whether Hofstede's (1983) cultural dimensions are still applicable today. Patel (2003) found that the characteristics of Chinese, Indian, and Australian cultures corroborated Hofstede's study results. Patel's study of the relationship between business goals and culture, measured by correlating the relative importance attached to the various business goals with the national culture dimension scores from Hofstede's study, found that

although the four cultural dimension scores were nearly 20 years old, they were validated in this large, cross-national survey. In a study that measured 1800 managers and professionals in 15 countries, statistically significant correlations with the Hofstede indices validated the applicability of the first study's cultural dimension findings (Hofstede, Van Deusen, Mueller, & Charles, 2002). The findings from these studies suggest that Hofstede's cultural dimensions continue to be robust and are still applicable measure components of national culture differences.

Note: Hofstede (1991) subsequently included an additional dimension based on Chinese values referred to "Confucian dynamism." Hofstede renamed this dimension as a long-term versus short-term orientation in life.

Education (LCME), the accrediting body of medical schools, introduced the following accreditation standard for cultural competence:

> The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in healthcare delivery, while considering first the health of the patient.

This standard has given added impetus and emphasis to medical schools to introduce education in cultural competency into the undergraduate medical curriculum (Association of American Medical Colleges, 2005, p. 1). In addition, The Joint Commission has implemented patient-centered communication accreditation standards, which require hospitals to meet certain mandates related to qualifications for language interpreters and translators, identifying and addressing patient communication needs, collecting patient race and ethnicity data, patient access to a support individual, and nondiscrimination in care (The Joint Commission, 2014).

Over the past decade, the Commonwealth Fund has been a leader in the effort "to eliminate the cultural and linguistic barriers between health care providers and patients, which can interfere with the effective delivery of health services" (Beach, Saha, & Cooper, 2006, p. vi). The Commonwealth Fund (2003), in addition to funding initiatives regarding quality of care for underserved populations, has initiated an educational program that assists health care practitioners in understanding the importance of communication between culturally diverse patients and their physicians, the tensions between modern medicine and cultural beliefs, and the ongoing problems of racial and ethnic discrimination. The goals of this program are for clinicians to:

1. Understand that patients and health care professionals often have different perspectives, values, and beliefs about health and illness that can lead to conflict, especially when communication is limited by language and cultural barriers.
2. Become familiar with the types of issues and challenges that are particularly important in caring for patients of different cultural backgrounds.
3. Think about each patient as an individual, with many different social, cultural, and personal influences, rather than using general stereotypes about cultural groups.
4. Understand how discrimination and mistrust affect the interaction of patients with physicians and the health care system.
5. Develop a greater sense of curiosity, empathy, and respect toward patients who are culturally different, and thus be encouraged to develop better communication and negotiation skills through ongoing instruction.

Reproduced from *Worlds Apart, Facilitator's Guide* by Alexander Green, MD, Joseph Betancourt, MD, MPH, and J. Emilio Carrillo, MD, MPH, The Commonwealth Fund, p. 4.

In addition to the Commonwealth Fund, the W. K. Kellogg Foundation has led efforts to lessen the recognized disparity of racial and ethnic minority groups' representation among the nation's health professionals. It was the Kellogg Foundation that requested the Institute of Medicine's (2004) study entitled *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. The Institute of Medicine found that racial and ethnic diversity is important in the health professions for the following reasons:

1. Health care professionals who are members of racial and ethnic minorities are significantly more likely than their peers to serve minority and medically underserved communities, thereby helping to improve problems of limited minority access to care.
2. Minority patients who have a choice are more likely to select health care professionals of their own racial or ethnic background. Moreover, patients who are members of racial and ethnic minorities are generally more satisfied with the care that they receive from minority professionals, and minority patients' ratings of the quality of their health care are generally higher in racially concordant settings than in racially discordant settings.
3. Diversity in health care training settings may assist in efforts to improve the cross-cultural training and competencies of all trainees.

In addition to the Commonwealth Fund and the W. K. Kellogg Foundation, other organizations are active in bridging cultural differences in an attempt to lessen health disparities. For example, in 2000, the OMH developed a list of standards for Culturally and Linguistically Appropriate Services (CLAS), which health care organizations and practitioners should use to ensure equal access to high-quality health care by diverse populations. In 2013, these standards were expanded to reflect the growth in the field of cultural and linguistic competence. There are now 15 standards under four categories: (1) Principal Standard, (2) Governance, Leadership, and Workforce, (3) Communication and Language Assistance, and (4) Engagement, Continuous Improvement, and Accountability.

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

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
2. Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
3. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

1. 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.
2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
4. 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

1. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
2. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
3. 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.
4. 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.
5. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
6. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
7. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Reproduced from the National CLAS Standards, Office of Minority Health, U.S. Department of Health and Human Services, 2018.

We pause to provide a brief overview of the efforts being made regarding the measuring and reporting of cultural competency. Measurement and reporting are needed to ensure that culturally competent care can be translated into (1) improved health outcomes and more patient-centered care and (2) actionable initiatives for providers that result in meaningful improvement. Through the support of the Robert Wood Johnson Foundation (RWJF), in 2009, the National Quality Forum (NQF) endorsed a comprehensive national framework based on a set of seven interrelated domains (and multiple subdomains) for evaluating cultural competency across all health care settings as well as a set of 45 recommended practices based on the framework. This was followed by RAND's development of a cultural competency implementation measurement tool. This tool is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices. In 2012, NQF endorsed 12 quality measures that address health literacy, language access, cultural competency, leadership, and workforce development (Robert Wood Johnson Foundation, 2014). These quality measures are the first endorsed by NQF that specifically address health care disparities and cultural competency.

On the basis of Dreachslin's and others' research, the NCHL, ACHE, IFD, and the American Hospital Association developed the Diversity, Equity, and Cultural Competency Assessment Tool for Leaders (see **Exhibit 3-2**). The assessment tool begins the process of developing a cultural awareness for the organization's workforce. Going forward, managers will need to develop models that establish benchmarks for cultural competency to enable their organizations to develop competent interventions, thereby improving the quality of health care (Betancourt, Green, & Carrillo, 2002).

Exhibit 3-2 **A Diversity, Equity, and Cultural Competency Assessment Tool for Leaders**

CHECKLIST		
As Diverse as the Community You Serve	**YES**	**NO**
Do you monitor at least every three years the demographics of your community to track change in gender and racial and ethnic diversity?		
Do you actively use these data for strategic and outreach planning?		
Has your community relations team identified community organizations, schools, churches, businesses, and publications that serve racial and ethnic minorities for outreach and educational purposes?		
Do you have a strategy to partner with them to work on health issues important to them?		
Has a team from your hospital met with community leaders to gauge their perceptions of the hospital and to seek their advice on how you can better serve them, in both patient care and community outreach?		
Have you done focus groups and surveys within the past three years in your community to measure the public's perception of your hospital as being sensitive to diversity and cultural issues?		
Do you compare the results among diverse groups in your community and act on the information?		
Are the individuals who represent your hospital in the community reflective of the diversity of the community and your organization?		
Do you have a strategy in place to partner with organizations who represent and relate to the diverse groups in your community for health outreach and other initiatives of importance to the community?		
Do you have a supplier diversity strategy that helps ensure that minority-, women-, and veteran-owned businesses have an opportunity to serve your organization?		
Are your public communications, community reports, advertisements, health education materials, websites, etc. accessible to and reflective of the diverse community you serve?		
Culturally and Linguistically Proficient and Equitable Patient Care		
Do you regularly monitor the your patient population to properly care for and serve gender, racial, ethnic, language, religious, and socio-economic differences and needs?		
Does your hospital/health system emphasize the importance of accurate, consistent and systematic collection of data on patient race, ethnicity and primary language?		
Do your patient satisfaction surveys take into account the diversity of your patients?		

Does your review of quality and patient safety data take into account the diversity of your patients in order to detect and eliminate disparities?		
Do you compare patient satisfaction ratings among diverse groups and act on the information?		
Have your patient representatives, social workers, discharge planners, financial counselors, and other key patient and family resources received special training in diversity issues?		
Does your hospital/health system provide language services, including identifying qualified individuals inside and outside your organization, who can help staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds?		
Does your hospital/health system provide ongoing training for staff on how to identify and access the need for language services, and have policies and procedures in place for the providing language services to a linguistically diverse patient populations		
Are your written communications with patients and families available in a variety of languages that reflects the ethnic and cultural fabric of your community?		
Depending on the racial and ethnic diversity of the patients you serve, do you educate your staff at orientation and on a continuing basis on cultural issues important to your patients?		
Are core services in your hospital such as signage, food service, chaplaincy services, patient information, and communications attuned to the diversity of the patients you care for?		
Does your hospital account for complementary and alternative treatments in planning care for your patients?		
Strengthening Your Workforce Diversity		
Do your recruitment efforts include strategies to reach out to diverse candidates, including gender, racial, ethnic, religious, disability status, sexual orientation, gender identity, veteran status, and socio-economic diversity?		
Does the team that leads your workforce recruitment initiatives reflect the diversity you need in your organization?		
Do your policies about time off for holidays and religious observances take into account the diversity of your workforce?		
Do you acknowledge and honor diversity in your employee communications, awards programs, and other internal celebrations?		
Have you done employee surveys or focus groups to measure their perceptions of your hospital's policies and practices on diversity and to surface potential problems?		
Do you compare the results among diverse groups in your workforce? Do you communicate and act on the information?		

(continues)

Exhibit 3-2 **A Diversity, Equity, and Cultural Competency Assessment Tool for Leaders** *(continued)*

CHECKLIST		
As Diverse as the Community You Serve	**YES**	**NO**
Strengthening Your Workforce Diversity		
Does your hospital/health system provide staff at all levels and across all disciplines training about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities?		
Is the diversity of your workforce taken into account in your performance evaluation system?		
Does your human resources department have a system in place to measure diversity progress and report it to you and your board?		
Do you have a mechanism in place to look at employee turnover rates for variances according to diverse groups?		
Do you ensure that changes in job design, workforce size, hours, and other changes do not affect diverse groups disproportionately?		
Collaborating and Creating Strong Partnerships		
Is your hospital/health system leveraging assets to address priority needs of the community, including food, education, employment, housing, transportation, violence prevention and other social determinants of health?		
Has your hospital/health system developed governance processes to share community resources and accountabilities in your efforts to improve the health of the population?		
Has your hospital/health system created successful partnerships to reach population health goals of the community?		
Does your hospital/health system develop your Board and leaders' ability to contribute to community health, workforce development and economic investment solutions within the community?		
Does your hospital/health system invest in change management processes to grow engagement, relationships and capacity of leaders to take action on the social determinants of health in community?		
Expanding the Diversity of Your Leadership Team		
Has your Board of Trustees discussed the issue of the diversity of the hospital's board? Its workforce? Its management team?		
Is there a Board-approved policy encouraging diversity across the organization?		
Is your policy reflected in your mission and values statement? Is it visible on documents seen by your employees and the public?		

Have you told your management team that you are personally committed to achieving and maintaining diversity across your organization?		
Does your strategic plan emphasize the importance of diversity at all levels of your workforce?		
Has your board set goals on organizational diversity, culturally proficient care, and eliminating disparities in care to diverse groups as part of your strategic plan?		
Does your organization have a process in place to ensure diversity reflecting your community on your Board and subsidiary and advisory boards?		
Have sufficient funds been allocated to achieve your diversity goals?		
Is diversity awareness and cultural proficiency training mandatory for all senior leadership, management, and staff?		
Have you made diversity awareness part of your management and board retreat agendas?		
Is your management team's compensation linked to achieving your diversity goals?		
Does your organization have a mentoring program in place to help develop your best talent, regardless of gender, race, or ethnicity?		
Do you provide tuition reimbursement to encourage employees to further their education?		
Do you have a succession/advancement plan for your management team linked to your overall diversity goals?		
Are search firms required to present a mix of candidates reflecting your community's diversity?		

Summary

As the population of the United States changes and continues to become more diverse, health care organizations must ensure that they are managing diversity and ensuring the cultural competency of their employees. Dobson (2012) states that although more research is needed, it makes good business sense for organizations to invest in leadership diversity. She argues that there are three interrelated strategies for organizations to consider: (1) linking diversity with performance, (2) linking investments in diversity to financial outcomes and organizational metrics of success, and (3) making organizational leadership responsible for cultural competency as a performance measure. When operational measures are connected with a culturally competent organization, the results will be a reduction in health disparities, increased patient satisfaction, and a more engaged workforce.

Discussion Questions

1. Explain the meaning of cultural competency.
2. What is diversity management?
3. Why do health care organizations need to have a diverse workforce?

Exercise 3-1

Visit the Hofstede Centre (https://geerthofstede.com/culture-geert-hofstede-gert-jan-hofstede/6d-model-of-national-culture/) and review the scores by country for the various cultural dimensions that Hofstede identified. In light of these scores, think about some interactions that you have had with people (colleagues, patients, friends, etc.) who were born and raised in other countries. Do your interactions make more sense given this new insight?

Exercise 3-2

You have been asked to join the hospital's task force for developing a plan to increase the organization's workforce diversity from its current 20% level to 40% over the next 5 years. How does your task force define diversity? What recommendations would you make as a member of the task force?

Exercise 3-3

With diverse patient populations come language translation issues. Medical interpretation is a challenge facing most health organizations. Medical interpretation and translation services are costly. You are a member of your hospital's task force challenged to establish customer-focused, cost-efficient communication programs (https://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf). What recommendations would you make as a member of the task force?

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CHAPTER 4

Attitudes and Perceptions

People may hear your words, but they feel your attitude

– John C. Maxwell

LEARNING OUTCOMES

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

- Appreciate the importance of attitudes to understanding behavior.
- Understand the three components of attitude.
- Understand how attitudes can be changed.
- Understand how perceptions allow individuals to simplify their worlds.
- Understand the four stages of the perception process.
- Understand social perception and the various subgroups.
- Understand the importance of using objective methods for employee selection.

Overview

This chapter explains how understanding the psychology of attitudes and perceptions can help us better manage the employees of the health services organizations in which we work. Psychological principles, when applied to organizational behavior issues, can help health care managers to deal with staff fairly, make jobs interesting and satisfying, and motivate employees to higher levels of productivity. By the end of this chapter, you will gain some key insights into attitudes and perceptions and how they relate to human behavior.

Attitudes

What is an attitude? Gordon Allport (1935) defined an attitude as a mental or neural state of readiness, organized through experience, exerting a directive or dynamic influence on the individual's response to all objects and situations to which it is related. A simpler definition of attitude is a mind-set or a tendency to act in a particular way toward an object or entity (i.e., a person, place, or thing) due to an individual's experience and temperament.

Typically, when we refer to a person's attitudes, we are attempting to explain their behavior. Attitudes are a complex combination of an individual's personality, beliefs, values, behaviors, and motivations. For example, we understand when someone says, "She has a positive attitude toward work" versus "She has a poor work attitude." When we speak of someone's attitude, we are referring to the person's emotions and behaviors. A person's attitude toward preventive medicine encompasses their point of view about the topic (e.g., thought) and how the person feels about this topic (e.g., emotion) as well as the actions (e.g., behaviors) in which they engage as a result of attitude to preventing health problems. This is the tricomponent model of attitudes (see **Figure 4-1**). An attitude includes three components: an affect (a feeling), cognition (a thought or belief), and behavior (an action).

Attitudes help us to define how we see situations as well as how we behave toward the situation or object. As the tricomponent model illustrates, attitudes include feelings, thoughts, and actions. Attitudes may simply be an enduring evaluation of a person or object (e.g., "I like John best of my coworkers") or other emotional reactions to objects and to people (e.g., "I dislike working on the department's annual budget" or "Jane makes me angry"). Attitudes also provide us with internal cognitions or beliefs and thoughts about people and objects (e.g., "Jane needs to work harder" or "Sam does not enjoy working in this department"). Attitudes cause us to behave in a particular way toward an object or person (e.g., "I return email messages within 24 hours because it upsets me when others do not follow up with me in a timely fashion"). Although the feeling and belief components of attitudes are internal to a person, we can often determine a person's attitude from their behavior.

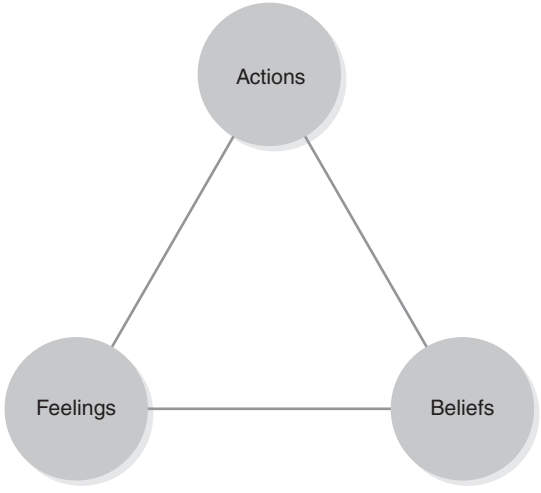

Figure 4-1 Tricomponent Model of Attitudes

Cognitive Dissonance

Alfred Adler (1870–1937), a Viennese physician who developed the theory of individual psychology, emphasized that a person's attitude toward the environment had a significant influence on their behavior. Adler suggested that a person's thoughts, feelings, and behaviors were transactions with the person's physical and social surroundings and that the direction of influence flowed both ways: Our attitudes are influenced by our social world, and our social world is influenced by our attitudes. However, these interactions may cause a conflict between our attitude and our behavior. This conflict is referred to as cognitive dissonance. Cognitive dissonance refers to any inconsistency that a person perceives between two or more of one's attitudes or between the person's behavior and attitudes. Festinger (1957) stated that any form of inconsistency that is uncomfortable for the person will prompt the person to reduce the dissonance (conflict). For example, suppose that Harry likes two coworkers, John and Mary, but John does not like Mary (i.e., inconsistency). If Harry becomes too uncomfortable with the inconsistency, he may (1) try to change John's feelings about Mary, (2) change his own feelings about either John or Mary, or (3) sever his relationship with either John or Mary (see **Case Study 4-1**).

CASE STUDY 4-1 Scott's Dilemma

Scott is a licensed physical therapist who works for a national rehabilitation company. The rehabilitation facility in which Scott works is located in an urban Southwest city. He has worked at this facility for four years and, until, recently, was satisfied with his working environment and the interactions he shared with his coworkers. In addition, Scott received personal fulfillment from helping his patients recover from their disabilities and seeing them return to productive lives.

Last year the health system went through reorganization, with some new people being brought in and others being reassigned. Scott's new boss, George, was transferred from one of the system's Midwest facilities. Almost immediately upon taking his new position, George began finding fault with Scott's care plans, patient interactions, and so forth. Scott began feeling as if he couldn't do anything right. He was experiencing feelings of anxiety, stress, and self-blame. Although his previous performance evaluations had been above average, Scott was shocked by his first performance review under George's authority—it was an extremely low rating.

Scott began trying to work harder, thinking that by working harder he could exceed George's expectations. Despite the long hours and addressing George's critiques, George continued to find fault with Scott's work. Staff meetings began to be a great source of discomfort and stress because George would belittle Scott and single him out in front of his colleagues.

Scott began to feel alienated from his family, friends, and colleagues at work. His eating and sleeping habits were adversely affected as well. Scott's activities held no joy for him, and the career that he had once loved and been respected in became a source of pain and stress. He began to call in sick more often and started visualizing himself confronting and even hurting George, which created even more guilt and anxiety for Scott.

As time went on, George encouraged Scott's coworkers to leave Scott alone to do his work. The perception of the coworkers became more sympathetic to George's point of view. Scott's coworkers mused that perhaps Scott really was a poor worker and that George knew better because of his position as the supervisor of the rehabilitation department. Eventually, Scott's coworkers began to distance themselves from him, in order to protect their own interests. They began to see Scott as an outsider, with whom it was unsafe to associate.

In an effort to resolve the situation, Scott spoke to George directly, stating his feelings and expressing an interest in how they might improve the situation. Rather than making the situation better, what George perceived as Scott's insubordination served to enrage George, and the personal attacks against

(continues)

CASE STUDY 4-1 Scott's Dilemma *(continued)*

Scott intensified. Feeling frustrated and helpless, Scott then decided to take his problem to the Human Resources Department (HRD). A human resources manager listened to Scott's complaints and suggested that Scott return with documented evidence of what Scott perceived to be George's mistreatment. In an effort to help ease the situation, the HRD manager discussed the issue with George, which only stirred the flames of George's anger and his negative behavior toward Scott.

As a last resort, Scott decided to go to George's boss, Rebecca. Rebecca met with George to get his side of the story. George portrayed Scott as an unproductive employee with no respect for authority. The result was a strong letter of reprimand in Scott's file for insubordination.

Discuss the cognitive dissonance reflected in Scott's Dilemma.

Reproduced from case discussion: Workplace bully, by J. Pinto, M. Vecchione, and L. Howard, October 2004, presented at the 12th Annual International Conference of the Association on Employment Practices and Principles, Ft. Lauderdale, FL.

Other approaches that a person may use to reduce the inconsistency are as follows:

- Eliminating their responsibility or control over an act or decision.
- Denying, distorting, or selectively forgetting the information.
- Minimizing the importance of the issue, decision, or act.
- Selecting new information that is consonant with an attitude or behavior.

For example, why do people continue to smoke cigarettes when the hazards of smoking are so well known? Using the cognitive dissonance theory, Kassarjian and Cohen (1965) attempted to analyze how smokers rationalize their behavior. They found that smokers justify their continued smoking by (1) eliminating their responsibility for their behavior ("I am unable to stop" or "It takes too much effort to stop"); (2) denying, distorting, misperceiving, or minimizing the degree of health hazard involved ("Many smokers live a long time" or "Lots of things are hazardous"); and/or (3) selectively relying on information that reduces the inconsistency of the smoker's behavior ("Smoking is better than excessive eating or drinking" or "Smoking is better than being a nervous wreck").

Although the theory of cognitive dissonance helps us understand how individuals try to make sense of the world they live in, it does not predict what an individual will do to reduce or eliminate the dissonance (as reflected in the previous example of Harry, John, and Mary). It only relates that the individual will be motivated to "do something" to bring attitudes and behaviors into balance. Cognitive dissonance theory has many practical managerial applications for motivating employees and is the theoretical basis for what are known as the equity theories of motivation (Ott, 1996). Equity theory predicts that employees will pursue a balance between their investments in work and the rewards gained from their work such that their own investment/reward ratio will be the same as that of similar others. Disturbance of this balance results in behaviors that will attempt to relieve the dissonance. For example, if an employee perceives that another employee is paid more for the same level of productivity, the first employee will be motivated to ask for a raise, lower their level of productivity, or seek another job.

Formation of Attitudes

How are attitudes formed? Attitude formation is a result of learning, modeling other individuals' actions and attitudes, and direct experiences with people and situations. Attitudes influence our decisions, guide our behavior, and affect what we remember (which is not always the same as

what we hear). Attitudes come in different strengths, and like most things that are learned or influenced through experience, they can be measured, and they can be changed.

Measurement of Attitudes

Since the publication of Thurstone's procedure for attitude assessment in 1929 (Thurstone & Chave, 1929), employee surveys have been widely used in organizations to obtain information about workers' attitudes toward their environments. As Fottler and colleagues (1995, pp. 281–282) point out, "from responses to these surveys, management can learn how employees view their jobs, their supervisors, their wages and benefits, their working conditions, and other aspects of their employment." Thus, employee attitude survey responses can help health care managers to determine whether management is doing the right things for retaining and motivating employees. For example, Lowe, Schellenberg, and Shannon (2003) found that workers who rated their work environments as "healthy" (in terms of task content, pay, work hours, career prospects, interpersonal relationships, security, etc.) reported higher job satisfaction, morale, and organizational commitment and lower absenteeism and intent to quit. Employee attitude surveys are usually designed using five-point Likert-type ("strongly agree–strongly disagree") or frequency ("never–very often") response formats. Some typical questions are illustrated in **Figure 4-2**. However, as Morrel-Samuels (2002) points out, organizations need to be cautious in designing employee attitude surveys to ensure that problem areas are not overlooked. Morrel-Samuels provided 16 guidelines for organizations to consider when designing an employee attitude survey (see **Exhibit 4-1**).

Effective managers continuously survey their employees so they can detect problem areas and implement the necessary changes.

Legend (check ☑ the correct number that applies to each question):

1 = Strongly disagree 2 = Disagree 3 = Neutral
4 = Agree 5 = Strongly agree

	1	2	3	4	5
1. Do you feel that your salary reflects your worth to the organization?					
2. Do you feel appreciated for your work performance?					
3. Do you feel a sense of achievement for your work efforts?					
4. Are you provided the opportunity for growth/advancement to higher level tasks?					
5. Do you feel that you contribute to the overall success of the organization?					
6. Would you recommend the organization to family and friends?					
7. Are you given the opportunity to learn new skills through formal training?					
8. Do you feel the organization provides adequate resources to complete your work?					
9. Do you feel overwhelmed by your workload?					
10. Do you experience ongoing interests in your job/tasks?					

Figure 4-2 Employee Attitude Survey

Exhibit 4-1 Guidelines to Help Companies Improve Their Workplace Surveys

Content

- Ask questions about observable behavior rather than thoughts or motives.
- Include some items that can be independently verified.
- Measure only behaviors that have a recognized link to your company's performance.

Format

- Keep sections of the survey unlabeled and uninterrupted by page breaks.
- Design sections to contain a similar number of items, and questions with a similar number of words.
- Place questions about respondent demographics last in employee surveys but first in performance appraisals.

Language

- Avoid terms that have strong associations.
- Change the wording in about one-third of questions so that the desired answer is negative.
- Avoid merging two disconnected topics into one question.

Measurement

- Create a response scale with numbers at regularly spaced intervals and words only at each end.
- If possible, use a response scale that asks respondents to estimate a frequency.
- Use only one response scale that offers an odd number of options.
- Avoid questions that require rankings.

Administration

- Make workplace surveys individually anonymous and demonstrate that they remain so.
- In large organizations, make the department the primary unit of analysis for company surveys.
- Make sure that employees can complete the survey in about 20 minutes.

Reproduced from Getting the truth into workplace surveys, by P. Morrel-Samuels, 2002, *Harvard Business Review, 80*(2), 111–118.

Changing Attitudes

How do you change someone's attitude? To change a person's attitude, you need to address the cognitive and emotional components. How would you convince another person to start an exercise program when the individual may say, "I don't have enough time" or "I'm just too busy"? One approach would be to challenge the person's behavior by providing new information. For example, explain to the other person how you made time in your day and how, as a result, both your cholesterol level and your blood pressure decreased. This is a cognitive approach when a person is presented with new information. Providing new information is one method for changing a person's attitude and therefore their behavior. Attitude transformation takes time, effort, and determination, but it can be done. It is important not to expect to change a person's attitudes quickly, as the following story illustrates:

"We can't meet tomorrow morning, I've got to go to my doctor," he told me.

"I hope it's nothing serious?"

"Only a colonoscopy," my friend reassured me.

"Only? Do you have pain?"

"No," he replied, "my doctor said I need to have one, I'm forty-five. Don't worry, in my family, nobody ever had colon cancer."

"It can hurt. Did your doctor tell you what the possible benefits of a colonoscopy are?"

"No," my friend said, "he just said it's a routine test, recommended by medical organizations."

"Why don't we find out on the Internet?"

We first looked up the report of the U.S. Preventive Services Task Force. It said that there is insufficient evidence for or against routine screening with colonoscopy. My friend is Canadian and responded that he does not bank on everything American. So we looked up the Canadian Task Force report, and it had the same result. Just to be sure, the men checked Bandolier at Oxford University in the United Kingdom, and once again we found the same result. No professional health association that we looked up reported that people should have a routine colonoscopy—after all, a colonoscopy can be extremely unpleasant—but many recommended the simpler, cheaper, and noninvasive fecal occult blood test. What did my friend do? If you think that he canceled his doctor's appointment the next day, you are as wrong as I was. Unable to bear the evidence, he got up and left, refusing to discuss the issue any further. He wanted to trust his doctor.

Reproduced from *Gut feelings: The intelligence of the unconscious*, by G. Gigerenzer, 2007, New York: Viking Penguin.

Managers need to understand that attitude change takes time, and they should not set unrealistic expectations for rapid change (Moore, 2003). Attitudes are formed over a lifetime through an individual's socialization process. An individual's socialization process includes their formation of values and beliefs during childhood years, influenced not only by family, religion, and culture but also by socioeconomic factors. This socialization process affects a person's attitude toward work and their related behavior (see **Case Study 4-2**).

CASE STUDY 4-2 What Changed in the Housekeeping Department?

Betty Smith, the newly assigned manager of the hospital's housekeeping department, could not understand why her employees never offered suggestions as to how their jobs could be performed more effectively and efficiently. Betty was of the opinion that she shouldn't have to tell her staff how to clean a floor or a patient's room; they should be telling her how they could do their jobs better. Finally, Sally, a 24-year-old recent Sierra Leone immigrant who had been employed in the hospital's housekeeping department for the past five years, confided in Betty during her performance-evaluation conference, "I don't offer suggestions because I'm only a housekeeper with no formal education. I don't want to look stupid."

Betty immediately put into place a three-month training program with the goal of giving her employees the skills to recognize problems and the self-confidence to bring them to her attention. The training program was designed to let employees know what is expected of them regarding performance, as well as how and where they "fit" in the overall organization. The training program helped the employees understand that their contributions make a difference to the organization achieving its goals.

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CASE STUDY 4-2 What Changed in the Housekeeping Department?

(continued)

After the employees had completed half of the training program, Betty started to hold staff meetings on Friday afternoons to discuss any problems that were encountered during the week. At the conclusion of a Friday's staff meeting, Betty asked, as she always did, if anyone had an item to discuss. Betty never received a reply, but she continued to ask the question in every staff meeting anyway. However, this Friday was different. Sally raised her hand and related that she "overheard" a physician talking to the emergency department (ED) manager about the delay of transferring his patients from the ED to the nursing floors. Sally thought that part of the delay might be related to patients' rooms not being cleaned in a timely fashion after a patient's discharge because the unit secretaries at the nurses' stations did not communicate when the patient was being discharged. Housekeepers were told after the fact—after the patient was discharged and after the ED called the nursing station secretaries informing them an ED patient needed to be transferred to the unit. Because of their other duties, sometimes a housekeeper could not get to the floor for cleaning for at least an hour or more. Sally asked, "Why can't the nursing station secretaries communicate with us before the patient is discharged so we can schedule our time appropriately?" Betty agreed with Sally. Why couldn't there be better communication between the nursing units and housekeeping? Betty told the group she would look into it.

Betty called the vice president of nursing, Mary Acton, and discussed her staff's observations regarding the turnaround time delay of a clean bed being made available for an ED patient transfer. Mary concurred with Betty, stating that administration had noticed that sometimes it took up to three hours from the time a bed became unoccupied to the time the bed was reported clean and available for patient use.

A team was formed that included nurse managers, nursing supervisors, floor nurses, unit secretaries, and housekeeping staff, including Sally, to discuss the problem and develop a solution that was workable for everyone. The solution* was simple, low-cost, and low-tech.

First, the nursing supervisors would e-mail a list of anticipated room discharges for the following day to housekeeping no later than midnight. The evening housekeeping staff would retrieve the e-mail and post the list for the morning shift so they could plan their daily job activities according to the anticipated discharges. Second, two jars were placed at the nurses' stations—one jar was marked for clean rooms and the other marked for dirty rooms. Third, once a patient was discharged, the nurse put a red slip of paper with the room number into the dirty-room jar. Fourth, when housekeeping finished cleaning and preparing the room for an incoming patient, they removed the red slip from the dirty-room jar and put a green slip with the same room number on it in the clean-room jar. Fifth, the green slip in the jar served as a visible reminder to the unit secretary that an open bed was available and ready to be filled when they received the call from the ED.

Mary Acton called Sally the following month to thank her for bringing her "proactive" observations to Betty's attention. Mary related that the new "communication" system had reduced the bed turnaround time from three hours to 30 minutes!

Betty related the news of the decreased turnaround time at her next Friday staff meeting, and she thanked Sally and everyone for participating in developing and implementing this new hospital procedure that had positively impacted both patient and physician satisfaction. When she asked if anyone had anything else to discuss, Sally raised her hand and said, "Barry and I noticed that an excessive amount of paper towels are being used throughout the hospital, and we have a few suggestions that may save the hospital money." Joe interjected, "I've also noticed that the hospital is not taking advantage of recycling its paper waste, which could save money and reduce our workloads." Tina related, "I have a few suggestions regarding . . ." Betty smiled as she listened to everyone's suggestions and recommendations.

Discuss why Sally and the other housekeeping staff's attitudes changed.

* Portions of the solution were reported as being implemented by University Hospital of University Health System. See Blueprint at the Seams: Improving Patient Flow to Help America's Emergency Department. Available from the Robert Wood Johnson Foundation Urgent Matters Program. Reprinted with permission.

Health care managers may use techniques employed in the counseling and conflict-resolution fields to develop a step-by-step process for changing employees' attitudes when necessary (see **Exhibit 4-2**). The importance of attitude assessment and change cannot be underestimated. One person with a consistently—and vocal—bad attitude can lower the morale of an entire workgroup in an otherwise "healthy" organization. Employees who demonstrate counterproductive work behaviors, also referred to as "toxic behavior," can seriously debilitate individuals, teams, and/or the organization over the long term (Kusy & Holloway, 2009). For example, Rosenstein (2011) reported, based on a survey of more than 4500 respondents in over 100 hospitals, that there was a strong perceived correlation between disruptive behaviors and the occurrence of medical error, compromised quality, adverse events, compromises in patient safety, and increased patient mortality.

The first step in the change process is to identify the problem, followed by efforts to adjust attitudes, reduce conflict, and seek solutions (see **Exhibit 4-3**). Open communication creates environments where workers feel safe to dissent and their opinions are respected. Everyone has attitudes, both positive and negative. To help workers realize their full potential requires ongoing efforts.

Exhibit 4-2 Step-by-Step Process for Changing Attitudes in the Workplace

1. Assessment of Attitudes
   a. Identification—Recognize common workplace attitude problems.
   b. Environment—Identify challenges in the workplace environment.

   Participants are introduced to common examples of "attitude-challenged" workers. Group activities help participants to identify and role-play how to handle different types of attitude challenges. The goals are to assess the impact of negative attitudes on workers, management, and patients/customers and to identify the causes of problems.
2. Adjusting Attitudes
   a. How listening, coaching, and providing feedback are the tools for attitude change.
   b. Role-play to practice how to use coaching and provide feedback with staff.
   c. Identify payoffs and rewards.

   Participants learn how to use open-ended questions, active listening, and tactful confrontation to address attitude problems in the workplace.
3. Common Management Mistakes
   a. How to be realistic and patient with attitude change.
   b. Why scolding employees does little to stop the problem.
   c. How to stop the culture of complaining and work to positively effect attitude change.
   d. Group activities include examples of common management mistakes and exercises to practice more realistic and positive ways to provide employee feedback, facilitate group discussion, and role-play the best methods for confronting negative attitudes.
4. Resolving Conflict
   a. The need to confront so that negative behaviors will not continue.
   b. Expectations and coping strategies of employees to stress and management directives.
   c. Recognizing personal conflict styles of workers and how to deal with them.

   Exercises include ways to analyze communications to identify employee styles, planning the meeting, and working collaboratively to discover win/win solutions.
5. How to Work with Problem Behaviors and Attitudes
   a. Analyze the cause of the problem.
   b. Privately confront with a calm, nondefensive professional demeanor.

   In this session, participants role-play with their preferred style for handling difficult employees. Managers and employees exchange roles and must reprimand or confront problem behaviors.

(continues)

Exhibit 4-2 Step-by-Step Process for Changing Attitudes in the Workplace *(continued)*

6. The Last Resort: Employee Termination and Legal Issues
   a. Legal issues of employee terminations.
   b. Requirements, documentation, and procedure.
   Exercises use case studies to work out remedial and probationary systems and to fully document intervention efforts prior to the need for termination or reassignment.
7. Creating a Positive Work Environment
   a. Evoke a positive, collaborative team environment.
   b. Top motivators include nonmonetary rewards.
   c. Characteristics of managing motivation in the workplace.

Exercises include engaging workers in teams, providing recognition awards for employees, and changing the climate by launching career development and advancement initiatives, leadership training, multicultural skills, and other positive incentive programs.

Exhibit 4-3 Facilitating an Attitude Workshop for Employees

Discussion groups are a great way to diagnose and treat attitude problems. Begin by stating the guidelines for the session to alleviate any anxiety and set a positive tone. Create a supportive atmosphere so that participants feel safe to examine their attitudes and beliefs.

The manager's role should be as facilitator rather than guiding a question-and-answer session. One task of the effective facilitator is activating the group's resources to bring out the best in the group. For example, plan activities in which people interact with one another at the start (e.g., an icebreaker type of exercise). Work with the energy of the group; use humor and laughter as well as healthy competition. These interactions build trust and help people to feel comfortable sharing ideas and considering new options.

The second task of the facilitator is to activate participants' internal wisdom. Ask questions and let people discover their own answers. You can assist participants by keeping the dialogue going to enable them to sort out their values and priorities, explore beliefs and assumptions, and feel encouraged to alter their work lives in ways that they choose.

The third task is to facilitate personal reflection by asking questions to help participants test the ideas that are being developed against their own experiences. List issues, goals, problems, and solutions that come up in the group dialogue. Write the main ideas on a board, perhaps focusing on negative attitudes and aspects of the workplace that may cause them. Ask participants to expand on these. Give personal examples, and ask how poor attitudes in others can make them feel.

Throughout the process, the facilitator's goal is to foster interpersonal support. Having participants share ideas and experiences initiates the process of people supporting one another. Encourage team building and interpersonal support as part of creating a work atmosphere where negative attitudes are exposed and positive attitudes flourish.

At the end of each session, it is important to provide a summary. This communicates to the participants that you have been actively listening and are prepared to offer a synthesis of the group's observations and insights. Begin by saying, "What I heard today is . . . ." Offer participants a chance to compare notes with one another for feedback. You might also ask participants to jot down ideas and feelings about the attitude dialogue to bring to the next meeting. Always provide a "take-home message" of commitment to change. Everyone should leave with at least one clear idea about what they will do next.

Discussions to identify negative workplace attitudes can be very effective. These discussions lead to solutions and group commitment to improved morale.

Modified from Kreitlow, B., & Kreitlow, D. (1997). *Creative planning for the second half of life.* New York, NY: Whole Person Associates. Reprinted with permission.

Perception

Perception is closely related to attitudes. Perception is the process by which organisms interpret and organize sensation to produce a meaningful experience of the world (Lindsay & Norman, 1977). In other words, when a person is confronted with a situation or stimuli, the person interprets the stimuli as something meaningful to them on the basis of prior experiences. However, what an individual interprets or perceives may be substantially different from reality.

The perception process follows four stages: stimulation, registration, organization, and interpretation (see **Figure 4-3**).

A person's awareness and acceptance of the stimuli play an important role in the perception process. Receptiveness to the stimuli is highly selective and may be limited by a person's existing beliefs, attitudes, motivation, and personality (Assael, 1995). Individuals will select the stimuli that satisfy their immediate needs (perceptual vigilance) and may disregard stimuli that may cause psychological anxiety (perceptual defense).

Broadbent (1958) addressed the concept of perceptual vigilance with his filter model. Broadbent argued that, on the one hand, because of limited capacity, a person must process information selectively; therefore, when presented with information from two different channels (i.e., methods of delivery, such as visual and auditory), an individual's perceptual system processes only that which they believe to be most relevant. However, perceptual defense creates an internal barrier that limits the external stimuli passing through the perception process when the stimuli are not congruent with the person's current beliefs, attitudes, motivations, and personality. This is referred to as selective perception. Selective perception occurs when an individual limits the processing of external stimuli by selectively interpreting what they see on the basis of beliefs, experience, or attitudes (Sherif & Cantril, 1945).

Broadbent's filter theory has been updated in recent years. A "Selection-for-Action View" suggests that filtering is not just a consequence of capacity limitations but is also driven by goal-directed actions (Allport, 1987, 1993; Neumann, 1987; Van der Heijden, 1992). The concept is

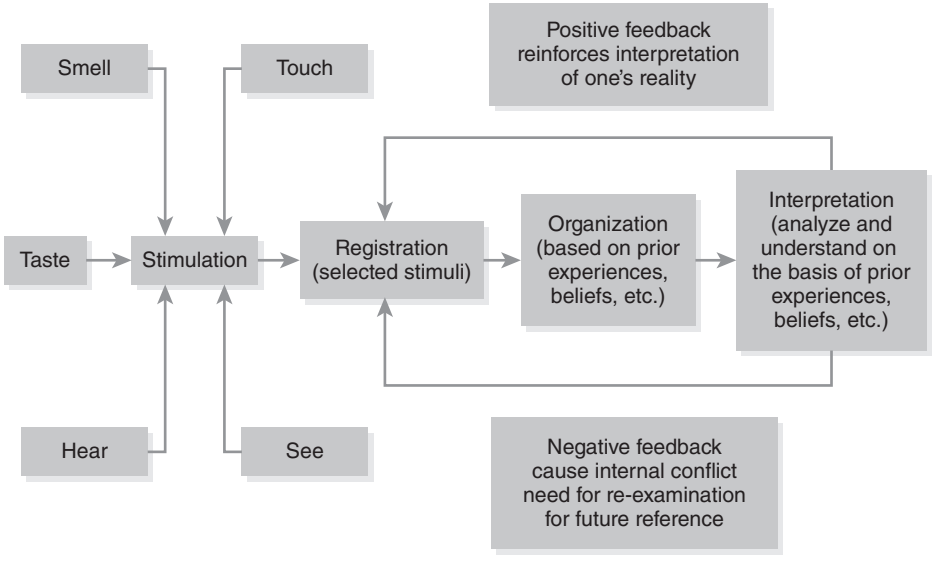

Figure 4-3 Perception Processing System

that any action requires the selection of certain aspects of the environment that are relevant to the action and, at the same time, filtering other aspects that are irrelevant to the action. Therefore, when one is working toward a goal, one will skip over information that does not support one's plan. Studies of the brain have also led to new models suggesting that there are multiple channels of processing (Pashler, 1989) and that selective perception occurs as a result of activation of cortical maps and neural networks (Rizzolatti & Craighero, 1998). In any case, people are selective in what they perceive and tend to filter information on the basis of their capacity to absorb new data, combined with preconceived thoughts.

Attribution Theory

Since the 1950s, researchers have tried to understand and explain why people do what they do. Attribution theory was first introduced by Heidler (1958) as "naive psychology" to help explain the behaviors of others by describing ways in which people make causal explanations for their actions. Heidler believed that people have two behavioral motives: (1) the need to understand the world around them and (2) the need to control their environment. Heidler proposed that people act on the basis of their beliefs, whether or not these beliefs are valid. Weiner (1979) suggested that individuals justify their performance decisions by cognitively constructing their reality in terms of internal–external, controllable–uncontrollable, and stable–unstable factors.

According to Weiner (1979), when one tries to describe the processes of explaining events and the relating behavior, external or internal attributions can be given. An external attribution assigns causality to an outside agent or force. An external attribution claims that some outside force motivated the event. By contrast, an internal attribution assigns causality to factors within the person. An internal attribution claims that the person was directly responsible for the event. Controllability refers to whether the person had the power to exert control over the events of the situation. Finally, stability of the cause relates to whether the behavior is consistent over time because of the individual's values and beliefs or because of outside elements such as rules or laws that would govern a person's behavior in the various situations.

Attribution theory is a concept from social psychology that examines people's explanations for why things happen. It is more concerned with the individual's cognitive perceptions than with the underlying reality of events (Daley, 1996). For example, fundamental attribution error occurs when the influence of external factors is underestimated and the influence of internal factors is overestimated in regard to making judgments about behavior. Self-serving bias is the tendency for individuals to attribute their own successes to internal factors while putting the blame for failures on external factors.

When employees make attributions about a negative event that happened at work, they tend to underemphasize internal (dispositional) factors such as ability, motivation, or personality traits and overemphasize (external) situational factors. For example, some workers are high achievers because of their attributions. They approach rather than avoid tasks because they are confident that success will come from their ability and effort. These high achievers persist when the work becomes more difficult rather than giving up because achieving their goals is self-rewarding and they will attribute their success to their personal drive and efforts. In contrast, the unmotivated (external) person will avoid or quit difficult tasks because that person tends to doubt their ability and attributes success to luck or other factors out of their control. Such external individuals have little drive or enthusiasm for work because positive outcomes are not thought to be related to their direct effort.

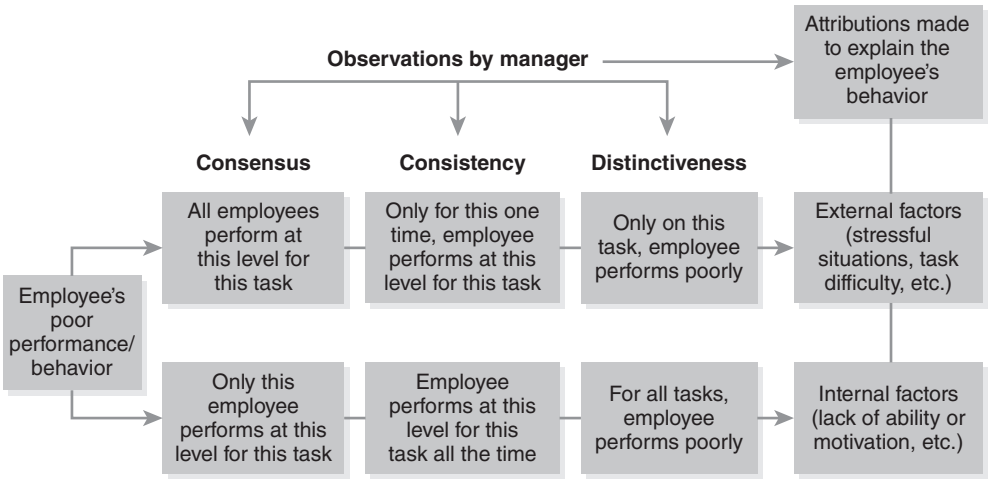

Figure 4-4 Kelley's Attribution Theory Model

Managers are often in a position in which they make causal attributions regarding an employee's behavior or work pattern. Kelley's (1967, 1973) model of attribution theory incorporates three attributions: consensus, consistency, and distinctiveness (see **Figure 4-4**).

Consensus relates to whether an employee's performance is the same as or different from that of other employees. Consistency refers to whether the employee's behavior is the same in most situations, whereas distinctiveness asks the question, "Does the employee act differently in other situations?" Managers will attribute an employee's behavior to external causes such as task difficulty if there is high consensus, low consistency, and high distinctiveness. For example, the regional director of an international pharmaceutical company attributes her top sales people's inabilities to reach their annual sales goals for a specific drug used to treat gastrointestinal conditions to recent negative media coverage of another, similar drug's linkage to a high number of patients suffering strokes (e.g., adverse effects to the drug). By contrast, managers will attribute an employee's behavior to internal factors, such as lack of ability, if there is low consensus, high consistency, and low distinctiveness.

Mitchell, Green, and Wood (1981, p. 199) gave the following example to demonstrate the preceding discussion: Suppose you are a physician and you have asked a nurse to administer a medication to one of your patients. When you check back later in the day, you find that the medication was not given. On further discussions with the nurse, the supervisor, and other involved parties, you discover that (1) this nurse has failed to administer the proper medication on other occasions (low distinctiveness); (2) this nurse has had difficulty with other tasks, such as charting or patient care (high consistency); and (3) none of the other nurses have failed to carry out a physician's order in the past 3 months (low consensus). The nurse has performed poorly on this task before; the nurse has performed poorly on other tasks; and no other nurses seem to have this difficulty. In this scenario, the physician will most probably make a person attribution: The cause of the poor performance was some characteristic or trait of that particular nurse (e.g., lack of effort or ability).

Managers need to remember that many issues factor into this process (i.e., explaining events and the relating behavior) and that organizational history, personal experiences, individual

tendencies (toward internal versus external views of causality and intrinsic versus extrinsic motivations), and prior knowledge all affect perceptions of causes. Managers should avoid the "blame game" and focus on correcting workplace behavior.

Social Perception

Social perception is how an individual "sees" others and how others perceive an individual. This is accomplished through various means, such as classifying an individual on the basis of a single characteristic (halo effect), evaluating a person's characteristics by comparison to others (contrast effect), perceiving others in ways that reflect a perceiver's own attitudes and beliefs (projection), judging someone on the basis of one's perception of the group to which that person belongs (stereotyping), causing a person to act erroneously on the basis of another person's perception (Pygmalion effect), or controlling another person's perception of oneself (impression management).

Halo Effect

The halo effect occurs when an individual forms a general impression about another person on the basis of a single characteristic, such as intelligence, sociability, or appearance. The perceiver may evaluate the other individual as being high on many traits because of their belief that the individual is high in one trait. For example, if an employee performs a difficult accounting task well and the manager believes that the employee is highly intelligent, the manager may also erroneously perceive the employee as having competencies in other areas such as management or technology.

The halo effect is applicable to individuals' perceptions of others and of organizations. For example, a hospital that is well known for its open-heart and cardiac programs may be perceived in the community as excellent in other clinical areas, such as obstetrics or orthopedics, whether that is true or not.

Opposite to the halo effect is the horn effect, whereby one person evaluates another as low on many traits because of a belief that the individual is low on a trait that is assumed to be critical (Thorndike, 1920). A study on obesity conducted with health care professionals and researchers reflects the horn effect. Study participants were asked to complete the Implicit Association Test to assess overall implicit weight bias (associating "obese people" and "thin people" with "good" versus "bad") and three ranges of stereotypes: lazy–motivated, smart–stupid, and valuable–worthless. The study respondents were much quicker to pair "fat" with "lazy" and other negative traits and/or stereotypes (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003).

The halo/horn-effect cognitive bias is a challenge that health care managers face when they are performing workers' evaluations. Managers need to avoid the tendency for an employee's positive or negative trait to spill over into other areas of the evaluation. For example, if an employee has been late to work for 3 days, the manager might conclude that this person has a poor attitude and doesn't care about their job. However, there may be external reasons for the employee's lateness, such as a car breaking down, a delay on public transportation, the babysitter being late, or bad weather. The manager who assumes, because of the lateness, that the employee is a poor worker will unfairly give the employee a negative overall evaluation.

Because these types of bias can lead to poor decisions by managers, many large organizations are allocating resources to diversity programs and sensitivity training. These training programs

assist managers and other employees to be aware of these biases especially in hiring, evaluating, and promotion decisions (Halvorson & Rock, 2015).

Contrast Effects

Research has provided evidence that perceptions are also subject to what are termed perceptual contrast effects. Contrast effects relate to an individual's evaluation of another person's characteristics based on (or affected by) comparisons with people who rank higher or lower on the same characteristics. For example, Wedell, Parducci, and Geiselman (1987) found that, if compared to a highly attractive person, a target person of average attractiveness is judged to be less attractive than they would have been judged if rated on their own. When asked to contrast a target person with people who were more physically attractive, ratings of attractiveness of the target were more negative, and when the target person was compared with people who were less attractive, it resulted in more positive evaluations (Thornton & Moore, 1993). In other words, the contrast effect relates to how an individual is perceived in relation to others around them. Not only do contrast effects apply to the perception of attractiveness, but they have also been shown to influence self-esteem, public self-consciousness, and social anxiety (Thornton & Moore, 1993). It stands to reason that a worker's performance would be judged in contrast to the workers around them. However, managers need to be aware of this contrast-effect bias when interviewing job candidates or evaluating a worker's performance.

Contrast is an important principle by which we make decisions. When we make judgments, they are not absolute judgments. We judge an individual or object in comparison with someone else or something else. By using the perceptual contrast-effects principle, one can persuade other people in their judgments by leveraging the following comparisons (changingminds.org):

- *Shortlists*: Individuals are not good at selecting from a large group, as there are too many contrasts to make. When faced with many candidates for a job, we will rapidly simplify the decision by breaking things down to a very short list.
- *Pairwise Comparison*: Although we can select from a group of things, we compare best when we have only two things from which to select. In fact, one of the reasons that we do reduce choices to a shortlist is that we have fewer pairs to compare. Even then, we will break things down further, comparing the top two or three, one against another.
- *Polarizing*: When we are seeking to separate two things, it is easier to differentiate if there is a higher contrast. We hence polarize, pushing our perceptions more toward extremes in order to say that "this is clearly different from that" rather than "this is a bit different from that." Living in a Black-and-White world is easier, if less accurate, and many people choose to take extreme views rather than living with uncertainty. We polarize by selectively amplifying the aspects that will support our position and downplaying or ignoring those that will not. In this way, we create selective distortion. We do this in particular when separating ourselves (and our friends) from other people, especially if values are involved, as we seek to ensure that we are all good and that we can project all bad things onto the other person.
- *Comparing with Prototypes and Stereotypes*: A prototype is an idealized stereotype, both of which are based on polarized thinking. Sometimes the standard against which we judge other things is a prototype that we have constructed. Thus, when selecting a job candidate, we will compare each interviewee against a nonexistent prototype that has all the wanted characteristics, traits, and so on. Prototypes are often made up of all the best parts from a wide range of experiences.

- *Comparing with What Is Available*: If two women are standing side by side, a man will evaluate one against the other, as the other woman is more immediately available than a recalled prototype would be. Women, of course, will do the same. In fact, we all tend to use whatever comparators are most available to us at the time of judgment. In our usual lazy mental manner, we are more likely to use the comparator that is easiest to access than to use one that may be more appropriate. Thus, given an unattractive person and an average-looking person, we will judge the average person to be more attractive than we would if we saw the average person alone.
- *Comparing Against Other People*: When evaluating ourselves, the main comparator is other people. We decide how happy, beautiful, and so on we are by comparing ourselves with others. In particular, we tend to compare ourselves to peers and people who are "like us." Thus, rich people compare themselves to other rich people (and often feel quite poor as a result!). People for whom being intelligent is important will compare themselves to other intelligent people. A result of this is that being rich, powerful, clever, and so on is no predictor of happiness. We may strive for success, but if we change our comparators along the way, we will not seem to have achieved that much.

Projection

Whereas contrast effects are the perception of an individual based on comparison to others, projection is the attribution of one's own attitudes and beliefs onto others. All of us are guilty of unconsciously projecting our own beliefs onto others. Sigmund Freud (1894/1966), along with his daughter Anna Freud (1936/1967), suggested that projection is a defensive mechanism whereby we attribute our own attitudes onto someone else as a defense against our feelings of anxiety or guilt. For example, if you strongly dislike someone, you might, instead of acknowledging your feeling, believe that they do not like you. Projection works by allowing the expression of the desire or impulse but in a way that the ego cannot recognize, therefore reducing anxiety or guilt. Projection can mean ascribing to others the negatives that we find inside ourselves, thereby protecting our self-esteem. For example, a person who is rude might constantly accuse others of being rude. Thus, the person does not have to deal with the fact that they are rude, which would require acknowledging that there is something wrong with them, which is generally undesirable. Projection thus makes the individual feel better about themselves. Who has never blamed others for making them late to work, going off a diet, or being in a bad mood (when it was themselves at fault)? Projection is an interesting human tendency. Projection allows one to perceive others in ways that really reflect oneself, because, in general, people are in favor of those who are most like themselves.

Stereotyping

In 1798, printers invented a new way to permanently fix and reproduce visual images. This precursor to modern photographic printing processes was called stereotyping. Over time, the word "stereotype" came to apply not just to visual printed images, but also to how we fit attributes of ability, character, or behavior to groups and/or populations in order to make generalizations. The term is now most often defined to mean a conventional image applied to whole groups of people and the treatment of groups according to a fixed set of generalized traits or characteristics.

Although stereotyping can be positive because it allows us to organize a complex world, it may be considered negative if it leads to overly generalized views about groups of individuals.

Researchers suggest that stereotypes wield a strong, covert influence on human behavior (even among those who do not agree with stereotypes). Social researchers have revealed that it is relatively easy for stereotypes to be activated across a wide range of contexts and situations because of many factors, including race, gender, religion, physical appearance, disability, and occupation (see Bargh, Chen, & Burrows, 1996).

Stereotyping regarding race and ethnicity is problematic for health care professionals and health service organizations. The Institute of Medicine (2003) found that "racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income are controlled . . . and found evidence that stereotyping, biases, and uncertainty on the part of health care providers can contribute to unequal treatment" (p. 1).

In addition to stereotyping racial and ethnic minorities, health care professionals have a tendency to stereotype other groups, such as older adults, homeless people, people with disabilities, and those dealing with obesity. Older adults are often stereotyped as infirm, inflexible, weak, deficient in vision and hearing, and being unable to advocate for themselves on health issues. Another example is the homeless population. There is a tendency to stereotype a person in this group as an elderly alcoholic male or perhaps a disheveled bag lady. However, homelessness also affects families, children, and young people—groups that do not fit the stereotypes. When it comes to obesity, Puhl and colleagues (2010) have published numerous studies documenting "harmful weight-based stereotypes that overweight and obese individuals are lazy, weak-willed, unsuccessful, unintelligent, lack self-discipline, have poor willpower, and are noncompliant with weight-loss treatment."

One of the most common forms of stereotyping involves gender and leadership. Women hold positions at all levels in health care organizations, but only between 10% and 18% of chief executive officer positions are held by women (Russell, Krentz, Abouzahr, & Doyle, 2019). The influence of gender stereotypes is one possible reason why it is sometimes difficult for people to accept women as leaders in the workplace. Traits that are often attached to leadership are stereotypically "masculine" qualities such as courage, persuasiveness, and assertiveness. An aggressive male leader may be viewed as "ambitious," compared with an assertive female leader, who may be viewed as "pushy." This is, in part, because the assertive female leader's behavior violates the gender stereotype that women should be less authoritarian and more sensitive, gentle, and nurturing (see **Exhibit 4-4**).

Whether we are aware of it or not, we all use stereotypes because they help us to simplify our world. However, we very often do not take the time to understand why we are perceiving groups in a certain way. We revert to our cognitive prototypes and ignore relevant information. These habits and biases are learned and, thus, can be unlearned. Training exercises can help to sensitize individuals to issues of bias such as racism, sexism, and ageism. One goal of management is to assist staff in recognizing that stereotypes are illogical by challenging these faulty cognitions. The need to challenge gender stereotypes and other stereotypes in the workplace is one of the reasons so much increased attention has been placed on managing diversity in organizations. It is important to be aware of how our perception of groups can influence our behavior, including hiring and management practices and interactions with workers. Stereotypes may lead to discrimination; therefore, it is important to discuss them and to work toward ridding the workplace of stereotypes. Negative stereotypes can be problematic for any organization, and proper training can be effective in minimizing widely held false beliefs (see **Exhibit 4-5**). Dobbin and his colleagues (2007) found that mandatory diversity training programs developed by companies to avoid liability in discrimination lawsuits were ineffective for increasing diversity in management. However, when diversity training was voluntary and undertaken to advance a company's business goals (and as part of the

Exhibit 4-4 Gender Stereotyping

In each culture, gender roles and gender stereotypes provide specific expectations of male and female behavior. When those expectations are violated (as in the case of a woman acting assertively), it often results in a negative label being used to describe the person who is violating the expectation. This was at issue in *Price Waterhouse v. Hopkins* (1989), as cited by Lord and Maher (1991).

Ann Hopkins was a high-performing but masculine-acting prospective partner at Price Waterhouse. When she was denied a partnership at Price Waterhouse, she charged that gender stereotyping had played a role in the decision (Fiske, Bersoff, Borgida, Deaux, & Heilman, 1991). At the time of her eligibility and consideration for promotion to partner, Hopkins was the only woman among 88 candidates nominated for partnership. Her close colleagues submitted an evaluation noting her "outstanding performance" and strongly urged her admission to the partnership. When she was not accepted as a partner by the promotion board, she sued.

In response to the suit, Price Waterhouse countered that Ms. Hopkins had interpersonal problems and was considered too "macho" for the position. The person responsible for explaining the board's decision to Ms. Hopkins advised her that in order to improve her chances for partnership, she "should walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry." Another board member repeatedly commented that "he could not consider any woman seriously as a partnership candidate and believed that women were not even capable of functioning as partners." Ms. Hopkins brought her gender discrimination lawsuit all the way to the U.S. Supreme Court and won.

Lord, R. G., & Maher, K. J. (1991). *Leadership and information processing: Linking perceptions and performance.* Boston, MA: Unwin Hyman.

Exhibit 4-5 Exercise to Identify Stereotypes Within Our Organizations and Profession

Discussion: Have you seen any evidence of stereotypes in your workplace?

Which of the following positions are filled more by MEN or by WOMEN:

Physician _____ Pharmacist _____ Nurse _____

Computer Programmer _____ Nurses Aide _____ Chief of Staff _____

Medical Receptionist _____ Radiology Technician _____

Statements:

Health services administrators need to be _____ to be effective.

The hospital cafeteria is staffed by people who are _____.

Older people that I have worked with are _____.

organization's culture), it was associated with increased diversity in management. According to the study, employees don't react well when sensitivity training is forced on them.

Pygmalion Effect

The Pygmalion effect, or self-fulfilling prophecy, describes a person's behavior that is consistent with another individual's perception, whether or not it is accurate. In other words, once an expectation is made known by another person, an individual will have the tendency to behave in ways that are consistent with the expectation. This can have negative or positive results. If a manager

sets high standards for a subordinate's performance, the subordinate is likely to respond accordingly with high performance. If a manager sets low standards for a subordinate's performance because the subordinate is viewed as lacking in ability and/or motivation, the resulting work performance is likely to be low. Thus, managers' expectations directly influence subordinates' performance. In other words, what a manager communicates as the expectation is what will result. Livingston (1969) stated that what was critical in the communication of expectations was not what the manager said as much as how the manager behaved. More often than not, indifferent and noncommittal treatment was the kind of treatment that communicated low expectations and led to poor performance. Livingston related that managers were more effective at communicating low expectations to their subordinates than at communicating high expectations.

Closely related to the self-fulfilling prophecy is the "Galatea effect." This effect relates to the expectations we have for ourselves rather than the expectations others have for us. To illustrate this concept, Livingston (1969) referred to "Sweeney's Miracle." James Sweeney was an industrial management professor at Tulane University who wished to disprove the theory that a certain IQ level was needed to learn how to program computers. Sweeney trained a poorly educated janitor whose IQ indicated that he would be unable to learn to type, much less program. The janitor not only learned to program, but also eventually took charge of the computer room along with the responsibility of training new employees to program and operate the computers. As Livingston pointed out, Sweeney's expectations were based on what he believed about his teaching ability (internal expectations), not on the janitor's learning capabilities. Livingston related that "the high expectations of superior managers are based primarily on what they think about themselves—about their own ability to select, train, and motivate their subordinates. What the manager believes about himself subtly influences what he believes about his subordinates, what he expects of them, and how he treats them" (Livingston, 1969).

Managers need to understand the effects of their own self-expectations and how these expectations interact with the expectations they hold and communicate about their subordinates' performance. Managers set the tone and culture of the workplace. By understanding the Pygmalion and Galatea effects, managers can set high but realistic performance expectations for their subordinates. If a manager rates subordinates as "excellent," they will continue their previous work behaviors. Managers can also have workers rate their own performance. Expectations about ourselves tend to be self-sustaining.

Impression Management

"You never get a second chance to make a first impression." This classic statement is all about impression management, whereby people try to shape others' impression of them. Impression management incorporates what we do, how we do it, what we say, and how we say it as we try to influence the perceptions others have of us. Individuals will try to present themselves in ways that will lead to positive evaluations by others by highlighting their achievements and avoiding the disclosure of failures. This behavior is common on social media, where a person seeks to share only their best moments and pictures. Giacalone and Rosenfeld (1989) point out that impression management is inherently neither good nor bad; rather, it is a fundamental part of our social and work lives, and we need to view it in the situations in which it is used. For example, consider the concept of self-handicapping. Self-handicapping occurs when people place obstacles in their own way so that if they do not succeed, they can blame the obstacles, or if they are successful, they can brag about performing successfully in spite of these barriers.

Schlenker and Weigold (1992) view impression management as a broad phenomenon in which we try to influence the perceptions and behaviors of other people by controlling the information they receive. They relate that people actively carry out impression management in ways that help them to achieve their objectives and goals, both individually and as part of groups and organizations. This can be done consciously and deliberately (e.g., by perfecting job-interview skills), or it may be unconscious. At times, the impression that is managed serves to bolster or protect our own self-image (e.g., dressing for success); at other times, we manage impressions in hopes of pleasing significant audiences. Sometimes impression management is truthful and accurate. At other times, it involves "false advertising" through the use of exaggeration, fabrication, deception, and lies (Schlenker & Weigold, 1992). Sadly, according to HireRight's 2017 employment screening benchmark report, 85% of surveyed employers uncovered a misrepresentation or falsehood on a cadidate's resume or job application. Over the years, cases of falsifying one's professional credentials have been reported in the popular press with negative consequences for the dishonest individual. For example, recently an Australian woman falsified her resume and faked references to obtain a high-paying governmental job. She was sentenced to prison for "deception, dishonesty, and abuse of public office" (Cheung, 2019).

Employee Selection

Because perceptions determine our behavior toward others and can cloud our judgments of them, one area that clearly benefits from using psychological principles has been the area of employee selection. The goals of selection are (1) to identify the knowledge, skills, abilities, and qualities necessary to perform a job well; (2) to design tests to measure applicants' levels on those key job requirements; (3) to administer and score the tests; and (4) to determine which applicants are most suitable for a given position, ensuring that the process is accurate and fair and does not discriminate against members of protected groups. The basis for this employee selection process is the ability to identify key invariant qualities of individuals (e.g., skills, character, motivation, attitude, leadership potential, and personality) that match up well with the demands of the position and the culture of the organization.

Psychometrics involves the measurement of human ability, potential, and attitude. This is most visible when employers use tests and special interview techniques in employee selection. Job analysis is designed to identify the skills, abilities, and attributes needed to perform well. Context-specific tests can measure applicants' skill levels on key job requirements, such as the operation of hardware and software. However, as with any tool, instruments that are used to measure human ability can be misused or misleading. Instruments that rely on self-report of personal information are subject to bias (such as impression management), and the interpretation of aptitude scores is also subject to bias (such as stereotypes and halo effects). Therefore, managers who are responsible for hiring and promoting should look for many sources of data from which to determine the qualities that are essential to the job, such as personality (see **Exhibit 4-6**).

One goal in this discussion is to help managers make accurate and fair assessments of staff members or potential staff members for various positions in their organizations. Who should function in positions of high contact with patients? Who is better at working with computers? Who is most able to direct a unit to promote the best clinical care? Who is best suited to manage the business office? How can we help employees who are not ready to assume a leadership role to develop the skills for leadership while still working comfortably in their current subordinate positions? These are the questions a manager or administrator must answer in making personnel

Exhibit 4-6 Five-Factor Model of Personality

Personality traits are the regularities that we observe in someone's behavior, attitudes, and expressions. Prior research suggests that virtually all personality measures can be reduced or categorized under the Five-Factor Model of Personality, also known as the "Big 5." The dimensionality of the Big 5 has been found to be applicable across all cultures.

The Big 5 model is based on the concept that personality can be described and measured on five broad dimensions and/or traits: openness, conscientiousness, extraversion, agreeableness, and neuroticism.

Dimensions/Traits	Descriptions
Openness	Imaginative, innovative, open-minded
Conscientiousness	Competent, responsible, dependable, hardworking, goal oriented, self-disciplined
Extraversion	Assertive, social, positive emotions
Agreeableness	Trusting, straightforward, compliant, warmhearted, generous, modest
Neuroticism	Emotional, insecure, self-conscious, impulsive, vulnerable

Data from McCrae, R. R., & John, O. P. (1992). An introduction to the five-factor model and its application. *Journal of Personality, 60,* 175–215.

decisions. To do so requires the manager to perceive the unchanging qualities of a person across situations, or the key "traits" that underlie success in a job.

Many instruments that are used to assess personnel and management/leadership potential, such as the Campbell Interest and Skills Inventory, or the Enneagram of Personality, are trying to identify "constants" of personality and work style. The Campbell Interest and Skills Inventory compares employee-reported interests and skills to those of people who describe themselves as satisfied with their careers and highlights occupational areas to consider during career exploration. Here, the invariant is a pattern of interests and work preferences that people carry from one job to another. The Ennagram of Personality groups individuals into nine interconnected personality types and helps them understand how their type relates to other types.

Another commonly used scale is the Myers-Briggs Type Indicator (MBTI), an instrument for measuring a person's preferences using four opposing-pole dimensions (extraversion/introversion, sensate/intuitive, thinking/feeling, and judging/perceiving). On the basis of how someone answers a series of questions, this instrument assigns a personality type. Each personality type is suited for specific occupations. For example, extroverts are better suited for sales positions, and introverts do well with information technology positions. There are many pros and cons to using Myers-Briggs, or any instrument, as the sole selector of occupational areas based on types. On the positive side, these instruments pick up patterns (invariants) in self-reported behavioral characteristics and provide a categorization of types that may be useful in assessing certain qualities relevant to leadership and workplace issues. They may also help managers identify areas where specific coaching or development might benefit the individual. On the negative side, these tests tend to generalize a person's likely traits, which may not be an entirely accurate reflection of that individual and can lead to incorrect stereotyping.

Summary

In this chapter, we reviewed several social psychology concepts that are important for managers to understand. These are factors that can influence and bias our perceptions; therefore, we need knowledge of these biases to temper and inform our perceptions. In discussing attitudes and how to change them, we become more aware of those distinctly unique human qualities that complicate the workplace but also make it so interesting. Likewise, if we understand how workers see the world, we are in a better position to facilitate a productive workplace. Today's health care managers have many resources at their disposal, including a wide-ranging scientific literature on organizational behavior, psychology, and human resource issues in the workplace. Ideally, this chapter will encourage you to develop and use your own skills as a social perceiver and give you some confidence that you can foster positive attitudes. We are always learning, improving, and building skills in social perception. In this way, we will continue to use our understanding of human behavior to create a positive and healthy workplace.

Discussion Questions

1. Define attitudes and provide examples.
2. What is meant by cognitive dissonance?
3. What are common methods to measure a person's attitude?
4. List and describe ways in which attitudes can be changed.
5. What is the difference between the halo effect and the horn effect?
6. Define the four stages of the perception process.
7. How does attribution theory allow managers to justify workers' behaviors?
8. Define social perception.
9. What is the difference between contrast effect and projection?
10. Is stereotyping negative or positive? Why?
11. Why is stereotyping so problematic for the health care industry?
12. What is the difference between the Pygmalion effect and the Galatea effect?
13. Is impression management negative or positive? Why?
14. Is employee selection an unbiased process? Why?

CASE STUDY AND EXERCISES

Exercise 4-1 Gender Stereotyping in Organizations

Role-Play

Choose a male and a female volunteer. Each member of the pair will argue over a situation in the workplace, such as departments negotiating over which gets to purchase a piece of new medical equipment (limited financial resources), deciding whether laptops or PCs are appropriate for the nursing stations, or choosing which color to paint the hospital's hallways.

Designate one of the participants as the "influencer," who should try to "win" the argument. Designate the other as the "influencee," who should resist.

The influencer has a fixed amount of time, perhaps 1 minute, to persuade the influencee.

After you have observed the interaction, break into groups for discussion of the influencer (i.e., leader), and make a list of adjectives used to describe the influencer. For example, was the leader "bossy" or "dominating" or "assertive"?

Have the male and female reverse roles with a new situation and repeat the discussion. Now discuss the two leadership influencers in both of the role-play episodes. Which one had more skill and fit your image of a leader? Record your responses.

Break into groups again, and describe the second influencer with an adjective list. Continue until several male–female dyads have role-played as influencers and influencees. Record the descriptive adjectives. Rate the overall leadership of each influencer. Record the responses.

Discussion Questions

1. Were differences in leader perceptions due to gender stereotypes or behavioral differences?
2. What social invariants (constants or traits) can you identify as being important for leadership positions?
3. Why are leadership perceptions important? Can attributions about leadership ability affect the behaviors of followers? If so, how?

Debriefing

Research by Butler and Geis (1990) suggests that in role-play exercises such as those in the preceding activity, the female leader was described differently in terms of her personality traits and was more likely to be the recipient of covert gender stereotyping compared with males.How do their findings match your results?

Exercise 4-2 Implicit Association Test

An interesting approach to uncovering personal hidden biases is the Implicit Association Test (IAT). IAT is a component of Project Implicit, a collaborative research effort between researchers at Harvard University, the University of Virginia, and University of Washington. IAT may be accessed at implicit.harvard.edu/implicit/.

This web-based self-assessment prompts the user to link words with images that appear on the computer screen. The links reveal the user's mental associations or automatic preferences, which are indicative of the user's tendency to view one identity group more positively over another. Millions of individuals have taken the IAT. An array of implicit bias assessments and answers to frequently asked questions about the IAT can be found at implicit.harvard.edu. As the website cautions, the test sometimes provides some challenging personal feedback!

Exercise 4-3 Jung Typology Test: Personality Assessment

A 72-item web-based assessment is available at www.humanmetrics.com. After completing the questionnaire, you will be given a description of personality type and your type formula according to the Carl Jung and Isabel Myers-Briggs typology. There are no right or wrong answers; the test is only for your own self-assessment.

Did the results accurately describe your personality traits? Share your results with a significant other. Does your significant other agree with your results? (Note: Short questionnaires, tests, and assessments can be unreliable in certain situations.) This web-based assessment is designed primarily to stimulate your thinking about yourself.

CASE STUDY 4-3 Only 15 Weeks to Thanksgiving!

Scene I

"I just hate the thought of going back to work," Mary told her brother Tom. It was the last night of her vacation, which Mary thought had been much too short. "It's 15 weeks until Thanksgiving."

"I know you're miserable," Tom replied. "You've been more and more unhappy in that job for the past 5 years. You're a totally different person when you're on vacation. I know we've discussed this a thousand times, but isn't there something else you can do?"

(continues)

CASE STUDY 4-3 Only 15 Weeks to Thanksgiving! *(continued)*

"Don't you think I'd do something else if I could?" Mary retorted. "I'm sorry, I know you're only trying to help, but I really think I'm trapped in this situation. With my diabetes and high blood pressure, I can't afford to retire early because I need the health insurance. I could get Social Security at 62, but the health care coverage doesn't start until 65. A supplemental policy would be much too expensive, even if I could get one. I know that as soon as I go back to work, my blood pressure and sugar will go up from the stress."

"Yes," said Tom, "and you'll start counting the days until the weekend. You've already figured out how long it is until Thanksgiving! There's got to be some other solution to this, Mary."

"Sure! Winning the lottery!" Mary said in disgust. "That's all I can think of!"

Scene II

Dan, the manager of the health information department of a large health care system in South Florida, sighed as he finished his coffee. He thought, "Mary will be back from vacation tomorrow. I keep hoping that she'll be less stressed out when she gets back, but it always seems to be the same. She has so much experience, and she could be a great role model for the younger people at work, but I just can't seem to get her attitude turned around. I've tried everything I can think of—special projects outside the department, adjusted work schedule, more responsibility and authority on day-to-day stuff, advanced computer training—but she's my big failure as a boss."

"Oh, I think she's just jealous of you," his wife Sonia replied. "You've really worked hard on the old witch. I just don't think she's worth the effort. Why doesn't she just retire?"

"It's a good thing the human resources people didn't hear that!" Dan laughed. "Sonia, you're just plain wrong about Mary. She knows everything about the department. Without her help, I couldn't have managed at all when I started there. I can't believe she's jealous of me. She's really been a lot of help. I just wish she weren't so unhappy. You know, I talked to Jean about her the other day. They started in the company together about 20 years ago. Jean said that she wasn't sure what was going on with Mary because they haven't been very close lately, but she said that Mary has always been really independent. Stubborn, even. And quite outspoken about things she disagrees with. She's usually right, but sometimes it's tough for people to listen to her because of the way she puts things. I don't think she's kidding when she says that's part of her New England upbringing. Did you know she got thrown out of college for objecting to some policy? And then she forced them to reinstate her because they hadn't followed due process?"

"Oh, so she's always been a witch? From Salem, perhaps?" Sonia replied. "Come on, Dan, give it a rest. You don't need to figure Mary out until tomorrow! Don't you want to watch the Miami Dolphins beat the Tampa Bay Bucs? Can you imagine? They favor the Bucs to win!"

In Scene I, what is Mary's attitude? Are you able to identify the three elements of an attitude in what she says?

In Scene II, Dan and Sonia have very different perceptions about Mary. Why?

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CHAPTER 5

Workplace Communication*

The greatest barrier to communication is the illusion of it in the mind of the sender

– William H. Whyte

LEARNING OUTCOMES

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

- Describe the communication process.
- Understand the importance of feedback in the communication process.
- Identify various verbal and nonverbal methods of communication.
- Explain the common barriers to communication and apply strategies to overcome these barriers.
- Discuss the elements of effective communication for knowledge management.
- Describe the various components of effective strategic communication.
- Understand the flow of intraorganizational communication.
- Comprehend the challenges of cross-cultural communication.
- Understand the flow of communication with external stakeholders and the public sector.

Overview

"Communication is perhaps one of the greatest challenges facing managers and leaders today" (Hicks, 2011, p. 86). Fundamental and vital to all health care managerial functions, communication is a means of transmitting information and making oneself understood by others. Communication is a major challenge for managers because they are responsible for providing

* We wish to acknowledge and thank Dr. Kristina L. Guo, who was a contributing author of the earlier versions of this chapter, which appeared in the previous editions of Organizational Behavior in Health Care, Jones & Bartlett Learning.

information that should result in efficient and effective performance in organizations. Every managerial function or activity involves some form of communication. To plan, organize, direct, or lead, a manager must communicate with and through others. Managerial decisions are effective only if they are communicated and understood by the people who are responsible for enacting the decisions. Furthermore, employee motivation and satisfaction depend on effective communication. Communication is essential to building and maintaining relationships in the workplace. Communication is the creation or exchange of thoughts, ideas, emotions, and understanding between sender(s) and receiver(s). Managers who understand this exchange can better analyze their communication patterns, resulting in more effective communication in the workplace.

Although managers spend most of their time communicating (e.g., sending or receiving information), one cannot assume that meaningful communication occurs in all exchanges (Dunn, 2006). Once a message has been sent, many are inclined to believe that communication has taken place. However, communication does not occur until information and understanding have passed between the sender and the intended receiver. For example, a receiver may hear a sender but might not have comprehended the sender's actual meaning. Effective communication occurs when the message received is the same as the one intended. Communication enables people to establish and maintain positive interactions in the workplace. An effective communicator overcomes barriers to engage in more meaningful and successful communication.

Communication Process

Communication is a complex and dynamic process. **Figure 5-1** illustrates the S-M-C-R model of the communication process. Information originates from the sender (S) and is encoded into

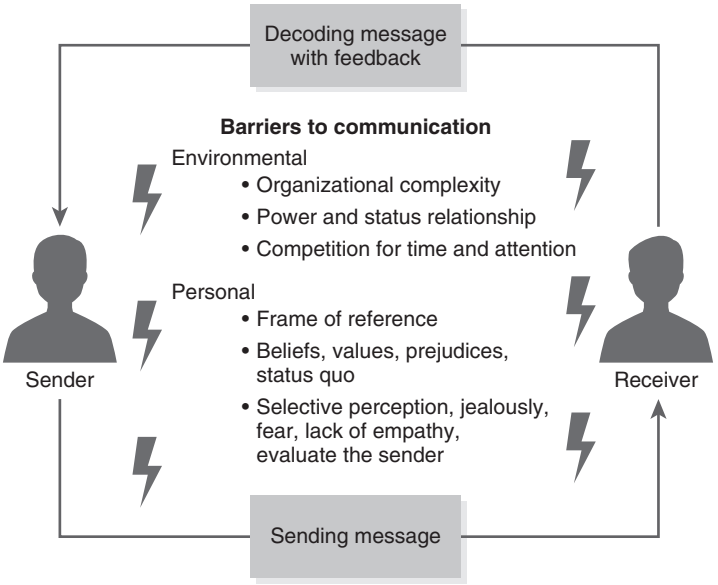


Figure 5-1 The Communication Process

a message (M) that is forwarded through a selected channel (C) to the designated receiver (R). Messages are received and decoded or interpreted by the receiver. Decoding is affected by the receiver's prior experiences and frames of reference. Accurate decoding of the message by the receiver is critical to effective communication. The closer the decoded message gets to the intent of the sender, the more effective the communication. However, environmental and personal barriers can hamper the communication process; these barriers are described in a later section of this chapter. For ensuring that messages are received as intended, feedback is a necessary component of the communication process. The receiver creates feedback to a message and encodes it before transmitting the feedback to the sender. The sender receives and decodes the feedback. Feedback is the destination's reaction to a message (Certo, 1992). It is an important element of communication, since it allows for information to be shared between the receiver and sender in a two-way communication process.

Feedback

Effective communication takes place when a sender's message is fully understood by the receiver. In essence, feedback is a response (i.e., a signal) from the receiver that enables the sender to determine whether a message has been received in its intended form. The response or signal may take the form of an oral comment, a written message, a smile, a sigh, raised eyebrows, or some other action. Even a lack of response by the receiver may be interpreted as a form of feedback. Without feedback, the sender cannot confirm that the receiver has interpreted the message correctly. Feedback is a key component in the communication process because it allows the sender to evaluate whether the message was decoded as intended or a corrective action is needed to clarify the intended message. For instance, a manager needs feedback to determine the level of staff acceptance of a new policy requiring employees to call and verbally confirm all patients' appointments 48 hours in advance. The feedback process suggests that both sender and receiver need to adjust their outputs as related to the transmitted information. In the absence of feedback, when the communication process does not allow for sufficient feedback to develop, or when feedback is ignored, a certain amount of feedback will occur spontaneously and will tend to take a negative form.

In one-way communication, a person sends an unidirectional message without interaction. For example, after reviewing a patient's lab results, a physician orders a medical test for the patient. The physician instructs the medical assistant to arrange the appointment within the week and notify the patient. The physician's order is an example of one-way communication that does not provide the opportunity for the patient to pose questions directly to the physician. Negative feedback may occur if the patient expresses frustration or anger at the physician for not directly explaining the necessity of the medical test. However, the same patient could express satisfaction and appreciation toward the medical assistant who explains the purpose of the medical test based on the patient's lab results. In this case, the opportunity for feedback results in two-way communication between the patient and the medical assistant. Two-way communication is more accurate and information-rich when the message is complex, although one-way communication is more efficient, as in the case of the physician's written order.

To be effective, communication must allow opportunities for feedback. Feedback can take several forms, each with a different intent. Keyton (2002) describes three different forms of feedback: descriptive, evaluative, and prescriptive.

- *Descriptive Feedback*: Feedback that identifies or describes how a person communicates. For instance, Manager A invites her friend, Manager B, to attend A's staff meeting and comment on

her form of communication. After the meeting, B tells A that she was very clear and instructive as she introduced her staff to the new computer database for managing patient accounts. In this example, B provides descriptive feedback of A's communication with her staff.

- *Evaluative Feedback*: Feedback that provides an assessment of the person who communicates. In the preceding example, if Manager B evaluates Manager A's form of communication and concludes that A was instructive and helpful, which enabled A's staff to feel comfortable when going to her for advice, then B has provided positive evaluative feedback of A's interaction with her staff.
- *Prescriptive Feedback*: Feedback that provides advice about how one should behave or communicate. For example, Manager A asks Manager B what changes she could have made to better communicate her message to her staff. B suggests that A be friendlier and more cooperative by giving the staff specific times when A is available for help with the new computer database. This type of advice is prescriptive feedback.

In addition to forms and intent, there are also four levels of feedback. Feedback can focus on a group or an individual working with specific tasks or procedures. It can also provide information about relationships within the group or individual behavior within a group (Keyton, 2002).

- *Task or Procedural Feedback*: Feedback at this level involves issues of effectiveness and appropriateness. Specific issues that relate to task feedback include the quantity or quality of a group's output. For instance, are patients satisfied with the new outpatient clinic? Did the group complete the project on time? Procedural feedback refers to whether a correct procedure was used appropriately at the time by the group.
- *Relational Feedback*: Feedback that provides information about interpersonal dynamics within a group. This level of feedback emphasizes how a group gets along while working together. It is effective when combined with descriptive and prescriptive forms of feedback.
- *Individual Feedback*: Feedback that focuses on a particular individual in a group. For example, is an individual in the group knowledgeable? Does the individual have skills that are helpful to this group? What attitudes does the individual have toward the group as the members work together to accomplish their tasks? Is the individual able to plan and organize within a schedule that contributes to the group's goal attainment?
- *Group Feedback*: Feedback that focuses on how well the group is performing. Questions like those raised at the individual feedback level are asked of the group. Do team members in the group have adequate knowledge to complete a task? Have they developed a communication network to facilitate their objectives?

Feedback can take the form of questionnaires, surveys, or audio or video recordings of group interaction. It can also occur in activities such as market research, client surveys, accreditation, and employee evaluations (Liebler & McConnell, 2008). Feedback should be used to help a group communicate more effectively by encouraging group members to identify with the group and increase its efficacy. Feedback should not be viewed as a negative process. O'Hair, Stewart, and Rubenstein (2006) point out that negative feedback does not imply "bad," and positive feedback does not imply "good." Negative feedback indicates that you should do less of what you are doing or change to something else. Positive feedback encourages you to increase what you are doing. Thus, managers should use feedback as a strategy to enhance goals, awareness, and learning.

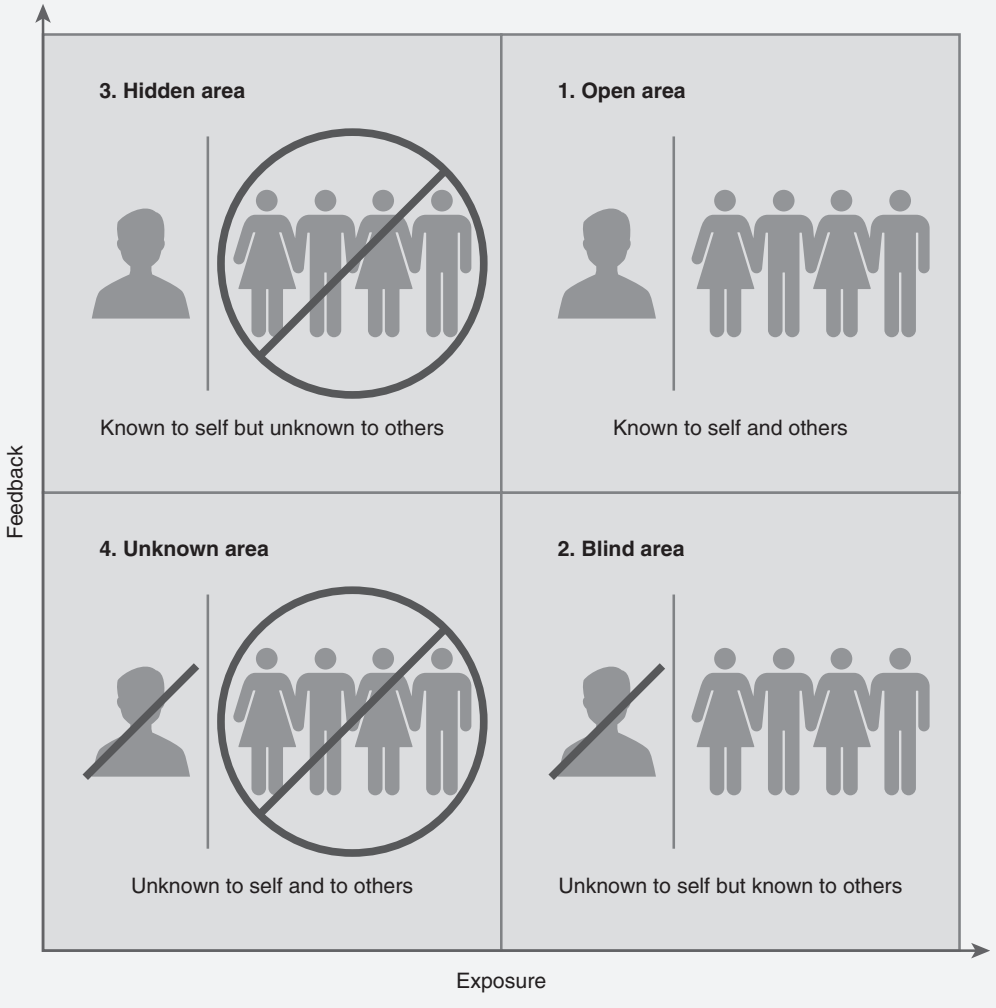
Feedback, as a managerial tool, enables managers to anticipate and respond to changes. Structured feedback enhances managerial planning and controlling functions. Because of the value of feedback, managers should encourage feedback and evaluate it systematically.

The Johari Window

The process of feedback can also be illustrated by the Johari Window, a useful communication model to improve understanding between individuals. It was created by Joe Luft and Harry Ingham in 1955 (hence the name "Johari") (Luft, 1984). The Johari Window model has two key concepts: (1) You can build trust with others by disclosing information about yourself, and (2) with the help of feedback from others, you can learn about yourself and come to terms with personal issues.

As shown in **Exhibit 5-1**, windowpane 1 is considered the open area, in which information about you is known both to you and to others. This includes your behavior, knowledge, skills, attitudes, and "public" history. Tubbs (2001) described this area the general cocktail party

Exhibit 5-1 The Johari Window



conversation in which an individual willingly shares personal information with others. For instance, at an office picnic, you might reveal to your coworkers that you are a vegetarian to support your desire for a healthier lifestyle. What is posted on social media may also be considered public. Windowpane 2 refers to a blind area in which others know information about you that you either are unaware of or do unthinkingly. For example, your colleagues know that although you are a nice and caring person, you chronically interrupt and talk over others in conversation.

The third windowpane is the hidden area, in which you have likes and dislikes that you are unwilling to share with others. This area includes your values, beliefs, fears, and past experiences that you would not wish to reveal. The fourth and last windowpane is the unknown—things that are unknown by you and are also unknown by others. This is an area of potential growth or self-actualization. It represents all the things that you have never tried, participated in, or experienced.

Increasing mutual understanding through feedback and disclosure allows one to increase the open area and reduce the blind, hidden, and unknown areas of oneself (McShane & Von Glinow, 2003). Luft (1984) argues for increasing the open area in the Johari Window so that you and your coworkers are aware of your limitations. This is done by receiving more feedback from others and decreasing one's blind area (windowpane 2) and by reducing the hidden area (windowpane 3) through disclosing more about oneself. The combination of feedback and disclosure may also help to produce more information in the unknown area (windowpane 4).

The Johari Window can be used for opening channels of communication. Open communication is important for improving employee morale and increasing worker productivity. Open communication allows supervisors and subordinates to freely discuss organization-related issues such as goals and conflicts. Nevertheless, Luft (1984) is cautious about the use of the Johari Window for all situations. He offers several guidelines for the appropriateness of self-disclosure. He recommends that self-disclosure is a function of an ongoing relationship. The timing and extent of disclosure are critical. A competent communicator knows when, with whom, and how much to disclose.

Communication Channels

Another important component of the communication process is selecting an appropriate communication channel. This is the means by which messages are transmitted. As Mazurenko and Hearld (2014, p. 2) note, "Individuals may have different attitudes toward [these] different communication channels, often varying as a function of different personal and contextual factors, which can result in recipients responding differently to the same message received via different channels."

There are two types of channels: verbal and nonverbal. Various channels of communication and the amount of information transmitted through each type are illustrated in **Figure 5-2**.

Verbal Communication

Verbal communication relies on spoken or written words to share information with others. Dialogue, a form of verbal communication, is a discussion or conversation between people in which participants may be exposed to new information. In an organization, the process may involve a series of meetings of organizational members representing different views on issues of mutual interest. According to Edgley and Robinson (1991), for dialogue to be successful, there are several fundamental principles: Engage motivated people, use a facilitator and a recorder to manage the process, have the group develop procedures and live by them, ensure confidentiality, and let the process move at its own pace. Adhering to these principles will improve dialogue and result in more effective communication.

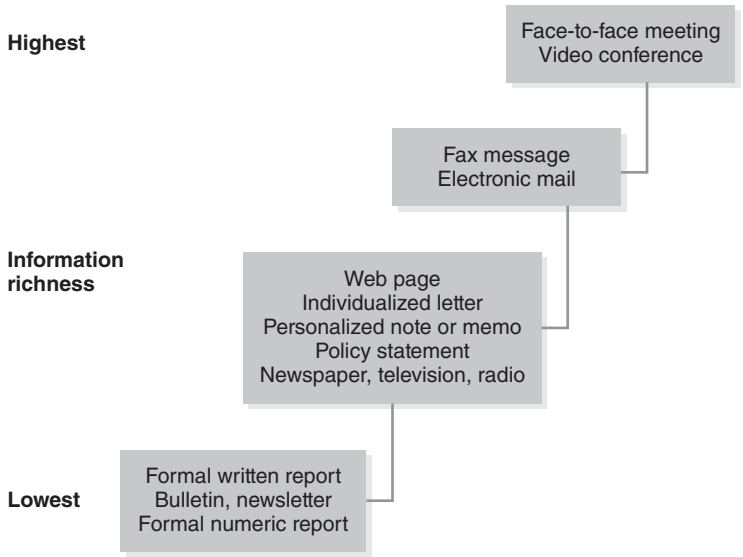


Figure 5-2 Communication Channels

Reproduced from Information richness: A new approach to managerial behavior and organizational design, by R. L. Daft and R. H. Lengel, 1984, in B. Staw and L. Cummings (Eds.), *Research in organizational behavior* vol. 6, pp. 191–233, Greenwich, CT: JAI Press.

There are different forms of verbal communication, which should be used for different situations. Face-to-face meetings are information rich, allowing for emotions to be transmitted and immediate feedback to take place. Written communication is more appropriate for describing details, especially those of a technical nature, as in the example of monitoring a patient's complex medical condition. Although traditional written communication was comparatively slow, the development of email and other forms of electronic communication such as texting has enabled written communication through these channels to dramatically improve efficiency (see **Case Study 5-1**).

CASE STUDY 5-1 Are We Getting the Message Across?

James Warick, director of physical plant at Southern Hospital, emailed Diane Curtis, director of nursing, informing her of a water leak in Operating Room 1, which would need to be shut down for repairs early the next morning. Curtis forwarded the message to Joanne Messing, the operating room nurse supervisor on duty for the night shift. Messing, tired from a long night's work, handwrote a message to the nurse supervisor on the day shift to switch the 8:00 A.M. operation from Room 1 to Room 8 and taped the message onto the bulletin board. David Swanson, the day-shift nurse supervisor, arrived at 7:30 A.M. and found Dr. Roberts shouting that his patient was ready for surgery but no rooms were available because Dr. Jones had already taken Room 8.

Discussion Questions

1. What were the channels of communication used by each person?
2. Should a different channel of communication have been used instead?
3. What can be done to resolve the problem?
4. What policies should be put in place to prevent this from occurring again?

Electronic Communication

The use of information technology is dramatically affecting how we communicate. Consider the following:

> When Mohandas Gandhi wanted to inform the world of injustices committed by imperialist Great Britain toward South Africa and India in the 20th century, he relied on the written word. His journals and those of his colleagues, as well as firsthand observations by journalists, provided details of wrongdoing. Looking through the lens of the 21st century, Gandhi's message traveled slowly and only to limited parts of the world. Fast-forward to a century later, when citizens protesting a planned petro chemical plant near the Chinese city of Xiamen organized their forces by using cell phones, text messaging, emails, and blogs. Images of the protest were virtually available to the world in real time. In response to this negative publicity, the Chinese government postponed construction of the petro chemical plant, acceding to the protestors' demands that an environmental impact study be completed. (Heraty, 2014, p. 111)

The Internet is a global network of interconnected yet independently operated computers. An intranet is an organization's private Internet. Especially in the case of health care organizations, the intranet helps to protect privacy and confidentiality of company records, such as patients' medical records. An extranet is an extended intranet that enables employees to stay connected with selected customers, clients, suppliers, and other partners, such as health care insurance companies and health care vendors. The Internet, intranets, and extranets enable employees to access, manage, and distribute information. If properly set up and managed effectively, these systems can enhance communication. On the other hand, ineffective management can hinder communication and result in decreased productivity.

Email and other forms of electronic communication have revolutionized the communication process, allowing for rapid communication across any distance. Email and other forms of electronic messaging allow information to be quickly created, changed, saved, and sent to many people at the same time. Various scheduling apps and shared calendars can be used to check availability, coordinate meeting times, and send meeting reminders and alerts. Although emails, texts, and other forms of electronic messaging are convenient forms of communication, they have several problems and limitations. The most obvious is information overload. Users can become overwhelmed by the number of messages they receive on a daily basis, many of which are unnecessary to the receiver. Another problem with these forms of communication is their ineffectiveness in communicating emotion. The tone of a message can easily be misinterpreted, causing misunderstandings between sender and receiver. Icons known as emoticons or emojis have been developed to represent emotions in email and text messages. However, the use of emoticons or emojis is not considered professional in many settings. Email can also reduce politeness and respect for others. Flaming is the act of sending an emotionally charged message to others, especially before emotions subside. This common problem occurs frequently in forms of electronic communication because the sender does not have to bear the discomfort of having a heated discussion face to face. In a face-to-face discussion, the act of scheduling and coordinating an in-person meeting allows a person to cool down and develop second thoughts. Additionally, a face-to-face meeting may allow the receiver of the heated message to respond quickly with feedback that may be uncomfortable for the sender. When you are tempted to respond with an emotionally charged message, it is best to acknowledge that you have received the message but

to wait at least 24 hours before crafting your response, to allow emotions to subside. To reduce these communication problems, training in communication through electronic means, may be useful (see **Table 5-1**).

Table 5-1 Email Etiquette

1. Before pressing send on an email, consider how your message would be perceived if it was forwarded to your entire organization. Keep your audience in mind before discussing private matters, expressing anger, or criticizing others. Emails last forever. There is no guarantee that your messages will stay private.
2. Think twice before discussing confidential information by email. If confidential patient information falls into the wrong person's hands, you could risk legal consequences.
3. Remember to briefly introduce yourself when emailing a new person for the first time. Don't assume the recipient already knows who you are, or remembers you from one interaction.
4. Be mindful of punctuation and go easy on exclamation points. More than one exclamation point per email may come across as overexuberant and unprofessional.
5. Reply to emails within one or two days. If your response will take longer, reply to let the person know you are working on an answer and will get back to them soon. Don't leave them waiting days, wondering whether you received their message.
6. Try not to send one word responses unless it is the end of the conversation. For example, just replying "Thanks" or "OK" could be perceived as unprofessional.
7. Avoid using text shorthand such as "u" instead of "you" or "idk" instead of "I don't know." Don't use emojis in a professional context. The occasional :) is ok in some contexts, but don't go overboard.
8. Make sure your subject line is clear and direct. It should concisely describe the crux of your message. Don't be vague. Make it easy for someone with a clogged inbox to see your message and understand it right away.
9. If your message is on a new topic, start a new thread. Don't reply to an old email with a message that has nothing to do with the previous conversation. If the topic changes, feel free to change the subject line in your reply.
10. Don't "reply all" unless all the recipients need to know your response. Avoid clogging people's inboxes with conversations that are irrelevant to them.
11. Keep your emails short and to the point. Don't send long blocks of text that require too much time and effort to decode. If your email has multiple questions, number them so they are easier to read and respond to.
12. If you find yourself typing out several long detailed emails, try calling the person instead. You'll find that speaking over the phone can resolve confusion and miscommunication in minutes while email correspondence might take all day.
13. After discussing issues in person, send a follow up email summarizing what was discussed as confirmation. This leaves a helpful paper trail for both of you.
14. Adjust your writing style to your audience. Keep your emails formal and polite when corresponding with higher ups and those who tend to write formally themselves. For other with a more informal style, you may adjust your tone to match theirs.
15. Include an automatic signature with your name, title, email, and other contact information such as phone number and address, if applicable.
16. Managers should communicate expectations regarding email etiquette. Don't assume your team already knows email best practices. Set the standard and communicate it.
17. Your emails affect your reputation. Every message you send reflects on you, your work ethic, and your level of professionalism. If your emails are rushed, full of typos, repetitive and disorganized, your colleagues will assume that your other work is low quality as well.

There are key benefits to using email or other electronic messaging tools. It reduces the time and cost of distributing information to employees. Furthermore, it has increased the potential for more employee collaboration and teamwork, increasing the speed of organizing meetings, and collecting feedback on documents. Another advantage of electronic messaging is its flexibility, especially as it can be easily accessed on computers, tablets, and smartphones, and watches. Senders and receivers can now communicate in a variety of settings while being mobile and are not restricted to one location. Handheld devices have contributed to the increased demand for access to information.

Nonverbal Communication

Nonverbal communication is sharing information without using words to encode messages. Mehrabian (1980) demonstrated that only 7% of any message is conveyed through words, 38% by the way in which the words are said, and 55% through nonverbal elements such as facial expressions, gestures, and posture.

There are four basic forms of nonverbal communication: proxemics, kinesics, facial and eye behavior, and paralanguage (Nelson & Quick, 2003). Proxemics is the study of an individual's perception of and use of space. Territorial space and seating arrangement are two examples. For instance, to encourage cooperation, coworkers working together on a patient safety report should sit next to each other. To facilitate communication, a manager should seat a subordinate at a 90° angle in order to discuss resolving staff complaints.

Kinesics refers to body language, which is used to convey meaning and messages. Pacing and drumming fingers are signs of nervousness. Wringing the hands and rubbing the temples signal stress. Facial and eye behavior is another example of nonverbal communication. For example, when a health care manager interviews a candidate for a position as a clinical care coordinator, the manager attaches meaning to frowns and eye contact. Avoiding eye contact tends to close communication. However, cultural and individual differences influence appropriate eye contact. Moderate direct eye contact communicates openness, while too much direct eye contact can be intimidating.

Paralanguage consists of voice quality, volume, speech rate, and pitch. Rapid and loud speech may be taken as signs of anger or nervousness. The communication process is impeded by negative nonverbal cues. For example, arriving late for an interview with the vice president of finance, talking very fast, avoiding eye contact, and getting too close during a conversation or in a seating arrangement for a committee meeting have negative effects on the communication process.

To determine the most appropriate channel of communication for sending messages, one needs to identify whether verbal or nonverbal communication should be used. At the same time, ideal channels of communications can be selected through an examination of the information richness and symbolic meaning of messages (Daft & Lengel, 1984). Information richness refers to the volume and variety of information that can be transmitted. As shown in Figure 5-2, face-to-face meetings have the highest information-carrying capability because the sender can use verbal and nonverbal communication channels and the receiver can provide instant feedback. When a wrong channel of communication is used, this wastes time and leads to more misunderstanding. When communication is nonroutine or unclear, information-rich channels are required for more effective communication. For example, suppose a gunshot victim is brought into a trauma center. Organizing the care of this patient requires face-to-face instructions to quickly coordinate work

flow and minimize the risk of confusion among various care providers. However, for routine communications, less information-rich channels can be used.

Choosing one communication channel over another lends meaning to the message; that is, there is symbolic meaning to the selection of a particular channel of communication beyond the message content. For example, when a manager tells an employee that they must have a face-to-face meeting, this symbolizes that the issue is important, compared with a brief email message with instructions.

In summary, one essential part of the communication process is selecting an ideal channel of communication. The use of different channels leads to differences in the amount and variety of information transmitted. Choosing an appropriate channel of communication involves understanding symbolic meanings and the information richness of messages.

Barriers to Communication

As is shown in **Table 5-2**, several forms of barriers can impede the communication process. Longest, Rakich, and Darr (2000) classify these barriers into two categories: environmental and personal. Environmental barriers are characteristic of the organization and its environmental setting. Personal barriers arise from the nature of individuals and their interactions with others. Both barriers can block, filter, or distort messages when they are sent and received.

Environmental Barriers

Examples of environmental barriers include competition for attention and time between senders and receivers. Multiple and simultaneous demands cause messages to be incorrectly decoded. Sometimes the receiver hears the message but does not understand it. A receiver who is not paying adequate attention to the message is not really listening. Listening is a process that integrates physical, emotional, and intellectual inputs into the quest for meaning and understanding. Listening is effective only when the receiver understands the sender's messages as intended. Thus, without engaging in active or mindful listening, the receiver fails to comprehend the message. Mindful listening is a skill that managers need to develop to be effective in the busy 24/7 world of health care. According to communication expert Rebecca Shafir (2003), the goal of mindful listening is to silence the noise and distractions of our external environment as well as our own thoughts so that the sender's entire message can be heard and understood.

Time is another barrier. Lack of time prevents the sender from carefully thinking through messages and structuring them accordingly. Lack of time also limits the receiver's ability to decipher messages and determine their meaning.

Other environmental barriers include the organization's managerial philosophy, multiple levels of hierarchy, and power or status relationships between senders and receivers. Managerial philosophy can promote or inhibit effective communication. Managers who are not interested in or fail to promote intraorganizational communication upward or disseminate information downward will create procedural and organizational blockages. A managerial philosophy requiring that all communication follow the chain of command shows a lack of attention and concern toward employees and restricts communication flow. Furthermore, when subordinates encounter managers who fail to act, the subordinate might be unwilling to communicate upward in the future because of a perception that communications are not taken seriously.

Table 5-2 Overcoming Barriers to Communication

Barriers to Communication	Overcoming Barriers to Communication
Environmental Barriers	
1. Competition for time and attention	1. Devote adequate time and attention to listening
2. Multiple levels of hierarchy	2. Reduce the number of links or levels of hierarchy
3. Managerial philosophy	3. Change philosophy to encourage the free flow of communication
4. Power and status relationships	4. Consciously tailor words and symbols and reinforce words with actions so that messages are understandable
5. Organizational complexity	5. Use multiple channels of community to reinforce complex messages
6. Specific terminology	6. Consciously define and tailor words and symbols, and reinforce words with actions so that messages are understandable
Personal Barriers	
1. Frame of reference 2. Beliefs 3. Values 4. Prejudices 5. Selective perception 6. Jealousy 7. Fear 8. Evaluation of the source (sender) 9. Status quo 10. Lack of empathy	1. Consciously engage in efforts to be cognizant of others' frames of reference and beliefs 2. Recognize that others will engage in selective perception, jealousy, fear, and prejudices to help diminish the barriers 3. Engage in empathy

Reproduced from *Managing health services organizations* (6th ed., pp. 678–681), by B. B. Longest, and K. Darr, 2014, Baltimore, MD: Health Professions Press.

Managerial philosophy affects not only communication within the organization but also the organization's communications with external stakeholders. For instance, when the chief executive officer (CEO) of one hospital became aware that patients might have been exposed to a dangerous infection while hospitalized, he immediately decided to cover up the incident and communicated that message down to his managers. However, another hospital CEO dealt with this situation in a very different manner. She used public media as a channel of communication to encourage patients to come forward and be tested. These reactions to similar events reflect different managerial philosophies about communication.

Multiple levels of hierarchy and complexities such as the size and degree of activity conducted in an organization tend to cause message distortion. As messages are transmitted upward or downward, they may be interpreted according to an individual's personal frame of reference. When multiple links exist in the communication chain, information could be misinterpreted. As a result, a message sent through many levels is likely to be distorted or even totally blocked. For example, the CEO of a health care organization asked department administrators to relay

his message of sincere congratulations and appreciation to the staff for their hard work toward obtain their institutional reaccreditation from The Joint Commission. This message was transmitted downward through several layers in the organization and was received in a more nonchalant manner than was originally intended. In another scenario, a report generated by the management information system analyst was given to his supervisor, who went on vacation and left it on his desk without giving it to the vice president, who had requested it a week earlier. In this case, the message did not reach its destination.

Power or status relationships can also affect transmission of a message. An inharmonious supervisor–subordinate relationship can interfere with the flow and content of information. Moreover, a staff member's previous experiences in the workplace may prevent open communication because of fear of negative sanctions. For instance, a poor supervisor–subordinate relationship inhibits the subordinate from reporting that the project is not going as planned. A subordinate who is fearful of the manager's power and status might prevent effective communication from taking place. Gardezi and colleagues (2009) observed silence as a form of communication in the operating room. They found that silence was often used by nurses because of a lack of understanding, fear of asking questions, and intimidation. They also found that silence was used in the operating room to communicate disrespect or power. Consider the following example from their study (p. 1397):

> This communication event takes place over a 45 minute period. The staff surgeon keeps asking the scrub nurse for 'burning forceps', but often he hasn't handed them back to her. Instead he's placed them on a rubber mat on the patient's chest. To retrieve them and hand them to the surgeon when he next needs them, the scrub nurse has to step down off her stool, reach around the surgical resident who is standing to her right, come back up on to the stool, and hand them across the patient's abdomen to the surgeon. The surgeon notices this and says, 'Just tell me it's up' and then 'We'll try to remember to pass it back to you'. This happens multiple times, however, with the scrub nurse stepping down and reaching and the surgeon repeating, 'Just tell me it's up!' The scrub nurse looks sort of bewildered. Once she very quietly says, 'Up,' but the next time she reaches for it instead. There is no strong emotion in the surgeon's tone as he repeats the instruction over and over.

Another environmental barrier that may lead to miscommunication is the use of specific terminology that is unfamiliar to the receiver or messages that are especially complex. Managers and clinical staff members in health care organizations use medical terminology, which may be unfamiliar to external stakeholders. Communication between individuals who use different terminology can be unproductive simply because people attach different meanings to the same words. Thus, misunderstandings can occur as a result of unfamiliar terminology.

Personal Barriers

Personal barriers arise because of an individual's frame of reference or beliefs and values. These barriers are based on one's socioeconomic background and prior experiences, and they shape how messages are encoded and decoded. One may also consciously or unconsciously engage in selective perception or be influenced by fear or jealousy. For example, some cultures believe in "don't speak unless spoken to" or "never question elders" (Longest et al., 2000). These beliefs inhibit communication. Others accept all communication at face value without filtering out erroneous

information. Still others provide self-promotion information, intentionally transmitting and distorting messages for personal gain. Unless one has had the same experiences as another individual, it can be difficult to completely understand the other individual's message. In addition to frame of reference, one's beliefs, values, and prejudices can alter and block messages. Preconceived opinions and prejudices are formed on the basis of varying personalities and backgrounds. Selective perception is a tendency to retain positive parts of the message and filter out negative parts.

Two additional personal barriers are status quo and evaluating the source (or the sender) to determine whether the receiver should retain or filter out messages. For instance, a manager always ignores complaints from Melissa, the medical receptionist, because Melissa tends to exaggerate issues and events. However, one must be careful to evaluate and distinguish exaggerations from legitimate messages. Status quo is when individuals prefer the present situation. They intentionally filter out information that is unpleasant. For example, a manager does not tell staff and patients that their favorite physician, Dr. Ames, has decided to leave the practice. To prevent patients from switching to another physician, the manager postpones the communication to retain status quo.

A final personal barrier is lack of empathy—in other words, insensitivity to the emotional states of senders and receivers. When a physician shouts for his assistants to hurry with preparing clean rooms because 50 patients are in the waiting room, his assistants should empathize with the physician and understand that he is under stress and pressure to see his patients, who are complaining that they have been waiting for up to 3 hours. At the same time, the physician should empathize with his assistants because the office is understaffed as a result of one of the three assistants calling in sick.

Overcoming Barriers to Improve Communication

Recognizing that environmental and personal barriers exist is the first step to effective communication. By becoming cognizant of their existence, one can consciously minimize their impact. However, positive actions are needed to overcome these barriers (see Table 5-1).

Longest et al. (2000) provide us with several guidelines for overcoming barriers:

1. Environmental barriers are reduced if receivers and senders ensure that attention is given to their messages and that adequate time is devoted to listening to what is being communicated.
2. A management philosophy that encourages the free flow of communication is constructive.
3. Reducing the number of links (levels in the organizational hierarchy or steps between the sender in the health care organization and the receiver, who is an external stakeholder) diminishes opportunities for distortion.
4. The power or status barrier can be removed by consciously tailoring words and symbols so that messages are understandable; reinforcing words with actions significantly improves communication among different power or status levels.
5. Using multiple channels to reinforce complex messages decreases the likelihood of misunderstanding.

Personal barriers to effective communication are reduced when senders and receivers make conscious efforts to understand each other's values and beliefs. One must recognize that people

engage in selective perception and are prone to jealousy and fear. Having empathy for the individuals to whom messages are directed is the best way to improve communication.

Communicating effectively in a complex, multisite health care system is challenging. Barriers may be difficult to overcome. Porter (1985) offers several approaches for achieving effective linkages among business units in a diversified corporation and suggests ways in which managers can overcome some of these barriers:

1. Use techniques that extend beyond traditional organizational lines to facilitate communication. For instance, the use of diagonal communication that flows through task forces or committees enhances communication throughout the organization.
2. Use management processes that are cross-organizational rather than being confined to functional or department procedures. Implementing management processes in the areas of planning, controlling, and managing information systems facilitates communication.
3. Use human resources policies and procedures (job training and job rotation) to enhance cooperation among members in organizations.
4. Use management processes to resolve conflicts in an equitable manner to produce effective communication.

Effective Communication for Knowledge Management

Communication plays an important role in knowledge management. Employees are the organization's brain cells, and communication represents the nervous system that carries information and shared meaning to vital parts of the organizational body. Effective communication brings knowledge into the organization and disseminates it to employees who require that information. Agarwal, Sands, and Schneider (2010) attempted to quantify the economic waste associated with communication inefficiencies in hospital settings at a national level. They found that U.S. hospitals waste more than $12 billion annually as a result of communication inefficiency among care providers.

Effective communication minimizes the "silos of knowledge" problem that undermines an organization's potential and, in turn, allows employees to make more informed decisions about corporate actions. Effective communication is one of the most critical goals of organizations (Spillan, Mino, & Rowles, 2002). Research suggests that an effective manager is one who spends considerable time on staffing, motivating, and reinforcing activities (Luthans, Welsh, & Taylor, 1988).

Shortell (1991) identified multiple key elements to effective communication in a model developed for physicians and hospital administrators to improve their communication abilities to disseminate knowledge within the organization. The following list summarizes these key elements:

- An effective communicator must have a desire to communicate, which is influenced both by one's personal values and the expectation that the communication will be received in a meaningful way.
- An effective communicator must have an understanding of how others learn, which includes consideration of differences in how others perceive and process information (e.g., analytic versus intuitive, abstract versus concrete, verbal versus written).

- The receiver of the message should be cued as to the purpose of the message, that is, whether the message is intended to provide information, to elicit a response or reaction, or to arrive at a decision.
- The content, importance, and complexity of the message should be considered in determining the manner in which the message is communicated.
- The credibility of the sender affects how the message will be received.
- The time frame associated with the content of the message (long versus short) needs to be considered in choosing the manner in which the message is communicated. More precise cues are needed with shorter time frames (see **Figure 5-3**).

A formula to evaluate an individual's effectiveness in communicating to others can be calculated as shown in **Exhibit 5-2**. The index of communication effectiveness (ICE) is a percentage of the reaction to the intended message over the total number of messages sent. If managers find that their ICE is low over time, they should evaluate their communication processes to identify ways to make improvements (Certo, 1992). Research suggests that to improve health care organizational communication and cohesion, exchanges between employees and leaders should involve leaders' direct support and encouragement of employees' constructive expressions of dissatisfaction and innovative ideas (Sobo & Sadler, 2002) (see **Case Study 5-2**).

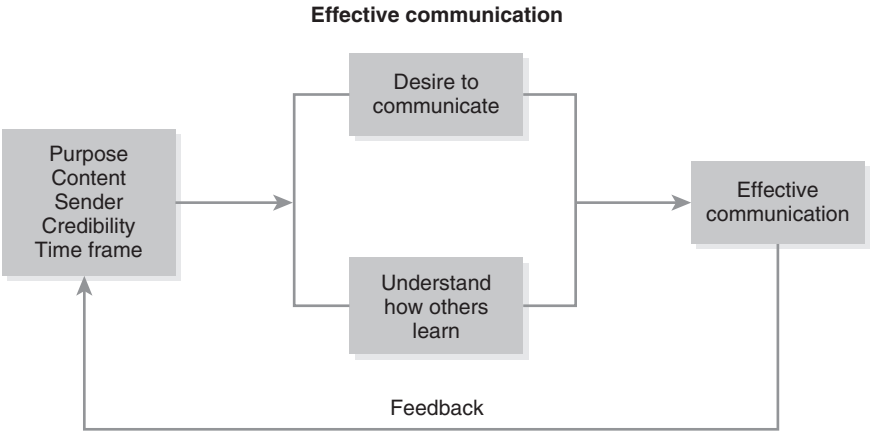


Figure 5-3 Interrelationships of Effective Knowledge-Management Communication

Reproduced from Shortell, S. M. (1991). *Effective hospital-physician relationship.* Ann Arbor, MI: Health Administration Press.

Exhibit 5-2 An Index of Communication Effectiveness

$$\text{Index of communication effectiveness (ICE)} = \frac{\text{RIM (reaction to intended message)}}{\text{TMS (total number of messages sent)}}$$

Reproduced from *Modern management: Quality, ethics, and the global environment* (5th ed., p. 395), by S. C. Certo, 1992, Boston, MA: Allyn and Bacon.

CASE STUDY 5-2 What Should We Do Now?

Jenny Taylor, receptionist at Caring Physicians Clinic, was responsible for calling patients to remind them of their appointments. Dr. Ann Ryan, medical director of the clinic, found Jenny to be hardworking and pleasant to the patients. One morning, Dr. Ryan arrived and found Jenny crying in the supply room. When she questioned Jenny, Jenny sobbed that for the past 3 months she had kept forgetting to order supplies. Jenny had been borrowing supplies from the pediatrics office next door. Now they were unwilling to lend her more. Jenny said that she had called the supply center once and had faxed a list of supplies over but had not followed through. This morning, Jenny had called the supply center again and had found that they were out of business. Jenny told her immediate supervisor, Barbara Lakes, patient care coordinator for the clinic. Lakes fired Jenny for incompetence. In the meantime, patients were waiting, and there were no clean sheets, gloves, or gowns.

Discussion Questions

1. What was the beginning of the problem?
2. What should Jenny have done?
3. Using the elements of effective communication, discuss what Dr. Ryan and Barbara Lakes should do now.

Strategic Communication

Strategic communication is an intentional process of presenting ideas in a clear, concise, and persuasive way. A manager must make an intentional effort to master communication skills and use them strategically, that is, consistently according to the organization's values, mission, and strategy. To plan strategic communication, managers must develop a methodology for thinking through and effectively communicating with superiors, staff, and peers. Sperry and Whiteman (2003) provide us with a strategic communication plan that consists of five components:

1. *Outcome*: The specific result that an individual wants to achieve.
2. *Context*: The organizatioanal importance of the communication.
3. *Messages*: The key information that staff members need to know.
4. *Tactical Reinforcement*: Tactics or methods used to reinforce the message.
5. *Feedback*: The way the message is received and its impact on the individual, team, unit, or organization.

Strategic communication requires forethought about the purpose and outcome of the message. Managers must be able to link the needs of the staff to the organization's mission and deadlines.

Flows of Intraorganizational Communication

Communication can flow upward, downward, horizontally, and diagonally within organizations. Upward communication occurs between supervisors and subordinates. Downward communication primarily involves passing on information from supervisors to subordinates. Horizontal flow is from manager to manager or from coworker to coworker. Diagonal flow occurs between different levels of different departments. Longest et al. (2000) provides us with several forms of intraorganizational communication for health care organizations, as described in the following paragraphs.

Upward Flow

The purpose of upward communication flow is to provide managers with information to make decisions, identify problem areas, collect data for performance assessments, determine staff morale, and reveal employees' thoughts and feelings about the organization. Upward flow becomes especially important with increased organizational complexity. For example, as Adelman (2012, p. 133) noted, the Institute of Medicine's 2004 report titled *Keeping Patients Safe: Transforming the Work Environment of Nurses* related that "a lack of critical upward feedback in the hospital setting has adverse effects on direct patient care and health outcomes." Therefore, managers must rely on effective upward communication and encourage it as an integral part of the organizational culture. Upward communication flow helps employees meet their personal needs by allowing those in positions of lesser authority to express opinions and perceptions to those in positions of higher authority. As a result, the employees make contributions to the organization, and participate in the decision-making process. Adelman (2012) found that award-winning high-performance hospitals' leaders have four key areas that promote effective upward communication:

1. Establishing a culture of excellence—in which employees feel comfortable voicing their concerns for improvement.
2. Creating employee voice opportunity—through leaders' visibility and approachability and the use of both formal and informal communication channels.
3. Reinforcing employee voice instrumentality—whereby leaders interact with employees often to actively solicit comments and provide feedback on decisions.
4. Removing of risks and costs—a climate of safety (i.e., trust) that allows employees to take interpersonal risks with regard to communicating improvement ideas to the leaders of the organization.

The hierarchical structure (chain of command) is the main channel for upward communications in health care organizations. To increase the effectiveness of upward communication, Luthans (1984) recommends the use of grievance procedures, open-door policies, counseling, employee questionnaires, exit interviews, participative decision-making techniques, and the use of an ombudsperson.

- *Grievance Procedure*: The grievance procedure allows employees to make an appeal upward beyond their immediate supervisor. It protects individuals from arbitrary action by their direct supervisor and encourages communication about complaints.
- *Open-Door Policy*: The supervisor's door is always open to subordinates. It is an invitation for subordinates to come in and talk to the supervisor about problems that trouble them, to seek advice, or to share information.
- *Counseling, Questionnaires, and Exit Interviews*: The department of human resources in a health care organization can facilitate subordinate-initiated communication by conducting confidential counseling, administering attitude questionnaires, and holding exit interviews for those leaving the organization. Information gained from these forms of communication can be used to make improvements.
- *Participative Decision-Making Techniques*: Through the use of informal involvement of subordinates or formal participation programs such as quality-improvement teams, union–management committees, and suggestion boxes, participative techniques can improve employee performance and satisfaction. Because employees can participate in the decision-making process, they feel that they can make valuable contributions to the organization.

- *Ombudsperson*: The use of an ombudsperson provides an outlet for persons who feel they have been treated unfairly.

In upward communication, subordinates can provide two types of information to supervisors: (1) personal information about ideas, attitudes, and performance and (2) technical information to provide feedback. Managers who encourage feedback enhance the upward flow of communication.

Downward Flow

Downward communication involves passing information from supervisors to subordinates. This includes verbal and nonverbal communication, such as instructions for completing tasks, as well as one-to-one communications. Downward communications include meeting with employees, written memos, newsletters, bulletin boards, procedural manuals, and clinical and administration information systems.

Horizontal Flow

Relying only on upward and downward communication is inadequate for effective organizational performance. In complex health care organizations, horizontal flow, or lateral communication, must also occur. The purpose of lateral communication is the sharing of information among peers at similar levels to keep organizational staff informed of all current practices, policies, and procedures (Spillan et al., 2002). For example, coordinating the continuum of patient care requires communication among multiple units. Committees, task forces, and cross-functional project teams are all useful forms of horizontal communication.

Diagonal Flow

The least-used channel of communication in health care organizations is diagonal flow, although it is growing in importance. Although diagonal flow does not follow the typical hierarchical chain of command, it is especially useful in health care for efficient communication and coordination of patient care. For example, diagonal communication occurs when the director of nursing asks the data analyst in the medical records department to generate a monthly report for all patients in the intensive care unit (see **Case Study 5-3**).

Communication Networks

Flows of communication can be combined into patterns called communication networks. These networks are interconnected by communication channels. A communication network is the interaction pattern between and among group members. A network creates structure for the group because it controls who can and should talk to whom (Keyton, 2002). Groups generally develop two types of communication networks: centralized and decentralized (**Figure 5-4**).

Decentralized networks allow each group member to talk to every other group member without restrictions. An open, all-channel, or decentralized network is best used for group discussions, decision making, and problem solving. The all-channel network tends to be fast and accurate compared with the centralized network, such as the chain or Y-pattern network (Longest et al., 2000). Nevertheless, a decentralized network can create communication overload, in which too much information or excessively complex communication may occur (Keyton, 2002).

CASE STUDY 5-3 Communication Flows

Sara Lang, a charge nurse at Sunny Nursing Home, has worked under the same president, Lisa Davis, for 5 years. In fact, the two have become good friends. They frequently socialize after hours. Rick Walters, director of nursing, is a capable person who has been working there for 3 years. Four nurses (Anna, Barbara, Charles, and Dan) report directly to Sara.

Anna, one of the nurses, was having personal difficulties. She asked Sara whether she could change her work schedule from the usual 8-hour shift of four days with three consecutive days off to 16-hour shifts for two days and five consecutive days off. Sara thought that was not a problem and told Anna that she would enter that information into the computerized scheduling system and that she would tell Lisa Davis of the change, since they were getting together for a drink after work.

Barbara overheard the conversation between Sara and Anna, and she immediately went to see Rick Walters to complain that Anna was getting preferential treatment and he wanted the same schedule. Rick, who always wanted to make sure that the nursing staff were happy and got along, approved Barbara's change in schedule. He made this change through the computerized schedule and did not tell anyone else. Barbara, who is good friends with Charles, told him of the new schedule. Charles, who works closely with the chief of staff, Dr. Goodman, told Dr. Goodman of the change in Barbara's schedule and asked Dr. Goodman to change his. Dr. Goodman thought it was a good idea and emailed Charles's new schedule to his assistant, Susan Stevens, to enter it into the scheduling system.

On the next Monday morning, changes were implemented to Anna's, Barbara's, and Charles' schedules. No one had discussed these changes with anyone else. When the schedule was printed out and posted, it showed that Anna, Barbara, and Charles were all off for five days that week, from Monday to Friday, and all three began work on Saturday. In the meantime, the only nurse left working was Dan.

Discussion Questions

1. What are the different forms of communication flow taking place in this scenario?
2. What changes should have been implemented?
3. What should be done now?

When communication overload is produced, messages may conflict with one another and result in confusion or disagreement. To reduce communication overload, a facilitator should be used to monitor group discussions.

A centralized network restricts the number of individuals in the communication chain. In a group setting in which a dominant leader takes over group discussions by controlling the number of messages and amount of information being passed, group members do not interact except through the leader. Such a network can create communication underload, in which too few or too simple messages are transmitted. In this type of network, group members feel isolated from group discussions and generally feel dissatisfied. In the chain network, communication occurs upward and downward and follows line authority relationships. An example is a staff nurse who reports to the charge nurse, who reports to the director of nursing, who reports to the vice president for clinical services, who finally reports to the CEO of a large hospital. This network delineates the chain of command and shows clear lines of authority.

Other types of centralized networks include the Y-pattern, the wheel pattern, and the circle network. The Y-pattern is similar to the chain network, with its hierarchical structure, except that it shows two employees at the same level who then follow the chain. An example is of two medical assistants in the organ transplant division who report to the clinical administrator for the division, who reports to the clinical administrator for the department of surgery, who reports to the vice president of clinical services, who finally reports to the CEO of the hospital.

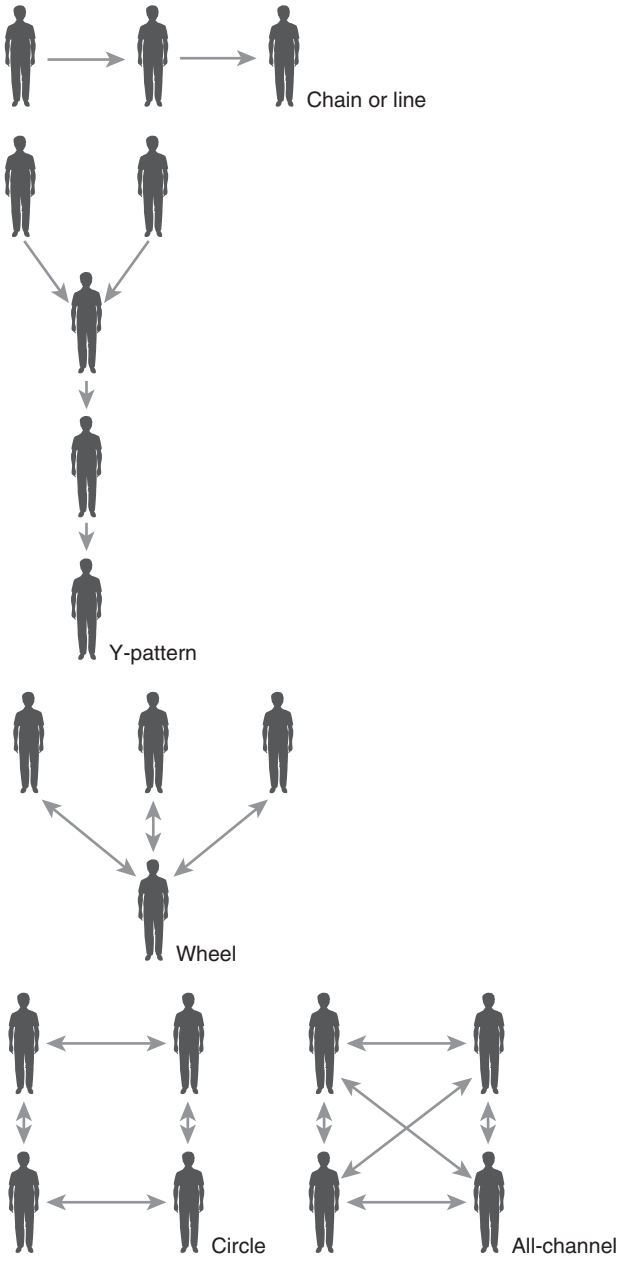


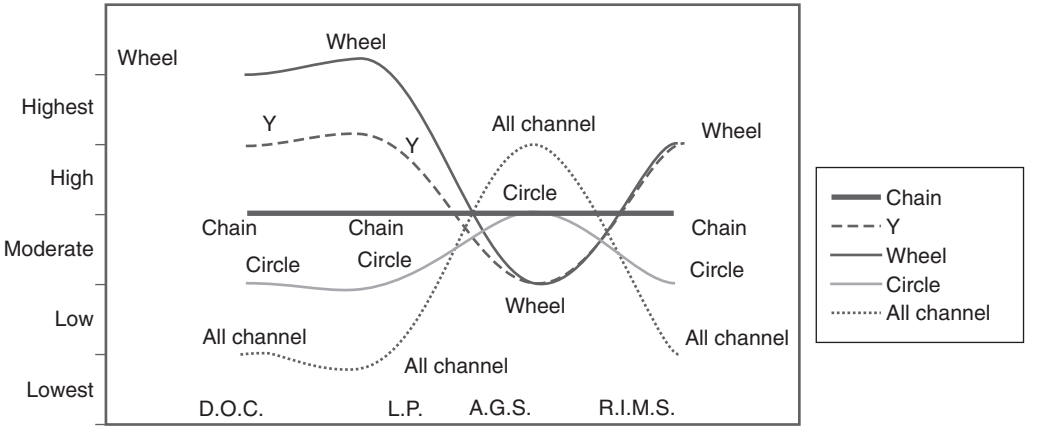
Figure 5-4 Two Types of Communication Networks: Centralized and Decentralized

The wheel pattern shows four subordinates reporting to one supervisor. Subordinates do not interact, and all communications are channeled through the manager at the center of the wheel. This pattern is rare in health care organizations and systems, although elements of it can be found in the example in which four vice presidents report to a president if the vice presidents have little

interaction with one another. Even though this network pattern is not routinely used, it may be used when urgency or secrecy is required. For example, the president with an organizational emergency might communicate with the vice presidents in a wheel pattern because time does not permit using other modes. Similarly, if secrecy is important, such as when investigating possible embezzlement, the president might require that all relevant communication with the vice presidents be kept confidential. The wheel pattern works well when there is pressure for time, secrecy, and accuracy.

The circle pattern allows communicators in the network to communicate directly only with two others. Because each person communicates with another in the network, there is no central authority or leader. The circle network works well when there are open channels of communication among all parties. However, it can slow down the communication process to enable everyone access to information.

There is no one type of communication network that is right for all situations. Different forms can be applied under varying circumstances. To be effective, health care managers must be able to select the appropriate flows of communication for specific situations. Identifying the best communication network for the situation is critical to successful communication. Health problems range from simple to complex, and simple problems can be easily resolved by using simple networks. For example, scheduling patient appointments for Dr. Davis can be easily accomplished through the superior–subordinate chain network. However, complex problems require many levels of decision making. For instance, whether Horizons Hospital should merge with its major competitor to gain more market share at the risk of making a major capital investment can be accomplished through the all-channel network, which is more useful and effective for tackling complex problems. Hellriegel and Slocum (2004) compared the five communication networks using four assessment criteria. **Figure 5-5** shows the specific criteria used in making a selection among the different types of networks.



D.O.C. – Degree of Centralization
L.P. – Leadership Predictability
A.G.S. – Average Group Satisfaction
R.I.M.S. – Range in Individual Member Satisfaction

Figure 5-5 Effects of Five Communication Networks

Reproduced from Hellriegel, D., & Slocum, J. W. (2004). *Organizational behavior* (10th ed.). Mason, OH: South-Western.

1. *Degree of Centralization*: Degree of centralization is the extent to which team members have access to more communication than others. In the case of the wheel network, because communication flows from and to only one member, this is the most centralized network. By contrast, the all-channel network provides everyone in the network with the same opportunity for communication; thus, it is the least centralized network.
2. *Leadership Predictability*: Leadership predictability is the ability to anticipate which member of the communication network is likely to emerge as the leader. In the case of the Y-pattern and the wheel pattern, the most centrally positioned individual is the most likely person.
3. *Average Group Satisfaction*: Average group satisfaction reflects the level of satisfaction of members in the communication network. In the wheel network, average member satisfaction is the lowest in comparison with other networks, since the most centrally positioned person plays the most crucial roles and leaves less important decision-making responsibilities for the people around the wheel.
4. *Range of Individual Member Satisfaction*: The range of an individual's satisfaction within the communication network has an inverse relationship with the average group satisfaction. Again, in the wheel, although average member satisfaction is low, the range of individual member satisfaction is high, because they are highly dependent on the individual in the middle. In the case of the all-channel network, average group satisfaction is high because there is greater participation by all members of the communication network, but individual satisfaction tends to be low.

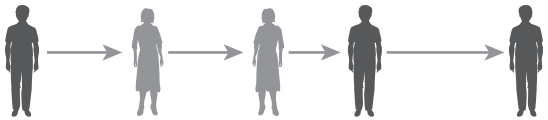
Informal Communication

In addition to formal communication flows and networks within health care organizations, there are informal communication flows, which have their own networks. Employees have always relied on the oldest communication channel: the grapevine. The grapevine is an unstructured and informal network that is founded on social relationships rather than organizational charts or job descriptions. According to some estimates, 75% of employees typically receive news from the grapevine before they hear about it through formal channels (McShane & Von Glinow, 2003).

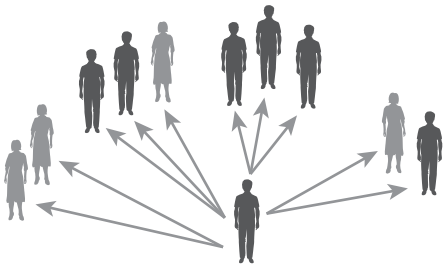
Early research identified several unique features of the grapevine. One feature of note is that it transmits information rapidly in all directions (Newstrom & Davis, 1993). **Figure 5-6** illustrates four common patterns that the grapevine can take.

The typical pattern of a grapevine is a cluster chain, whereby a few people actively transmit rumors to many others. The grapevine works through informal social networks, so it is more active for employees who have similar backgrounds and are able to communicate easily. Many rumors seem to have at least a little bit of truth, possibly because rumors are transmitted through information-rich communication channels and employees are motivated to communicate effectively. Nevertheless, the grapevine distorts information by deleting fine details and exaggerating parts of the message.

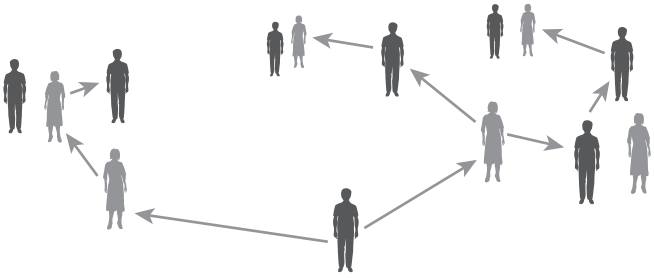
In this era of information technology, email, texting, other forms of electronic messaging and social media have replaced the traditional watercooler site of grapevine gossip. Instead, networks have expanded as employees communicate with one another inside and outside of the organization instantly through computer-aided communication. Furthermore, public websites such as Yelp and social media such as Twitter and Instagram have become virtual watercoolers for posting anonymous comments about specific companies for all to view. This technology extends gossip to anyone, not just employees connected to the social networks. A manager's responsibility is to utilize the informal network selectively to benefit the organization's goals (see **Case Study 5-4**).



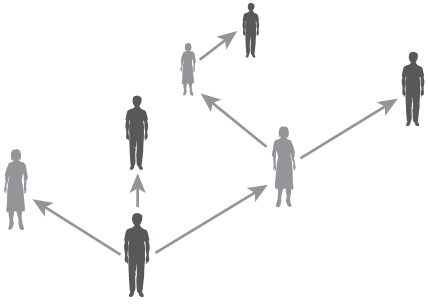
Single Strand – information travels from one person to the next person



Gossip – one individual transmits the message to others



Probability – one individual randomly selects others to communicate the message and these secondary people randomly pick others



Cluster – one individual randomly selects others to communicate the message

Figure 5-6 Grapevine Networks

Cross-Cultural Communication

Increasing information technology, globalization, and cultural diversity present a number of communication opportunities and challenges for organizations. Organizational personnel must be sensitive and competent in cross-cultural communication. While ethnic and racial diversity enriches the environment, it can also cause communication barriers that impede efficient and

CASE STUDY 5-4 Did You Hear the Latest?

Sally Reeds, a medical secretary for the department of neurology at Western Heights Hospital in Colorado, checked her phone last night and found a post on Facebook from her friend and coworker Justin Zeels, a social worker in the same hospital. Justin wrote that Dr. Sites, medical director of neurology, had been found under a bench outside the emergency department. The hospital security officers had allegedly reported that Dr. Sites was completely intoxicated, and he had been rushed home. Sally spiced up the tale and immediately posted it. This morning, Sally looked up and noticed Dr. Sites seeing his patients as if nothing had happened. She confronted him and asked him how he could possibly face everyone after what happened last night. Dr. Sites looked confused until a screenshot of Zeels's post was shown to Dr. Sites by another staff member. After reading it, Dr. Sites became livid and fired Justin for spreading such a malicious rumor. Meanwhile, Maria Hummingshire, another medical secretary, who saw the entire incident in the office, took a video, and texted it to her friends.

Discussion Questions

1. What did Sally do wrong?
2. What should Justin have done?
3. What should the organization do to prevent the spread of gossip through the grapevine?

effective service delivery. Communication difficulties arise from differences in cultural values, languages, and points of view. For instance, in the health care industry, one major barrier is language, because numerous languages may be encountered among staff and patients. As of 2017, more than 65 million people in the United States speak a language other than English at home. That is almost 22% of the total population! In the country's five largest cities, this percentage rises to nearly half the city's population (Zeigler & Camarota, 2018). Because language is the most obvious cross-cultural barrier, words can be easily misunderstood in verbal communication (Dutton, 1998). Although the English language is relied on as the common business language, English words may have different meanings in different cultures.

Voice intonation varies by country. For instance, in Japan, communicating softly is an expression of politeness, whereas in the Middle East, the louder the voice, the more one is believed to be sincere (Mead, 1993). To achieve effective communication, health care professionals can apply several strategies to reduce communication barriers. Thiederman (1996) provides us with several verbal and nonverbal techniques to improve cross-cultural communication:

- Write down in simple English the issues that have been agreed upon in order to obtain feedback on accuracy.
- Repeat a message when there is doubt.
- Watch for nonverbal signs of a lack of understanding.
- Listen carefully to an entire message, especially when the speaker's accent is different from one's own.
- Create a relaxed atmosphere so that tension is reduced to increase the flow of communication.
- Phrase questions in different ways to make it easier for the receiver to understand.

Opportunities for working with individuals from different cultures have increased dramatically. As U.S. industries branch into world markets through the interconnectedness of the Internet, email, social media, live chat, voice messaging, and smartphones, organizations and individuals are able to conduct business without ever meeting face to face. To be effective in cross-cultural communication, several guidelines are important.

- Understand your own identity. To develop sensitivity to other cultures, you must first understand your own culture and identity. Your personal identity encompasses who you are and who you want to be. That is, you choose your lifestyle, goals, occupation or profession, and friends. The choices that you make and the goals you pursue may be affected by racial, cultural, gender, and social class factors.
- Enhance personal and social interactions. Globalization has increased our opportunities to associate and develop close interactions with individuals who are different from us. The conscious decisions that we make to become more accommodating, flexible, and tolerant of others will broaden our views of the world and enrich our perspectives. Our relationships with people of different cultures help us to learn more about the world and to break stereotypes. These interactions also enable us to develop new skills for communicating with others and to learn from them.
- Solve misunderstandings, miscommunications, and mistrust. Take the time and make the effort to study, understand, and appreciate individuals of different cultures. Through open, honest, and positive communication, this will resolve misunderstandings, miscommunications, and mistrust.
- Enhance and enrich the quality of the work environment. Recognizing and respecting ethnic and cultural diversity through more open communication are the first steps toward valuing diversity and enriching the quality of the work environment (Hybels & Weaver, 2007).

Communicating with External Stakeholders

In health care organizations, managers must be competent communicators because they spend most of their time and energy communicating with large numbers of external stakeholders, individuals, groups, and organizations that are interested in the health care organization's actions and decisions. A competent communicator is an individual who has the ability to identify appropriate communication patterns in a given situation and to achieve goals by applying that knowledge. Competent communicators quickly learn the meaning that listeners take from certain words and symbols, and they know which communication channel is most appropriate in a particular situation. Moreover, competent communicators use this knowledge to communicate in ways that achieve personal, team, and organizational objectives. A manager with high communication competence would be better than others at determining whether an email, telephone call, or personal visit would be the best way to convey a message to an employee.

To competently communicate with external stakeholders, organizations and their managers are responsible for assessing the environment to gain information in order to make strategic decisions. Managers must utilize their roles as liaisons and monitors to scan the environment for opportunities and minimize threats. Furthermore, managers must utilize their strategist role to formulate and implement policies that are consistent with their organization's strategic goals and plans (Guo, 2003). **Exhibit 5-3** shows steps for analyzing stakeholders to increase the acquisition of useful information.

First, scanning the macroenvironment and the microenvironment results in information about stakeholders. **Figure 5-7** illustrates the diversity of stakeholders for a community hospital.

Relationships between the organization and its external stakeholders are complex and affect communication, since the organization is a dynamic, open system operating in a turbulent

Exhibit 5-3 Stakeholder Analysis

1. Scan the environment of the organization (macroenvironment: economic, regulatory, social/cultural, political, demographics, competitive, technology) (microenvironment: health care industry)
2. Identify strategically important issues (i.e., identify important stakeholders)
3. Monitor these issues (track stakeholders' views and positions)
4. Forecast trends (project trends in stakeholders' views and positions)
5. Assess their importance (assess the implications of stakeholders' views and positions)
6. Diffuse information (diffuse stakeholder information to those who need it)

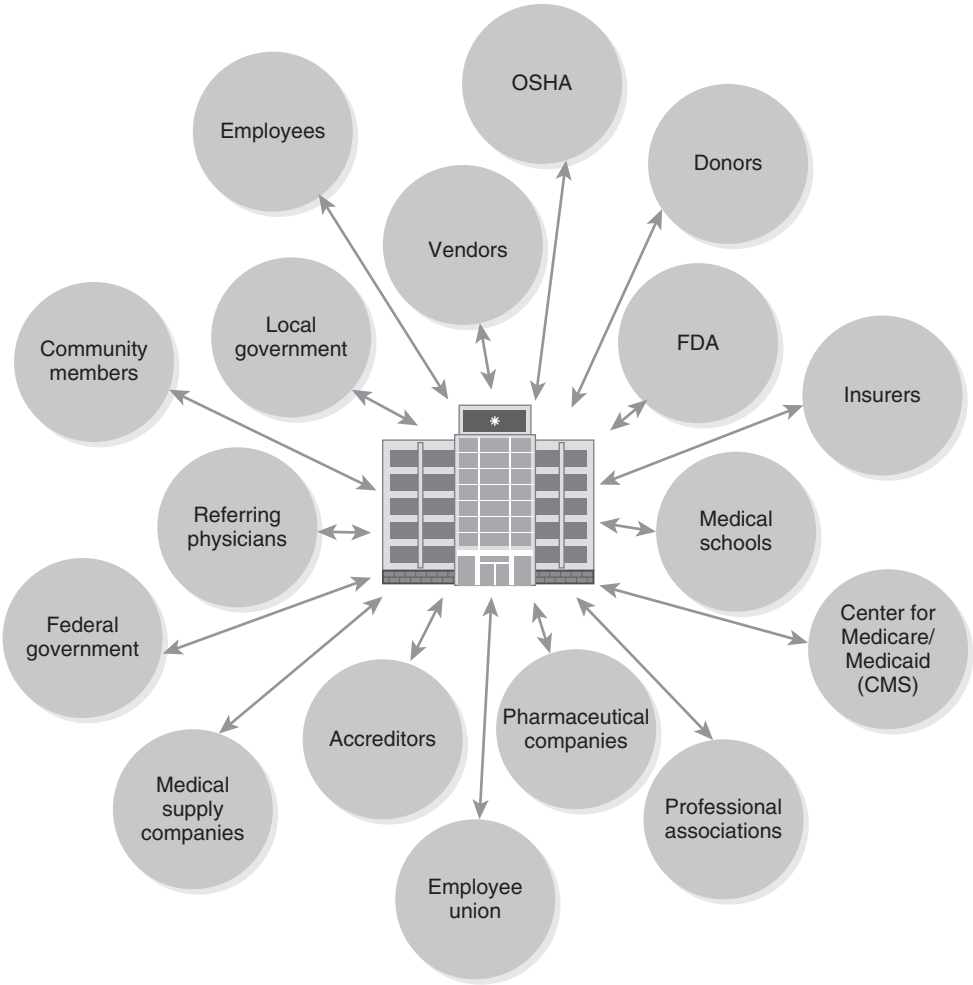


Figure 5-7 External Stakeholders

external environment. The size and variety of external stakeholders make communication complex, especially because stakeholders attempt to influence the decision making of organizations. Fottler, Blair, Whitehead, Laus, and Savage (1989) examined communication between a large hospital and its stakeholders and found different relationships. While some relationships are positive, others are neutral or negative. Positive relationships with external stakeholders are easier to manage, and communication tends to be more effective than is the case in negative relationships.

In the stakeholder analysis, important issues and stakeholders are identified through the environmental scan. Next, monitoring the activities of stakeholders is crucial. Managers must be able to take the views of stakeholders and use that information to incorporate trends into their decision-making process.

Finally, managers must evaluate the value of the information, take the information gathered, and transmit it to those who need the information.

Another way to describe communication with external stakeholders is known as boundary spanning. Boundary spanning, or external communication links, provides opportunities for organizational learning in areas such as strategic planning or marketing (Johnson & Chang, 2000). Communicating with all external stakeholders is essential; however, each stakeholder may be viewed for its unique position and benefits to the organization. For instance, in interactions with the public sector, health care organizations are affected by public policies. Government is a major stakeholder because of its legislative and regulatory powers and because it is one of the largest purchasers of health services. For example, issues such as access to care, cost containment, and quality concerns have driven federal government debate, reforms, and involvement in health care. Therefore, health care organizations cannot be insulated from public policies and must make strategic responses to reflect the needs of the public sector. A health care organization has a special relationship with the geographical community where the organization is located. Meeting the particular needs of the community is a primary goal of health care organizations.

For effective communication to take place, both parties must form realistic expectations. Health care organizations have six areas of responsibility toward their communities (Longest et al., 2000):

1. Engaging in the core, health-enhancing activities in the community.
2. Providing economic benefits to the community.
3. Offering unique benefits or a niche to the community.
4. Pursuing philanthropic activities in a broad and generous manner.
5. Being in full compliance with legal requirements.
6. Meeting ethical and fiduciary obligations.

Summary

Communication in the workplace is critical for establishing and maintaining high-quality working relationships in organizations. Communication is the creation or exchange of thoughts, ideas, emotions, and understanding between sender(s) and receiver(s). Feedback is information that individuals receive about their behavior. Feedback can be used to promote more effective communication. The Johari Window is a model to improve an individual's communication skills through identifying one's capabilities and limitations. The channels of communication are the means by which messages are transmitted. Verbal communication relies on spoken or written words to share

information with others. Computer-aided communication, such as email, has greatly enhanced the communication process. Especially in health care, other forms of technology (such as high-speed, high-definition images; telemedicine; and wireless, handheld digital electronic medical records) can be used to bridge communication gaps between clinicians and administrators. Nonverbal communication is the sharing of information without using words to encode messages. This includes proxemics, kinesics, facial and eye behavior, and paralanguage.

There are two types of barriers to communication: environmental and personal. Barriers can be overcome by conscious efforts to devote time and attention to communication, reduce hierarchical levels, tailor words and symbols, reinforce words with action, use multiple channels of communication, and understand one another's frame of reference and beliefs.

Key elements of effective communication include the desire to communicate, understanding how others learn, the intent, the content, the sender's credibility, and the time frame. Strategic communication is an intentional process of presenting ideas in a clear, concise, and persuasive way. Five components of strategic communication are outcome, context, messages, tactical reinforcement, and feedback.

Intraorganizational communication flows upward, downward, horizontally, and diagonally. Various flows of communication can be combined to form communication networks, such as the chain, Y-pattern, wheel, circle, and all-channel. Certain networks may work better than others, depending on the situation. A manager's role is to determine the best network to use for simple or complex communications. Informal communication results from interpersonal relationships developed in the workplace. Although informal networks can be useful, they can also be misused.

Cross-cultural communication can be challenging. Communication difficulties arise from differences in cultural values, languages, and points of view. Organizational personnel must be sensitive and competent in cross-cultural communication. Several techniques and guidelines for improving cross-cultural communication are provided.

Health care organizations must manage relationships with large numbers of external stakeholders: individuals, groups, and organizations that are interested in the organization's actions and decisions. Effective communication with external stakeholders involves environmental assessments to enable managers to identify and make strategic decisions for their organizations.

Discussion Questions

1. What are the various components of the communication process?
2. What are the three forms and four levels of feedback?
3. What is the Johari Window? How is it used in communication?
4. What is verbal communication? Give an example.
5. What are the different types of nonverbal communication?
6. What are the appropriate uses of verbal and nonverbal communication channels?
7. What are the two types of barriers to effective communication?
8. What methods are available to overcome these barriers?
9. What are the elements of effective communication?
10. What are the five components of a strategic communication plan?
11. What are the different forms of intraorganizational flows of communication?
12. What are the various networks available for formal and informal communication?
13. Why is cross-cultural communication important to today's health services organizations?
14. What competencies are needed by managers for communicating with external stakeholders?

CASE STUDIES

Case Study 5-5 "Now We Can Finally Talk"

Comfort Zone is a 60-bed, for-profit intermediate-care facility in northern California. The rehabilitative department manager, Jamie Richards, has been working at Comfort Zone for only 6 months. She holds monthly staff meetings as well as additional individual meetings with staff members to address specific patient-related issues. On most days, she eats lunch in a quiet corner of the cafeteria so that she can catch up on her paperwork at the same time.

Catherine Williams, one of her staff members, who has been working at the facility for more than 25 years, spotted her in the cafeteria one day and sat down uninvited. Catherine has never attended any of the monthly meetings and always has an excuse for not attending. Catherine said, "I've been waiting to tell you this ever since you began working here, but I wanted you to get adjusted first. Now we can finally talk. I have been here for a long time and have seen all kinds of comings and goings."

Catherine proceeded to tell Jamie about members of her staff who were constantly tardy or absent. She also told Jamie about the things the staff members had been doing behind her back, such as using the Internet for personal matters, going shopping during lunch hour and coming back late, and going home early without permission. Catherine concluded, "At your monthly meetings, the staff show up to tell you that everything's just fine, when I know differently. I'm too busy working to attend these meetings. If you want my opinion, I would fire them all since they are incompetent."

Discussion Questions

1. How should Jamie deal with the information that Catherine provided?
2. What do you think of Jamie's methods of communicating with her staff?
3. Do you think that Jamie should use a different form of communication with Catherine?

Case Study 5-6 It's Not My Job

In the medical unit of the Northeastern Medical Center, Leah Hernandez is an insurance claims specialist who works with one nurse, one certified nursing assistant, and one medical assistant/receptionist. The physician and the administrator are located in a separate building of the medical center. The administrator, Dan Jules, spends 3 hours a day in the clinic, from 9:00 to 10:30 every morning and from 2:00 to 3:30 every afternoon. He never varies the times that he is in the clinic.

One morning at 9:00 A.M., Dan was in the clinic with nurse Kate Williams, addressing the concerns of the patient in room 2, when the phone rang. A second phone line rang a few seconds later and then a third. The nursing assistant was in room 1 with the physician, and the medical assistant/receptionist was in room 3 with another patient. The only staff member available to answer the phone was Leah, who was holding on the line with an insurance company. She yelled, "Anybody? Somebody, pick up the phone already! It's driving me crazy!" Everyone in the clinic, including the patients, heard her shouting. Kate rolled her eyes and told Dan that it was like this every day. Dan excused himself and rushed into the reception area to pick up the phone. Later on, Dan asked Leah why she couldn't pick up the phone. Leah answered, "It's not my job. I was busy with the insurance company."

Discussion Questions

1. What should Dan do to address the problem?
2. Should Dan meet with Leah individually or communicate with all staff members?
3. Because Dan works in a different building, who should have communicated this ongoing problem to Dan?

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PART II

Understanding Individual Behaviors

In *Motivation and Personality* (1954), Abraham Maslow asked, "What conditions of work, what kinds of work, what kinds of management, and what kinds of reward or pay will help motivate humans?" In Part II, we answer Maslow's questions with three chapters dedicated to the discussion of motivation.

In Chapter 6, we describe and explain four content theories of motivation: (1) Maslow's Hierarchy of Needs, (2) Alderfer's ERG Theory, (3) Herzberg's Two-Factor Theory, and (4) McClelland's Three-Needs Theory. These theories attempt to explain what motivates employees, and each theory contains some parts of the others.

In Chapter 7, we examine five process theories of motivation: (1) Expectancy Theory, (2) Equity Theory, (3) Satisfaction–Performance Theory, (4) Goal-Setting Theory, and (5) Reinforcement Theory. Although Reinforcement Theory is not usually included with process theories of motivation, it does assist managers with understanding what reinforcements control an individual's behavior. Process theories contain some components of the content theories and vice versa.

In Chapter 8, we examine attribution theory. The discussion of attribution theory and its relevance in the workplace provides managers with a better understanding of the highly cognitive and psychological mechanisms that influence individuals' motivation levels.

CHAPTER 6

Content Theories of Motivation

LEARNING OUTCOMES

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

- The definition of motivation.
- The difference between content theories and process theories of motivation.
- Maslow's Hierarchy of Needs Theory and criticisms of the theory.
- Alderfer's ERG Theory.
- Herzberg's Two-Factor Theory and how it relates to job design.
- Hackman and Oldham's Job Characteristics Model.
- McClelland's Three-Needs Theory.

Overview

We will begin by defining motivation before we explore two groups of motivation theories: content theories and process theories. Motivation is described as the conscious or unconscious reason or reasons that one has for acting in a particular way and one's general desire or willingness to do something. (see **Figure 6-1**). Motivation is the psychological process through which unsatisfied needs or wants lead to desires that are the basis for goals or incentives. The purpose of an individual's behavior is to satisfy needs or wants. In this context, a need is anything a person requires or desires. A want is the conscious recognition of a need. The presence of an unsatisfied need or want creates an internal tension, from which an individual seeks relief.

In organizational behavior, the concept of motivation has been researched over many years. Through this research, we have identified and categorized motivation theories into two groups: content and process.

Content theories of motivation (also referred to as needs theories) explain the specific factors that motivate people. The content approach focuses on the assumption that individuals are motivated by the desire to satisfy their inner needs. Content theories answer the question "What drives

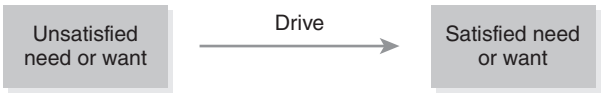


Figure 6-1 Process of Motivation

behavior?" Content theories help managers to understand what arouses, energizes, or initiates employee behavior.

Process theories of motivation (also referred to as cognitive theories) focus on the cognitive processes underlying an individual's level of motivation. This approach provides a description and an analysis of how behavior is energized, directed, sustained, and stopped. Process theories help to explain how an employee's behavior is initiated, redirected, and halted.

Employee motivation has a direct impact on a health services organization's performance; therefore, managers need to understand what motivates employees. By understanding what motivates them, managers can assist employees in reaching their fullest potential. There are some factors the manager can control, such as extrinsic factors (e.g., salary, working conditions, interpersonal relationships). For the motivating factors that are intrinsic to the employee (e.g., need for recognition, achievement), managers can be influential by providing a work environment that allows employees the opportunity to satisfy their personal needs and, simultaneously, the organization's goals.

Motivating staff is not about hanging posters with cute sayings in the office. Motivating is something managers do by establishing an organizational structure and environment that provide the opportunity for employees to satisfy both their intrinsic and extrinsic needs. Remember, motivation is an individual's voluntary drive to satisfy a need or want!

Maslow's Hierarchy of Needs Theory

The most popular and widely cited human motivation theorist is Abraham Maslow. Maslow (1954) is considered the father of humanistic psychology. Briefly, humanistic psychology incorporates aspects of both behavioral psychology and psychoanalytic psychology. Behaviorists believe that human behavior is controlled by external environmental factors, whereas psychoanalytic psychology is based on the idea that human behavior is controlled by internal unconscious forces. Early in his career, Maslow concluded that human behavior is controlled not only by internal factors or only by external factors (e.g., needs) but by both. He also proposed that some factors have precedence over others. From this concept, Maslow created his five-tier Hierarchy of Needs (see **Figure 6-2**).

According to Maslow, humans have five levels of needs and are driven to fulfill these needs. The most basic needs are physiological, such as the need for air, water, and food. After the basic physiological needs have been achieved, an individual moves toward satisfying safety and security needs. At this lower level of the hierarchy, individuals are interested in having a home in a safe neighborhood, job security, a retirement plan, and health/medical insurance. Because employees are concerned about satisfying these external (extrinsic) needs, these motivators need to be addressed by employers, such as by providing employees with an adequate benefits package. The next three levels in Maslow's Hierarchy of Needs Theory are somewhat less tangible and more psychological. The third level in the hierarchy is a desire to be loved, to belong, and to be approved of by others. Humans have a drive to feel needed and loved. In the workplace, employees seek

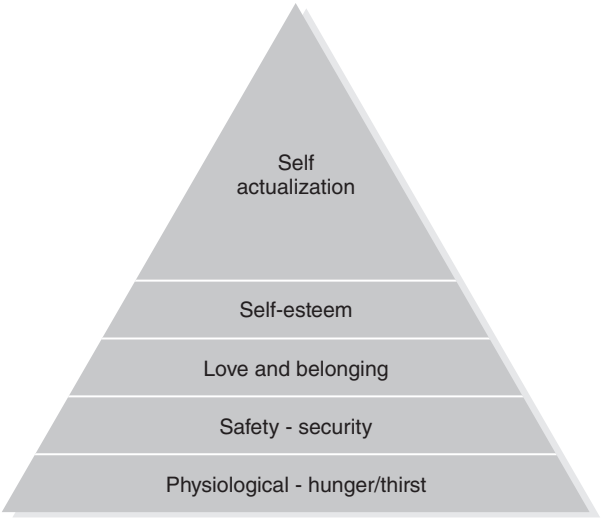


Figure 6-2 Maslow's Hierarchy of Needs

Reproduced from Maslow, A. H. (1954). *Motivation and personality*. New York, NY: Harper & Row.

a sense of community and belonging. To achieve this, they seek the approval and acceptance of their peers and supervisors. Managers, by helping staff feel connected to the organization and its mission, can provide this sense of belonging and community. After an individual's physiological, safety, and belonging needs are satisfied, the next tier in the hierarchy is self-esteem. Maslow noted two versions of esteem needs: a lower one (external) and a higher one (internal). External esteem is satisfied by achieving the respect of other people, social and professional status, recognition, and appreciation. The higher form of esteem, internal esteem, involves the need for self-respect, a feeling of confidence, achievement, and autonomy. Individuals want to be competent in what they do, and self-esteem increases when one receives attention and recognition from others for one's accomplishments. Therefore, careful use of praise and of positive feedback to staff members is an important means of motivating them. A word of praise or encouragement for a job well done or other forms of positive feedback go a long way toward motivating staff to perform. Managers should also provide employees with opportunities to demonstrate their competence. Encouraging staff participation in continuing education and other professional development activities and providing opportunities for challenging and meaningful work are effective motivators. These opportunities allow employees to achieve feelings of self-esteem and accomplishment.

Maslow described the preceding four levels (physiological, safety, belonging, and self-esteem) as deficiency needs (D-needs) because if any of these motivators are not satisfied, an inner tension is created within the individual that must be relieved (see **Case Study 6-1**). However, if these needs have been satisfied, they cease to motivate the individual, who moves to the next level in the hierarchy. Maslow believed that individuals must satisfy their lower-level needs, *at least to an acceptable state*, before they can be motivated to achieve the higher levels in the hierarchy.

The highest level of need is an individual's desire to become all that they can be. Although Maslow used a variety of terms to refer to this level, it is most commonly referred to as self-actualization. Self-actualization is the desire to become more of what one is and everything that one is capable of becoming. It is referred to as a "being need" (B-need) because it is motivating

CASE STUDY 6-1 Poor Cindy, What Should She Do?

Cindy has been employed by Memorial Health System for the past 25 years, working her way up the organization's hierarchy. She started working for the organization as a medical coder after obtaining her bachelor's degree. After 10 years, Cindy returned to school to earn a master's degree in health services administration so that she could qualify for management positions. After many years of hard work, she became the system's director of compliance. However, she has recently been hearing rumors that the organization is not doing well because of the national health reform changes and that layoffs may be announced in the near future. This is causing Cindy stress and worry. Memorial is the only organization she has worked for! She has tried to stay focused, but it is extremely difficult for her to do so, especially after she talked with Harry last week.

Harry and Cindy went to graduate school together and have kept in touch over the years since Harry moved to another state to work for a larger health care system. Last week, Harry told Cindy that he had been laid off 3 months earlier and had not been able to secure even an interview with other provider organizations because of the uncertainty in the marketplace due to the reform changes. Knowing about Harry's experience further stressed Cindy as she thought about how she could be in the same situation soon. She tried to get reassurance from her boss about her job security, but he just seemed to give her the runaround. Because of her preoccupation with her job security, Cindy's quality of work began slipping, and she became forgetful of project deadlines. She now spends most of her time worrying and has had to call in sick a few times over the past 4 weeks because she had stomach cramps and headaches.

Discuss Cindy's situation using Maslow's Hierarchy of Needs.

without there being a deficiency, as with the D-needs. In Maslow's view, self-actualization is not an endpoint; rather, it is an ongoing process that involves many growth choices that entail risk and require courage (O'Connor & Yballe, 2007). In addition to describing what is meant by self-actualization in his theory, Maslow (1970) identified key characteristics of a self-actualized person:

- *Acceptance and Realism*: Self-actualized people have realistic perceptions of themselves, others, and the world around them. They easily accept themselves and others as they are.
- *Problem-Centering*: Self-actualized individuals are concerned with solving problems outside of themselves. They often dedicate themselves to a larger purpose in life based on ethics or a sense of personal responsibility.
- *Spontaneity*: Self-actualized people are spontaneous, natural, and open in their behavior and thoughts. However, they can easily conform to conventional rules and expectations when situations demand such behavior.
- *Autonomy and Solitude*: Although they accept and enjoy other people, self-actualized individuals have a strong need for privacy and independence. They focus on their own potential and development rather than on the opinions of others.
- *Continued Freshness of Appreciation*: Self-actualized people continue to appreciate the simple pleasures of life with awe and wonder.
- *Peak Experiences*: Self-actualized people commonly have peak experiences, or moments of intense ecstasy, wonder, and awe during which their sense of self is lost or transcended. The self-actualized person may feel transformed and strengthened by these peak experiences.

Although progress to self-actualization is often interrupted by failure to meet lower-level needs as a result of situations such as illness (lack of physiological well-being), loss of a job (lack of security), or divorce (lack of sense of being loved), individuals can learn that satisfying basic needs becomes an integrated, consciously managed aspect of a whole life and is not compulsive or

dominating of all other concerns. As O'Connor and Yballe (2007, p. 749) point out, "a paradigm shift takes place. An individual becomes a person who has needs, not a needy person."

Managers need to ask themselves, "How can I motivate my employees?" When answering this question, managers need to be conscious of the fact that not all employees are driven by the same needs, nor is any employee driven by only one need at a time. For example, right now as you read this book, you may have several needs operating simultaneously—curiosity, a need for new knowledge, thirst, and so forth. Managers need to recognize the needs of each employee, individually. Managers who simultaneously address each employee's lower level of needs will benefit from workers who are motivated to achieve the higher levels of Maslow's Hierarchy of Needs (see **Figure 6-3**).

Although Maslow introduced his Hierarchy of Needs Theory more than 60 years ago, there have been only a limited number of studies that support his theory, and those that have been published have reported mixed findings (Alderfer, 1972). In fact, some research contradicts Maslow's specific ordering of needs. For example, Huizinga, as cited by Griffin (1991), attempted to validate the theory in the workplace. Because of its scope and different cultural setting, Huizinga's study is one of the more ambitious attempts to verify the principles of the hierarchy. Huizinga surveyed over 600 managers drawn from five industries in the Netherlands. His sample included people from production, personnel, research and development, finance, and top management. They ranged in age from 20 to 65 years, and their educational backgrounds extended from the Dutch equivalent of grade school to university graduates. Huizinga found that no matter how many ways he analyzed the data, there was simply no evidence that workers had a single dominant need, much less that the need diminished in strength when gratified (Griffin, 1991, p. 131).

Figure 6-3 How Managers Can Satisfy Employees' Needs at Different Levels of Maslow's Hierarchy of Needs

Maslow's needs theory also had difficulty explaining individuals such as Mother Teresa, who neglected her lower-level needs in pursuit of her spiritual calling to serve the poor in India. Maslow himself used the example of a starving artist pursuing his creativity needs (e.g., self-actualization) while ignoring physiological needs. Despite the gap in empirical research to support Maslow's Hierarchy of Needs Theory, it remains "popular with managers because (1) its core elements are simple to present, (2) it accords with the values held by many managers, and (3) it draws a parallel between organizational hierarchies and needs hierarchies" (Dolea & Adams, 2005, p. 5).

Alderfer's ERG Theory

To address the criticisms of Maslow's Hierarchy of Needs, in the late 1960s, Clayton Alderfer (1972) introduced an alternative needs hierarchy, referred to as the ERG Theory. Alderfer's hierarchy relates to three identified categories of needs: existence, relatedness, and growth (see **Table 6-1**).

- *Existence* refers to an individual's concern with basic material and physiological requirements such as food, water, pay, fringe benefits, and working conditions.
- *Relatedness* refers to the need for developing and sustaining interpersonal relationships such as those with family, friends, supervisors, coworkers, subordinates, and other significant groups.
- *Growth* refers to an individual's intrinsic need to be creative and to make useful and productive contributions, including personal development with opportunities for personal growth.

When compared with Maslow's Hierarchy of Needs, Alderfer's ERG Theory differs on three points. First, the ERG Theory allows for an individual to seek satisfaction of higher-level needs before lower-level needs have been satisfied. In other words, the ERG Theory does not require a person to satisfy a lower-level need for a higher-level need to become the driver of the person's behavior. Although the ERG Theory retains the concept of a needs hierarchy, it does not require a strict ordering, as in Maslow's theory.

Second, the ERG Theory accounts for differences in need preferences between cultures; therefore, the order of needs can be different for different people. This flexibility allows the ERG Theory to account for a wider range of observed behaviors. For example, it can explain Mother Teresa's behavior of placing spiritual needs above existence needs.

Table 6-1 Alderfer's ERG Theory

Level of Need	Definition	Properties
Growth	Drives a person to make creative or productive effects on themselves and the environment.	Satisfied through a person using their capabilities fully (and developing additional ones) in problem solving; creates a greater sense of wholeness and fullness as a human being.
Relatedness	Involves relationships with significant other people.	Satisfied by mutually sharing thoughts and feelings; acceptance, confirmation, understanding, and influence are elements of the relatedness process.
Existence	Includes all of the various forms of psychological and material desires.	When resources are limited and must be divided among people, one person's gain is another's loss.

Third, and perhaps the most important aspect of the ERG Theory, is the frustration–regression principle. The frustration–regression principle explains that when a barrier prevents an individual from satisfying a higher-level need, the person may "regress" to a lower-level need to achieve feelings of satisfaction. For example, a person wants existence-related objects when their relatedness needs are not satisfied; a person wants relationships with significant others when growth needs are not being met.

Managers must recognize that an employee may have multiple needs to satisfy simultaneously, and focusing exclusively on one need will not effectively motivate an employee. In addition, the frustration–regression principle affects workplace motivation. For example, if growth opportunities are not provided, employees might regress to relatedness needs and socialize more with coworkers, or they might look to other types of organizations for satisfaction of this need—for example, a union. If the work environment does not satisfy an employee's need for social interaction, the employee might feel an increased desire for more money or better working conditions. If a manager is able to recognize these conditions, steps can be taken to satisfy the employee's frustrated needs until the employee is able to pursue growth again (see **Case Study 6-2**).

CASE STUDY 6-2 I Get by with a Little Help from My Friends

Jennifer Smith, RN, has worked at St. Joe's Medical Center for the past 5 years as an operating room nurse. She enjoys her work and the interaction it provides with patients, physicians, and especially her coworkers. In fact, she has developed strong friendships with many of her coworkers. They eat lunch together almost every day, they have monthly dinner parties at one another's homes, and they frequently go on vacations together. Helen Jones, the director of surgical services, has remarked about the cohesiveness of the group and how well they work together, creating a well-functioning team. However, during the past year, Jennifer has made frequent remarks to her coworkers that she feels that her nursing career is at a stalemate and she is getting bored with doing the same thing every day. She has been questioning why she went back to school to earn her MSN degree when Helen has never given her an opportunity to apply what she learned. Jennifer has started to think about looking for a new position at a different hospital that would give her opportunities to grow professionally. Jennifer's coworkers empathize with her, and when a vacancy was posted on the hospital's job bulletin board for an assistant clinical manager position in her department, they encouraged her to apply. After reviewing the job description, Jennifer agreed that with her clinical experience and graduate degree, she was the perfect candidate for the job. She submitted her application, fully confident that Helen would offer her the position. Jennifer was very excited and looked forward to the challenges she would face when promoted.

However, when Helen informed Jennifer that another staff member with more management experience had been offered the position, Jennifer could not disguise her disappointment. She wondered what she should do now. Should she quit and seek a new position at a different hospital? But what about her friends at St. Joe's?

Jennifer's coworkers knew how upset she was and made special efforts to ease her disappointment by scheduling more outings together. They told her that other opportunities would come and that, with a little more experience, she would be promoted. Being with her coworkers was like group therapy for Jennifer.

After a few weeks, Jennifer returned to the level of enjoyment she had obtained from her work before this episode. In addition, Helen approached Jennifer to discuss her enrolling in a mentorship program that the hospital had recently established. The mentorship program, similar to an internship, would provide clinical staff members with hands-on management experience. Jennifer did not hesitate; she enrolled in the program the following week. Jennifer was confident that she would be ready when the next opportunity presented itself.

Discuss how Jennifer displayed the frustration–regression principle of Alderfer's ERG Theory.

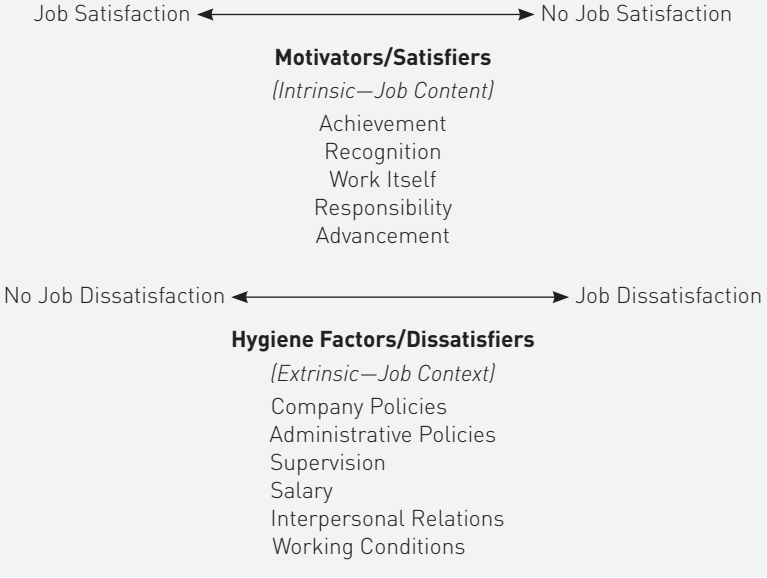
Herzberg's Two-Factor Theory

Frederick Herzberg developed his Two-Factor Theory, also known as the Motivation–Hygiene Theory, from a study designed to test the concept that people have two sets of needs: (1) avoidance of unpleasantness and (2) personal growth. In Herzberg's original study (1959), 200 engineers and accountants were asked about events they had experienced at work that had resulted in either a marked improvement in job satisfaction or a marked reduction in job dissatisfaction. From Herzberg's research (1966), five factors stood out as strong determiners of job satisfaction (i.e., motivator factors) and are related to job content: (1) achievement, (2) recognition, (3) work itself, (4) responsibility, and (5) advancement. The determinants of job dissatisfaction (i.e., hygiene factors) that are related to job context were found to be (1) company policies, (2) administrative policies, (3) supervision, (4) salary, (5) interpersonal relations, and (6) working conditions. It is important to note that Herzberg used the term "hygiene" to describe factors that are necessary to avoid dissatisfaction but that by themselves do not provide satisfaction or motivation (see **Exhibit 6-1**).

Herzberg's research findings are significant to managers because the factors involved in producing job satisfaction are separate and distinct from the factors that lead to job dissatisfaction. As Exhibit 6-1 illustrates, these two factors are not opposites of each other. As Herzberg pointed out, the opposite of job satisfaction is not job dissatisfaction but rather no job satisfaction. Similarly, the opposite of job dissatisfaction is no job dissatisfaction, not satisfaction with one's job.

In a practical sense, this means that dissatisfiers, referred to as hygiene factors, support and maintain the structure of the job (job context), while satisfiers, referred to as motivators, assist employees in increasing their motivation to do their work (job content). Unfortunately, Timmreck's (2001) study of 99 health services middle managers found that only a minority actually believed in and used motivators to stimulate subordinates' behavior.

Exhibit 6-1 **Job Satisfaction**



One of the criticisms of Herzberg's Two-Factor Theory is that a factor may be a motivator for one person but cause job dissatisfaction for another. For example, increased responsibility may be welcomed by one employee but avoided by another. Another criticism has been Herzberg's placement of salary or pay in the dissatisfier category, which has caused some peopleto believe that Herzberg did not value money as a motivator. However, what Herzberg meant was that if pay did not meet expectations, employees were dissatisfied, but if pay met employees' expectations, salary was not a need to achieve satisfaction. This view is reiterated in Daniel Pink's (2011) book *Drive: The Surprising Truth About What Motivates Us*. Pink refers to an employee's salary as a "baseline reward." If this baseline reward is not adequate, then employees will focus on the inadequacy of their remuneration, which will lead to anxiety about their financial circumstances, resulting in very little motivation. Herzberg believed that the absence of good hygiene factors, including money, would lead to dissatisfaction and thus potentially block any attempt to motivate the worker (see **Exhibit 6-2**).

Exhibit 6-2 Stop Demotivating, Before You Start Motivating

When people think about motivating employees, they're usually thinking about ways to reward them. What carrots can be offered to get employees to work harder; what can we dangle in front of them to encourage them to take the actions we desire? There are entire books written on ways to reward our employees, and multimillion-dollar consulting engagements built on those books. They include issues big and small, like money, pay-for-performance plans, flexible shifts, thank-you notes, gift cards, extra days off, promotions, educational opportunities, public recognition, and private pats on the back.

Although rewarding employees is important, it misses a hugely important point. If someone is hitting your foot with a hammer, you can't stop the pain with a backrub. This is an odd bit of folk wisdom, but here's the lesson. In one of our recent studies, 76% of employees said that in the past 12 months, their managers had done things that made them want to quit. And 89% of employees said that their organization had done something that made them want to quit.

Every day, employees face various demotivators, things that cause them to lose their passion for their jobs and even cause them to consider quitting. And before we can try to "motivate" them, we've got to stop "demotivating" them. To make this concept a little easier, instead of talking about demotivators and motivators, we're going to talk about Shoves and Tugs. Shoves are those issues that cause people to lose their passion, enthusiasm, and even consider quitting. Tugs are those issues that get people excited, ignite their passion, and make them committed to staying with an organization or boss.

This tends to be a radical concept for most leaders, so let's walk through an example.

Pat is a nurse at a major teaching hospital. She's worked there for 8 years and thinks it's a great place to work. She loves doing research, and this organization has hundreds of ongoing studies in which she can participate, and even publish. Her major Tug is doing intellectually challenging work with really smart people. But two weeks ago, the hospital instituted flexible work schedules and changed all the shifts. This is causing Pat serious difficulty because she had timed her kids' schedules around her old shift start/end times, and this change disrupts everything. For Pat, this scheduling change is a Shove.

Now, here's the radical part. Before Pat's manager can address her Tugs, they will have to fix her Shoves. When you see Pat's issues described separately as Shoves and Tugs, it becomes pretty clear that she's going to be much less excited about the opportunity to publish as long as her schedule is causing her problems. But because most leaders don't initially separate Shoves and Tugs into two distinct issues, the typical leader will ignore the scheduling issue and just try to give Pat more research work. Or try to buy her compliance with money.

(continues)

Exhibit 6-2 Stop Demotivating, Before You Start Motivating *(continued)*

Shoves are often focused on basic issues like working conditions, schedules, compensation, an acceptable relationship with the boss, and so on. Tugs often encompass higher-order issues like enjoying the work, career advancement, working with interesting people, organizational culture, and so on.

If we had only asked Pat what excited her about her job, what really made her love this hospital, we'd have gotten an answer about doing intellectually stimulating work. And if we had only asked Pat what could make her life sufficiently miserable to cause her resignation, we'd have gotten an answer about her schedule and her outside-of-work obligations. It's only when we ask about both issues that we get the complete picture.

When you're working with low performers, when you're working terrible hours, or you've got a terrible working environment, you could be so frustrated that you feel like you're being Shoved out the door. You could feel so frustrated that you no longer notice all of the other good things about your job that Tug at you to stay—the autonomy, the ability to have control over an entire process, the ability to work on innovative projects and teams. If your organization is like the organizations in our studies, as much as 35% of your workforce could feel this way. And these people are huge retention risks.

On the other hand, you could have a working environment that is free from Shoves, but also lacking in any significant Tugs. You're not being Shoved out the door by frustration, but neither are you being Tugged to remain at the company. And once again, if yours is anything like the organizations in our studies, as much as 50% of your workforce could feel this way. The good news is that these people probably aren't spending their days on Monster.com actively applying for jobs. The bad news is that if the economy changes, or one of your competitors makes a play for them, or they just happen across another opportunity, they will leave.

To get someone really truly committed to your organization, you must first eliminate any Shoves and fulfill at least some Tugs. In essence, you've got to meet their basic needs and afford some opportunity to address their higher-order needs.

Reproduced from Murphy, M. (2008). Stop Demotivating, Before You Start Motivating. Leadership IQ. Retrieved from https://www.leadershipiq.com/stop-demotivating-before-you-start-motivating

Dent (2002) relates that when Herzberg first presented his work, it was very controversial in the academic community but very popular in industry because it helped to answer employers' questions as to why the level of an employee's productivity does not equate to the compensation received.

In the late 1950s, the U.S. economy was experiencing a tremendous upswing. The issue of motivation was critical for retaining good people, who often had several other opportunities. The primary advice coming from industrial psychologists was to motivate through compensation packages. As a result, employers were paying higher and higher salaries but felt that they were not getting higher levels of performance in return. Herzberg's work validated what the employers were feeling. Herzberg suggested that higher performance levels would come not from higher salaries but from giving employees the opportunity to create and affect their own environments (Dent, 2002, p. 276).

Although managers need to provide employees with a reasonable salary, a degree of job security, and safe and comfortable working conditions (hygiene factors), focusing on these matters will not contribute to an employee's motivation or performance improvement (Sashkin, 1996). Herzberg promoted the concept that if the work one does is significant, it will ultimately lead to satisfaction with the work itself. In other words, employees will be motivated to do work that they perceive to be significant (see **Case Study 6-3**).

CASE STUDY 6-3 Why Don't I Just Quit?

Robin Williams sat at her desk, going through her mail, and asked herself the same question she had asked herself a hundred times before: "Why don't I just quit?" Robin thought, "I don't need this job. I have enough money in my savings account to last a year, and with my degree and experience, I could go anywhere." Robin graduated from one of the top schools in the country with a Master of Social Work (MSW) and has been a social worker for the Alpine Medical Center for the past 4 years. Although she loves her interactions with her clients and the ability and freedom to help them through the system, thus enabling them to satisfy their social and medical needs, she is unhappy with the required 60-hour work week for a salary far less than what her friends who graduated with an AS/Nursing degree are earning. In addition, Robin believes that her boss is trying to set her up to be fired just because she told him that he was an incompetent administrator. "Well, he is," thought Robin. He hadn't been able to find the money in the department budget to purchase a new computer that she desperately needed to help her clients. To make matters worse, her coworkers, who "live in their own worlds," never extended the courtesy of asking her to join them for lunch. "Not that I would go with them," Robin thought. "They are just as useless as the director—and didn't they forget that yesterday was my birthday?"

As she thought the issues over in her mind, she opened a thank-you letter from a client she helped last month. He just wanted to tell her how much he appreciated her help through his illness and to say that without her assistance, he would not have known all the community services available to him so that he could remain at home versus being admitted into a nursing home.

Robin smiled and put the card aside. She was still trying to figure out why she didn't quit her job. She wished she knew the answer.

Using Herzberg's Two-Factor Theory, discuss why Robin has not resigned from her position.

To build on this concept, jobs should be designed with special attention for opportunities relating to achievement, responsibility, meaningfulness, and recognition. Pink (2011) relates that organizations need to focus on individuals' intrinsic needs for autonomy (providing employees with the control over some or all of their work), mastery (allowing employees to become better at something that matters to them), and purpose (fulfilling employees' natural desire to contribute to a cause greater and more enduring than themselves).

According to Herzberg, motivation comes from job content. Therefore, it is important for managers to consider the nature of the jobs that they ask their employees to do. Herzberg's approach can be summarized as follows: "If you want people to do a good job for you, then you must give them a good job to do." As Sethi and Stubbing (2019, p. 1) explain, "[P]eople want to do good work, in two ways: (1) they want intrinsically rewarding experiences, and (2) they want to make a contribution that fits their values." Managers need to be concerned with job-design characteristics, including job enrichment. Job enrichment is the vertical expansion or loading of the job as opposed to a horizontal expansion (job enlargement) (see **Table 6-2**). In other words, vertical loading is providing employees more responsible tasks in order to develop their skills.

Job Design

Job-design research in the past three decades has generated many insights into the relationship between job characteristics and job satisfaction. The well-known and widely researched Job Characteristics Model was developed by Hackman and Oldham (1976, 1980) (see **Figure 6-4**).

Table 6-2 Herzberg's Principles of Vertical Job Loading

Principle	Motivators Involved
Removing some controls while retaining accountability	Responsibility and personal achievement
Increasing the accountability of individuals for own work	Responsibility and recognition
Giving a person a complete natural unit of work (module, division, area, and so on)	Responsibility, achievement, and recognition
Granting additional authority to an employee in their activity; job freedom	Responsibility, achievement, and recognition
Making periodic reports directly available to the worker themselves rather than to the supervisor	Internal recognition
Introducing new and more difficult tasks not previously handled	Growth and learning
Assigning individuals specific or specialized tasks, enabling them to become experts	Responsibility, growth, and achievement

Reproduced from Herzberg, F. (1983). One more time: How do you motivate employees? *Harvard Business Review, 81*(1), 93.

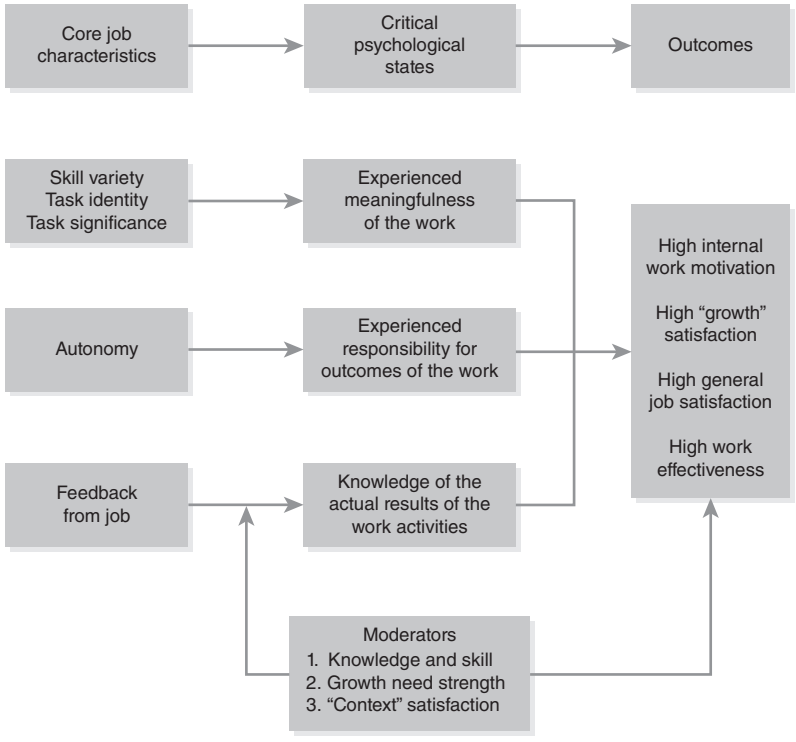


Figure 6-4 The Job Characteristics Model of Work Motivation

Reproduced from Hackman, J. R., & Oldham, G. R. (1980). *Work redesign* (p. 90). Reading, MA: Addison-Wesley.

Hackman and Oldham (1980) listed five core motivational job characteristics:

- *Skill Variety*: The degree to which a job requires a variety of different activities in carrying out the work, involving the use of a number of different skills and talents of the person.
- *Task Identity*: The degree to which a job requires completion of a whole and identifiable piece of work—that is, doing a job from beginning to end with a visible outcome.
- *Task Significance*: The degree to which the job has a substantial impact on the lives of other people, whether those people are in the immediate organization or in the world at large.
- *Autonomy*: The degree to which the job provides substantial freedom, independence, and discretion to the individual in scheduling the work and in determining the procedures to be used in carrying it out.
- *Feedback*: The degree to which the work activities required by the job provide the individual with direct and clear information about the effectiveness of his or her performance (pp. 78–80).

As reflected in Figure 6-4, each core job characteristic or combination of factors leads to critical psychological states for an employee. Hackman and Oldham (1980) relate that the combination of skill variety, task identity, and task significance leads to the psychological state of experienced meaningfulness, in which the worker perceives that the job is significant. Autonomy leads to the psychological state of experienced responsibility for outcomes (i.e., the employee feels individual responsibility for the work), and feedback leads to the psychological state of knowledge of the actual results of work activities. These critical psychological states lead to an employee's high levels of internal motivation, growth, job satisfaction, and work effectiveness (quality and quantity).

Using the moderators in the Job Characteristics Model, Hackman and Oldham (1980, pp. 82–88) attempted to explain why some employees "take off" on jobs that are high in motivating potential and others are "turned off." The first moderator is knowledge and skills. If people have sufficient knowledge and skills to perform their job well, they will experience positive feelings as a result of their work activities. However, people who are not competent to perform their tasks well will experience unhappiness and frustration at work.

The second moderator is growth-needs strength. Some people have strong needs for personal accomplishment, for learning, and for developing themselves beyond where they currently are. These people are said to have strong "growth needs." Other people have less strong needs for growth or personal accomplishment. Therefore, individuals with high growth needs respond positively to the opportunities provided by enriched work. However, individuals with low growth needs might not recognize the existence of enriching opportunities, might not value them, or might find them threatening and complain about being pushed or stretched too far at work.

The third moderator is satisfaction with the work context. Employees who are relatively satisfied with their job context (pay, job security, coworkers, etc.) will respond more positively to enriched and challenging jobs than will employees who are dissatisfied with their job context.

Managers need to pay close attention to the moderators. If an employee is fully competent to carry out the work required by a complex and challenging task, has strong needs for personal growth, and is well satisfied with the work context, then the manager should expect the employee to exhibit high personal satisfaction and high work motivation and performance. If an employee lacks any of these moderators, the opposite results are likely to occur.

To assist managers in designing jobs that will increase motivation for employees, Hackman and Oldham (1975) developed the Job Diagnostic Survey (JDS). The JDS measures the degree to which the various job characteristics are included in the job. The job characteristics can then be altered to enrich the job and increase its motivational potential (Lunenburg, 2011). The JDS generates a

summary score reflecting the overall motivating potential of a job in terms of the core job dimensions (Hackman & Oldham, 1975). The motivating potential score (MPS) is calculated as follows:

$$\text{MPS} = \frac{(\text{skill variety} + \text{task identity} + \text{task significance}) \times \text{autonomy} \times \text{feedback}}{3}$$

The core job characteristics of skill variety, task identity, and task significance are combined, whereas the job characteristics of autonomy and feedback stand alone. Because of the additive and multiplicative relationships of the job characteristics in the MPS formula, one or more of skill variety, task identity, and task significance could be missing or measured as zero, and the employee could still experience the work as meaningful. However, if either autonomy or feedback were missing, the job would offer no motivating potential (MPS = 0) because of the multiplier effect (Lunenburg, 2011, p. 5).

In a recent study, Grant, Fried, and Juillerat (2010) found that job redesign for bank tellers increased both job performance and job satisfaction, with positive effects lasting up to 4 years. Grant and his colleagues' work supports the idea that careful job redesign that increases performance and satisfaction is an important factor not only for employees but also for organizations. Grant's research was conducted at a large bank where managers, using a research survey, found that bank tellers were very dissatisfied with their jobs, stating that they were "just glorified clerks"—micromanaged with boring jobs and no decision-making responsibilities. The bank managers decided to redesign the teller jobs. New tasks were added to provide variety requiring a broad range of skills. The tellers were also given more autonomy in their roles as well as decision-making responsibilities. Job satisfaction increased, and when a survey was administered 6 months later, it showed that the tellers not only were more satisfied with their roles but also were more committed to the organization (Grant et al., 2010).

McClelland's Three-Needs Theory

David McClelland (1985) experimented with individuals' responses to pictures of various groups of people gathered together. On the basis of the participants' responses, McClelland identified three types of motivational needs: achievement, power, and affiliation.

- Achievement (*n*-Ach) is described as the need to excel or succeed. In general, high achievers tend to seek moderately challenging tasks, take personal responsibility for their performance, and require feedback to confirm their successes.
- Power (*n*-Pow) is described as an individual's need to influence others. This can be positive or negative, as we will discuss later.
- Affiliation (*n*-Aff) is described as an individual's need to be liked and approved of by others. As such, *n*-Aff people have a strong need for interpersonal relationships.

McClelland (1985) believed that most people have a combination of these motivational needs, with some exhibiting a stronger tendency to one particular motivational need (e.g., a high power need versus a high achievement need). This tendency affects a person's behavior and management style. For example, McClelland suggested that a high affiliation need weakens a manager's objectivity and decision-making capability because of the manager's need to be liked by their subordinates, colleagues, and supervisors. Although individuals with high power needs are attracted to leadership roles, they might not have the required flexibility and human relations skills necessary to be effective. McClelland argues that individuals with strong achievement needs make the best leaders, although they can have a tendency to demand too much of their staff

in the belief that they are all similarly and highly focused on achievement (i.e., results driven). One interesting aspect of McClelland's theory is that individuals can learn or acquire a need for achievement by being associated with success and failure in the past (and the effect that accompanies success and failure).

Achievement

A significant part of McClelland's research focused on the achievement motivational need (*n*-Ach). Through his research, McClelland concluded that while most people do not possess a strong *n*-Ach motivation, those who do have it display a consistent behavior of moderate risk-taking. To support his theory, McClelland (1985) performed the now famous ring-toss experiment.

Participants played a ring-toss game in which the subjects determined how close or far away they would stand from the peg. One group of participants stood very close to the peg to ensure that they would never miss. Another group stood so far away that if they actually did place the ring on the peg, it was because of chance, not ability. The third group calculated their distance from the peg. They didn't stand so far away as to make the task impossible, nor did they stand so close as to make it too easy. If they missed the first toss, they would move closer; if they made the toss, they would take a step back for the next toss. McClelland referred to the third group as moderate risk-takers—individuals who desired a challenge but whose success was based on their abilities, not chance, as with the second group.

McClelland (1961) relates that *n*-Ach people have various attributes. First, *n*-Ach individuals are not high risk-takers as compared to a gambler who has no control over the outcomes. High achievers are moderate risk-takers. Achievement-motivated individuals set difficult goals, but these are goals that they believe to be achievable through their efforts and abilities. High achievers work harder and more efficiently when the task is challenging and requires creativity, such as designing new systems or just a better way of doing things. Second, *n*-Ach individuals view goal achievement as their reward and require feedback that is quantifiable and factual. They view more money and/or higher profits as the measurement or feedback of their success. Job security is not an important issue for *n*-Ach people. They prefer occupations that allow them the flexibility and the opportunity to set their own goals, such as in sales, business, or entrepreneurial roles. Although high achievers can work in groups, they receive their satisfaction by knowing that they initiated an action that contributed to the group's success.

McClelland (1961) believed that *n*-Ach individuals are the ones who make things happen and get results in an organization. They are successful in obtaining the resources, including employee buy-in, to achieve organizational goals. However, high achievers may be viewed as demanding of staff and insensitive to the needs of others because of their results-driven attitude.

Power

McClelland (1985) relates that a high need for power may be expressed as personalized power or socialized power. Individuals with a high need for personalized power tend to display impulsive aggressive actions, to abuse alcohol, and to collect prestige "toys" such as fancy cars. They seek to control others for their own benefit. Their attitude is "I win, you lose." Individuals with a high need for personalized power demand personal loyalty from staff, not loyalty to the organization. Yukl (2001) points out that when a high personalized power leader leaves an organization, the result is usually chaos, loss of direction, and low morale.

Socialized power need is associated with effective leadership. These leaders direct their power in ways that benefit others and the organization rather than for their own personal gain.

As McClelland (1985) and Yukl (2001) relate, these leaders are interested in seeking power because it is through power that they can influence other people to accomplish tasks. They empower others who use that power to enact and further the leader's vision for the organization.

Affiliation

Individuals with a high need for affiliation seek to be with and interact with others. McClelland (1985) relates that they are concerned with establishing, maintaining, or restoring positive relationships with others. High affiliation individuals want to please others and engage in more dialogue with others. Individuals are very important to *n*-Aff people. They prefer friends over experts when working in groups (*n*-Ach individuals prefer experts over friends as working partners) and prefer feedback on how well the group is getting along rather than how well they are performing on the task. They avoid conflict and criticism and have a fear of rejection by others. Therefore, individuals with a high need for affiliation do not make good managers (see **Case Study 6-4**).

CASE STUDY 6-4 The Office Manager's Dilemma

When Karen Lewis was promoted to office manager for Dr. Green's orthopedic practice, she was thrilled. She had worked for Dr. Green for almost 6 years and considered the office her home away from home and her coworkers as her extended family. Karen was the office organizer for picnics, Friday night get-togethers, and holiday parties. She always made sure that staff members' birthdays and anniversaries were recognized and celebrated. She was very concerned about whether everyone was happy, and she was always available to help other coworkers with any problems.

In addition, Karen was competent in all areas of the office operations. Although originally hired as an X-ray technician, she had performed, at one time or another, the duties of all the positions within the practice. She had covered the receptionist, medical records, and billing staff members' positions when they were on vacation or ill or when there was an unfilled vacancy. Not only was she responsible for running the X-ray area of the practice, but over the years, she had also assumed the responsibilities for ordering supplies and scheduling surgeries.

Karen thought that making the transition to office manager would be easy, and the first few months went well. But in her fourth month, other staff members came to her complaining about Suzie, the new appointment-scheduling clerk. Karen was surprised to hear that Suzie was not doing her job well and that her errors were affecting the entire office operations. Suzie was scheduling patients to come to the office when Dr. Green was at the hospital performing surgery and during staff members' lunch periods. She was also overscheduling, causing patients to wait for hours. Karen told the other office staff members that she would discuss the matter with Suzie as soon as possible.

However, Karen found it very difficult to schedule a meeting with Suzie to discuss the problems. Every time Karen approached Suzie about the subject, she found that her stomach tightened and she began to sweat. The best she could do was to ask Suzie, "How is everything going?" Suzie replied, "Everything is great. I love working in such a warm and friendly office."

A week later, some of the staff members approached Karen again and asked whether she had spoken with Suzie because the problems were getting worse. Karen lied and said that last week was so busy that she did not get an opportunity but that she would talk with Suzie this week. Again, Karen found it difficult to discuss the matter with Suzie. She didn't want to hurt Suzie's feelings because Suzie thought she was doing a good job. However, if she didn't speak with Suzie soon, Karen knew Dr. Green would start to question whether she was capable of handling the duties of the office manager position. She couldn't bear to think that she let Dr. Green down and that he might be displeased with her work. In addition, there were rumors circulating through the office grapevine that if the "appointment-scheduling" problem was not fixed soon, a few staff members were thinking about quitting because the mistakes had caused their workload to increase 20%.

Karen decided that she would discuss the matter with Suzie the following day. Karen asked Suzie to come in 10 minutes before office hours started so that they could have a chat. Karen had a restless night's sleep. When she awoke, she noticed that she had developed a rash over her entire body. She had no choice; she called the answering service to tell Dr. Green and the staff that she was too ill to come to work.

Using McClelland's Three-Needs Theory, discuss whether Dr. Green made the right decision in promoting Karen Lewis to office manager. Why or why not?

Summary

When the content theories of motivation are compared, there are notable similarities (see **Table 6-3**). The theories describe an individual's various needs in similar terms. Herzberg's hygiene factors parallel Maslow's physiological, security, and belongingness needs and Alderfer's existence and relatedness needs. Maslow's self-esteem and self-actualization needs are similar to Herzberg's motivators and Alderfer's growth requirement. McClelland's achievement is closely related to Herzberg's motivators, and his power and affiliation can be related to Alderfer's relatedness needs because of an individual's need to influence (power) or satisfy a need for warm feelings (affiliation) (Alderfer, 1972). It is clear that Maslow's Hierarchy of Needs Theory has had a great influence on the study of organizational behavior and continues to do so even after 60 years (Latham & Pinder, 2005).

Discussion Questions

1. Define motivation.
2. Connect the five tiers of Maslow's Hierarchy of Needs to the workplace.
3. Discuss how Alderfer's ERG Theory satisfied the criticisms of Maslow's Hierarchy of Needs.
4. Explain Herzberg's Two-Factor Theory as it relates to job design.
5. Explain the various components of Hackman and Oldham's Job Characteristics Model.
6. Discuss McClelland's Three-Needs Theory as it relates to a manager's success in the workplace.
7. Discuss the relationship between the various content theories of motivation.

Table 6-3 Comparisons of Content Theories of Motivation

Herzberg's Two-Factor Theory	Maslow's Hierarchy of Needs	Alderfer's ERG Theory	McClelland's Three-Needs Theory
Motivators	Self-actualization	Growth	Achievement
	Self-esteem		
Hygiene factors	Love	Relatedness	Power (influencing others)
			Affiliation (exchange of warm feelings)
	Safety	Existence	
	Physiological		

CASE STUDIES AND EXERCISES

Case Study 6-5 All in a Day's Work

Sarah Goodman, senior manager of network development for Holy Managed Care Company, looked over her calendar for the day and sighed deeply. It seemed as if there would be no time at all to work on the project she'd been putting off for most of the week. Circumstances seemed to be such that she simply didn't have any control over her own time anymore.

Well, first things first, she determined. At 9:00 she was due at a meeting of senior managers who were involved in trying to devise a strategy for counteracting a threatened unionization drive by the company's nonexempt employees. As Sarah thought about the people working for her, she began to wonder exactly what they wanted. They had a pleasant working space, good benefits package, and secure employment. She heard the laughter and chatter drifting into her office as people came into work and thought what a pleasant and congenial group they were. What more could they want?

Then at 10:30 there was another meeting. This one could be very exciting! In 6 months Sarah's office was scheduled to be moved to a new industrial park on the west side of town. The plans she'd seen so far had all kinds of great perks for employees: on-site day-care center, fitness center, ample parking, great facilities for training. The company was certainly spending a lot of money on this new site. Sarah hoped it would help increase productivity; it certainly would make the employees happier and make recruitment easier.

She'd have to hurry to her lunch meeting with the adviser for the MHA program at Saint Thomas University. Sarah had decided as a part of her New Year's resolution that she was finally going to begin her graduate degree. She felt she was simply stagnating in her job and, after looking around at positions in her company that looked interesting, she realized she needed a graduate degree if she were going to progress. The only problem was that she wasn't sure how enthusiastic Richard, her husband, would be about the whole idea. And her mother certainly wouldn't be happy! The hints about grandchildren had become an outright discussion over the holidays.

Discuss the various motivation theories reflected in this case study.

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Case Study 6-6 Develop a Motivation Plan

Jane Couch is the director of nursing for a 400-bed nonprofit hospital in the Southwest. Susan Smith joined the hospital as a staff nurse 3 years ago after relocating from the Northeast. She is 30 years old and has been a staff nurse since graduating from a 2-year college nursing program 10 years ago. She is married to a lawyer, and they have two children, aged 6 and 8.

The hospital's inpatient census has been extremely high because of another hospital's closing. The tension on the nursing floors has increased because of pressures to discharge patients early, lack of professional staff, and an upcoming accreditation visit from The Joint Commission. Because of time restraints, Jane was unable to complete the staff's annual performance evaluations. However, all nurses received a 5% pay increase. With this increase, the hospital staff is now the highest paid of all the hospitals in the region. Jane believes that the higher pay compensates the nursing staff for their increased workload and related stress levels.

Until recently, Jane had been pleased with Susan's performance. Susan had demonstrated a willingness to work hard and had made very few, if any, patient-care errors. However, over the past 3 months, Jane has noticed that Susan is not performing at her usual productivity level and appears to argue frequently with the treating physicians and other nurses about the patients' treatment plans. Jane often hears Susan complaining that "no one listens to me," "no one wants to hear my opinion," and "they don't pay me enough to do this job."

Susan was once a highly motivated, productive member of the nursing staff. Jane understands that everyone is experiencing more stress than usual because of the increased workload, but what can be done to motivate Susan to return to her prior performance?

Within the principles of the content theories of Maslow, Herzberg, and Alderfer, explain to Jane why Susan is behaving the way she has over the past 3 months.

Case Study 6-7 Employees' Motivation Needs

Although cash bonuses can improve physician executive job performance, money isn't too helpful when it comes to improving job satisfaction, a recent survey found.

According to the survey of physician executives, personal growth, personal development, life/work balance, effective communications, and personal relationships are the true keys to improving satisfaction. The informal survey questioned 104 physician leaders and included CEOs, vice presidents of medical affairs, medical directors, department chairs, and consultants. It examined both individual and organizational views of job satisfaction. When asked to describe successful methods of improving job satisfaction for their staff:

- 46% of respondents described improving communications and personal relationships.
- 9% mentioned improving leadership quality.
- Only 3% of respondents stated that bonuses successfully could be used to improve satisfaction at the staff level.

When it comes to dealing with staff, "listen to them and treat them with respect," one survey respondent said. "Give them credit for their help and ideas whenever there is an opportunity, especially in front of my bosses or in a large group. Ask them what they need to do their job better and then try to give it to them. If we can't give it to them, be honest and ask for other suggestions." Another participant said more money is certainly not the answer. "Added pay for added responsibility does not work if they really did not want the responsibility in the first place."

Using Herzberg's Two-Factor Theory, explain the informal survey's results regarding employees' motivation needs.

Reproduced from Matheny, G. L. (2008). Money not key to happiness, survey finds. *Physician Executive, 34*(6), 14–15.

Case Study 6-8 We Only Wanted to Scare Management into Making Changes!

A small group of nurses at a large community hospital were unhappy about their work environment and met daily during lunch to discuss the situation. A recent change in the hospital's senior management was causing a high level of uncertainty and anxiety among the nursing staff. The nurses felt overworked. They were being asked to forgo their break times, work overtime, and take extra on-call work because of the hospital's hiring freeze (which included nursing positions) and the high daily occupancy rate with sicker patients. Their wages and benefits had been stagnant, with no salary increases for the past 2 years, and the cost of living in their community had increased by 10% during this period. They felt that they were falling behind economically. In fact, a few nurses complained that they could no longer afford to send their children to private schools.

The nurses saw the situation as management requiring them to do more work with fewer resources and with no appreciation or recognition of their efforts. In addition, because of recent layoffs of support staff, the nurses were losing precious time caring for their patients each day as they hunted for needed medications and supplies. The nurses felt that these "hunting and gathering" activities threatened patient safety because they took the nurses away from the bedside. The nurses also were tired of the physicians' verbal abuse and disruptive behaviors. Whenever the nurses approached management about these matters, they perceived their concerns as falling on deaf ears, since no changes were ever made.

Feeling that they had no other choice, the nurses contacted a labor union. The labor union began an organizing effort in the hospital shortly thereafter, waging an aggressive campaign over a 6-week period. There was tremendous peer pressure, as some of the well-respected members of the nursing staff became active leaders for unionization, although they had not been among the initial group of nurses

(continues)

Case Study 6-8 We Only Wanted to Scare Management into Making Changes! *(continued)*

who had first contacted the union. The election was held, and the union was voted in by two-thirds of the nursing staff. In the weeks that followed, the original group of nurses remarked that they were surprised by the union's victory; they had only wanted to scare management into making changes to their work environment.

1. Using Maslow's Hierarchy of Needs, diagram the nurses' issues within each level.
2. Explain why the nurses were motivated to contact the labor union using Herzberg's Two-Factor Theory.

Exercise 6-1 Job Survey

Introduction

Objective: To learn how job design affects performance.
Time: About 25 minutes.
Instructions: Take the survey below. Once you have completed it, total your scores. Compare your final score with others in the class and discuss the following questions:

- Normally, persons who are in a position of leadership will have scores that are higher than their workers'. Why is this?
- If your employees were to take this survey today, what do you think their average scores would be?
- Discuss Hackman and Oldham's five dimensions and how they help to motivate a job holder. Ask for a few examples of how a job could be redesigned under each of the five dimensions.

Job Design Questionnaire

Directions: Listed below are some statements about your job. For each statement, write in your response based on how much you agree or disagree with it.

Strongly Disagree	Slightly Disagree	Disagree	Undecided	Slightly Agree	Agree	Strongly Agree
(1)	(2)	(3)	(4)	(5)	(6)	(7)

My job:

- Provides much variety. _____
- Allows me the opportunity to complete the work I start. _____
- Is one that may affect a lot of other people by how well the work is performed. _____
- Lets me be left on my own to do my own work. _____
- Provides feedback on how well I am performing as I am working. _____
- Provides me with a variety of work. _____
- Is arranged so that I have a chance to do the job from beginning to end. _____
- Is relatively significant in the organization. _____
- Provides the opportunity for independent thought and action. _____
- Provides me with the opportunity to find out how well I am doing. _____
- Gives me the opportunity to do a number of different things. _____
- Is arranged so that I may see projects through to their completion. _____
- Is very significant in the broader scheme of things. _____
- Gives me considerable opportunity for independence and freedom in how I do my work. _____
- Provides me with the feeling that I know whether I am performing well or poorly. _____

Summary

Scoring for Job Design Questionnaire

The survey is designed to analyze five dimensions of the job:

- Skill Variety: Total the scores for questions 1, 6, 11 _____
- Task Identity: Total the scores for questions 2, 7, 12 _____
- Task Significance: Total the scores for questions 3, 8, 13 _____
- Autonomy: Total the scores for questions 4, 9, 14 _____
- Feedback About Results: Total the scores for questions 5, 10, 15 _____

The lower scoring dimensions (normally, anything below 15) should be investigated to see whether the job environment can be improved.

About the Survey

Hackman and Oldham's Five Dimensions of Motivating Potential

- *Skill Variety*: The degree to which a job requires a variety of challenging skills and abilities.
- *Task Identity*: The degree to which a job requires completion of a whole and identifiable piece of work.
- *Task Significance*: The degree to which the job has a perceivable impact on the lives of others, either within the organization or in the world at large.
- *Autonomy*: The degree to which the job gives the worker freedom and independence in scheduling work and determining how the work will be carried out.
- *Feedback*: The degree to which the worker gets information about the effectiveness of his or her efforts, either directly from the work itself or from others.

Exercise 6-2

The Healthy People 2020 initiative has identified social determinants of health that are important nonclinical elements affecting the health of individuals. Often, these social determinants can influence whether or not patients will take good care of their bodies, engage in healthy lifestyles, seek preventive care, or address more pressing health concerns before they progress. Often, navigating the complex system of hospitals and insurance takes significant motivation and initiative on the part of the patient. As health care institutions are facing new pressures to care for the health of their populations instead of just handling acute cases that come into the hospital, it is important for administrators to understand what motivates members of the community to take care of their health. Discuss how each of the elements below relates to Maslow's Hierarchy of Needs and how barriers in these areas might affect one's motivation to engage in a healthy lifestyle.

- Economic Stability
  - Employment
  - Food Insecurity
  - Housing Instability
  - Poverty
- Education
  - Early Childhood Education and Development
  - Enrollment in Higher Education
  - High School Graduation
  - Language and Literacy
- Social and Community Context
  - Civic Participation
  - Discrimination
  - Incarceration
  - Social Cohesion

- Health and Health Care
  - Access to Health Care
  - Access to Primary Care
  - Health Literacy
- Neighborhood and Built Environment
  - Access to Foods That Support Healthy Eating Patterns
  - Crime and Violence
  - Environmental Conditions
  - Quality of Housing

More information available at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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CHAPTER 7

Process Theories of Motivation

LEARNING OUTCOMES

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

- The various components of Expectancy Theory and how they affect an individual's level of motivation.
- Equity Theory and the methods to resolve inequity tension.
- The significance of the Satisfaction–Performance Theory.
- Goal-Setting Theory and the steps necessary for successful implementation.
- Reinforcement Theory and the four types of reinforcement.

Overview

Understanding individuals and what motivates them is a conundrum for health care managers, especially since we need to manage such diverse groups of employees. These employees are diverse not only in culture, race, and gender, but also in their varying levels of education. On a daily basis, we need to manage not only secretarial staff who might have minimal education, but also highly skilled individuals such as nurses, physicians, and other licensed health care professionals. Process theories can assist us in predicting employees' behavior so that we may influence their behavior, if necessary.

In this chapter, we examine five theories of motivation: (1) Expectancy Theory, (2) Equity Theory, (3) Satisfaction–Performance Theory, (4) Goal-Setting Theory, and (5) Reinforcement Theory.

Expectancy Theory

One widely cited theory of motivation is Victor Vroom's (1964) Expectancy Theory (also referred to as the VIE Theory). Expectancy Theory suggests that for any given situation, the level of a person's motivation ("force" in Vroom's conceptualization) with respect to performance depends

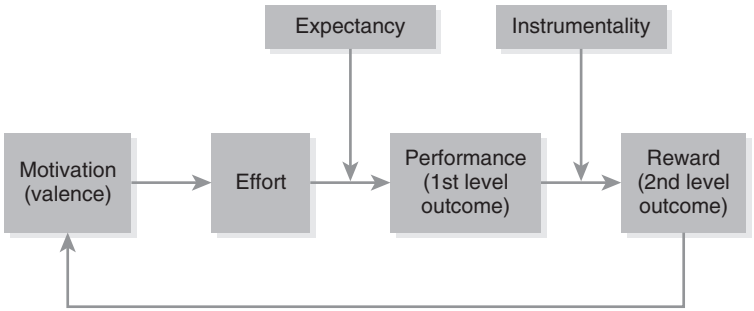

Figure 7-1 Vroom's Expectancy Theory (VIE)

on (1) the desire for a certain outcome, (2) the perception that individual job performance is related to obtaining the desired outcome, and (3) the perceived probability that individual effort will lead to the required performance. The theory may be expressed as $M = V \times I \times E$ (see **Figure 7-1**).

Vroom (1964) explains that the force that drives a person to perform depends on three factors: valence, instrumentality, and expectancy.

Valence is the strength of an individual's want or need for, or dislike of, a particular outcome. An outcome has a positive valence when the person prefers attaining the outcome to not attaining it, a valence of zero when the person is indifferent to attaining or not attaining the outcome, and a negative valence when the person prefers not attaining the outcome to attaining it. Thus, valence can have a wide range of both positive and negative values. The strength of a person's desire for, or aversion to, an outcome is based on the intrinsic properties of an outcome that are valued or not (a second-level outcome in Vroom's conceptualization) and/or on the anticipated satisfaction or dissatisfaction associated with other outcomes that are related to any given outcome (a first-level outcome in Vroom's conceptualization). For example, some workers may value an opportunity for promotion or advancement because of their need for achievement. For these individuals, one outcome, advancement, is positively related to or instrumental with respect to achieving another outcome—achievement. Others might not want the promotion because it would require an additional time commitment and therefore would reduce time available to spend with family or friends. For these individuals, one outcome, advancement, is negatively related to or instrumental with respect to another outcome: need for affiliation.

Instrumentality is an individual's perception that their performance is related to other outcomes, either positively or negatively. It is an outcome–outcome association. In other words, an individual will perform in a certain manner because they believe that behavior will be rewarded with something that has value to the person. For example, an individual might believe that producing both high-quality and high-quantity work will result in recognition (e.g., praise) or a promotion from the person's supervisor.

Expectancy is an individual's perception that their effort will positively influence their performance. It is an action–outcome association. It can be defined as a momentary belief concerning the likelihood that a particular act (effort) will be followed by a particular outcome (performance). Expectancies can be described in terms of their strength. Maximal strength is indicated by subjective certainty that the act will be followed by the outcome, while minimal (or zero) strength is indicated by subjective certainty that the act will not be followed by the outcome. For example,

an individual might perceive that if they work overtime, the management report will be completed by the deadline (maximal strength). However, if the employee perceives the deadline to be unrealistic and not obtainable because of the time required to complete the report, the expectancy strength is minimal.

Newsom (1990) summarized Expectancy Theory with what he termed the "Nine Cs":

1. *Challenge*: Does the individual have to work hard to perform the job well? Managers need to review an employee's job design. Is the job routine and unchallenging? Does it incorporate Herzberg's Two-Factor Theory motivators?
2. *Criteria*: Does the individual know the difference between good and poor performance? Managers need to effectively communicate to an employee the responsibilities and/or requirements of the task and how the employee will be measured as to its successful completion. A manager should not assume that an employee knows the criteria for performing satisfactorily. In addition, managers need to provide feedback so that an employee is aware of what they are doing right and what needs to be improved.
3. *Compensation*: Do the outcomes associated with good performance reward the individual? Nadler and Lawler (1983) discussed the mixed message an organization sends to employees when employees are rewarded for seniority rather than performance. What the organization gets is behavior oriented toward safe, secure employment rather than efforts directed at performing well.
4. *Capability*: Does the individual have the ability to perform the job well? Employees who lack the necessary skills, knowledge, and experience to perform a task well will become frustrated and are likely to avoid future growth opportunities.
5. *Confidence*: Does the individual believe that they can perform the job well? Employees need to believe that they can perform a task well. An employee might have the knowledge and skill but might not see themselves as having the ability to perform the task well. This may be based on past experiences of failure.
6. *Credibility*: Does the individual believe that management will deliver on promises? Managers must deliver what they promised.
7. *Consistency*: Does the individual believe that all workers receive similar preferred outcomes for good performance and similar less-preferred outcomes for poor performance? Managers need to treat all employees equally on the basis of objective criteria.
8. *Cost*: What does it cost an individual in time and effort to perform well?
9. *Communication*: Does management communicate well and consistently with the individual in order to affect the other eight Cs? Managers need to set clear goals and provide the right rewards for different people (see **Figure 7-2**).

For managers, Expectancy Theory is very useful because it helps them to understand a worker's behavior. An employee's lack of motivation may be caused by indifference toward, or desire to avoid, the existing outcomes. Expectancy Theory is based on the assumption that individuals calculate the costs and benefits in choosing among alternative behavioral actions. For example, if an employee wants to move up the corporate ladder, then a promotion has a high *valence* for that employee. If the employee believes that high performance will result in excellent evaluation ratings, then the employee has a high *expectancy*. However, if the employee believes that the organization will not promote from within, then the employee has low *instrumentality* and will not be motivated to perform their job at a high level. So the important question for managers to ask is, "What rewards (outcomes) do my employees value?" (see **Case Study 7-1**).

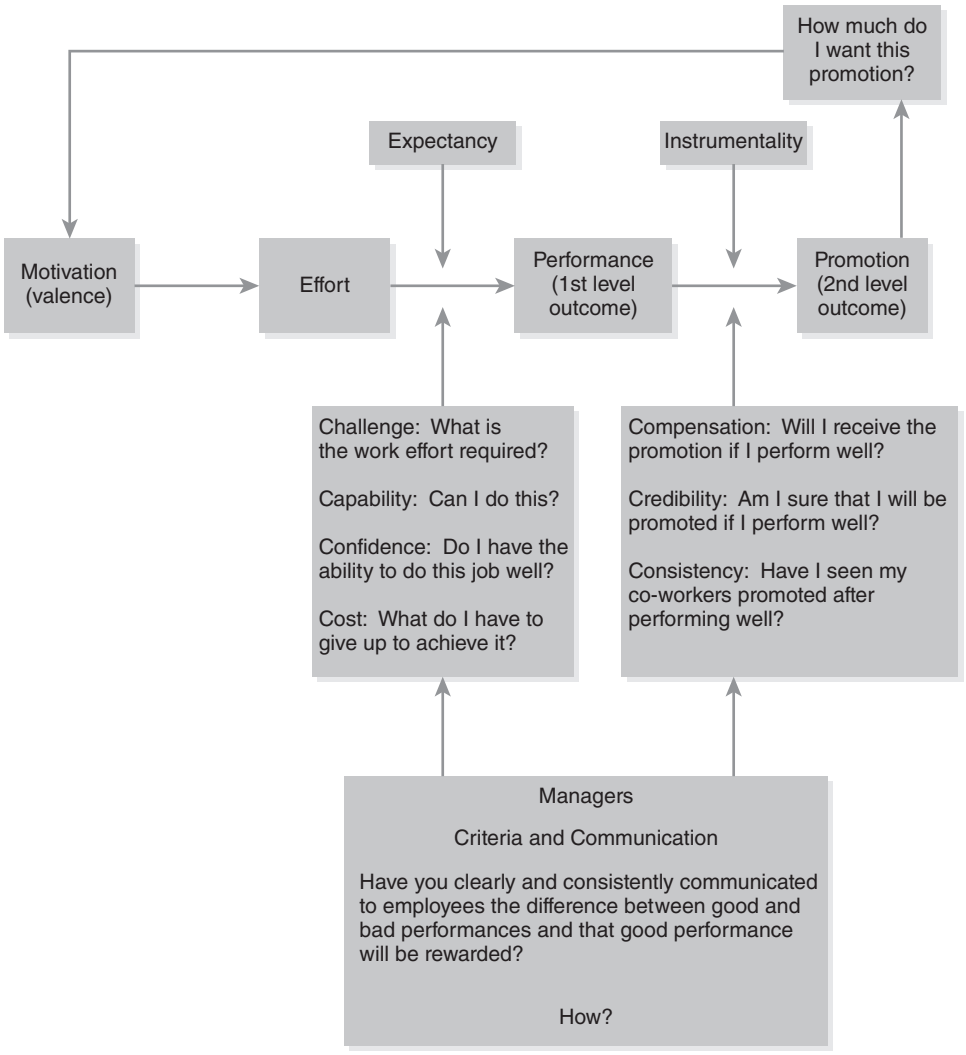

Figure 7-2 Application of Expectancy Theory Using Newsom's Nine Cs

Equity Theory

In his Equity Theory, J. Stacy Adams (1963, 1965) proposed that a person evaluates their outcomes and inputs by comparing them with those of others. Adams's theory is based in the social-exchange theories that center on two assumptions. The first assumption is that there is a similarity between the process through which individuals evaluate their social relationships and economic transactions in the market. Social relationships can be viewed as exchange processes in which individuals make contributions (investments) for which they expect certain outcomes (Mowday, 1983). The second assumption concerns the process through which individuals decide whether a particular exchange is satisfactory. If there is relative equality between the outcomes

CASE STUDY 7-1 Jane Wants to Be an RN

Jane Smith is a 21-year-old single mother of two children, ages 3 and 4 years. She lives in a small apartment and depends on her mother to help care for her family. Jane is saving money to send her children to preschool in the fall. The preschool is located across the street from her mother's house and two blocks from the nursing home where Jane works as a LPN. She works a straight day shift with an obligation to work every third weekend. A grant has been obtained from a national health agency that will provide for full tuition for Jane and others like her to go to school to become an RN. The only drawback to this opportunity is that classes will begin in the fall (it is now June), which means that to take advantage of this opportunity, Jane must attend classes on a full-time basis during the day and still continue to work in her current job but on the evening shift. The program is scheduled to last one full year. The nursing home administrators have stated in a blanket policy that they will allow shift changes to employees who pursue this opportunity. Jane wants to accept the opportunity to pursue her education.

Using Vroom's Expectancy Model, explain Jane's motivation to pursue her education.

Gyurko, C. G. (2011). A synthesis of Vroom's model with other social theories: An application to nursing education. *Nursing Education Today, 31*(5), 507. Reprinted with permission.

and contributions of all parties to an exchange, satisfaction is likely to result from the interaction (Mowday, 1983). If an inequality is perceived, then dissatisfaction occurs, triggering an internal tension within one or more of the individuals. For example, a hardworking, dedicated employee believes that they are paid a fair salary, given their experience and education, until they become aware that other departmental staff members with the same level of seniority and education are paid higher salaries. This new information could cause the employee to become unmotivated, thus lowering their level of productivity.

The two major components in Equity Theory are inputs and outcomes. Inputs are defined as the things that a person contributes to an exchange. In the workplace, an employee's inputs are typically experience, education, efforts, skills, and abilities. Outcomes are those things that result from the exchange, such as salary, bonuses, promotions, and recognition. Adams states that equity exists when the ratio of a person's outcomes to inputs is equal to the ratio of other people's outcomes and inputs (see **Figure 7-3**).

Adams' theory has several important aspects. First, the determination of whether inequity exists is based on the individual's perceptions of input and outcomes, which may or may not be reality. Second, inequity will not exist if the person has high inputs and low outputs, as long as the other person has a similar ratio. Third, inequity exists when a person is either underpaid or overpaid. For example, if employees perceive that they are overcompensated, they may increase their level of productivity. If employees perceive that they are undercompensated, they may either decrease their level of productivity or attempt to obtain additional compensation.

Adams (1965) proposed that when an individual perceives an inequity, (1) it creates tension within the person, (2) the tension is proportional to the degree of inequity, (3) the tension created within the individual motivates them to relieve it, and (4) the strength of the motivation to reduce the tension is proportional to the perceived inequity. Adams states that several cognitive and behavioral mechanisms are available to individuals to reduce the psychological discomfort (i.e., inequity tension) associated with the perceived inequity. He refers to these cognitive and behavioral mechanisms as methods of inequity resolution. The six methods described by Adams are as follows:

1. *Altering Inputs*: Reduce productivity, take longer break times, and use sick days for personal activities.

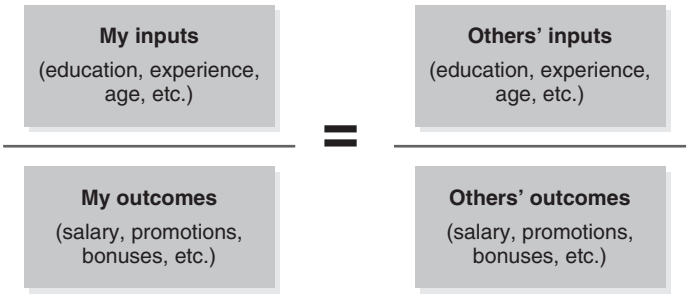

Figure 7-3 Adams's Equity Theory

2. *Altering Outcomes*: Try to obtain an increase in pay, a bonus, or a new job title or resort to taking supplies from the company for personal use (i.e., stealing).
3. *Cognitively Distorting Inputs or Outcomes (Self)*: Describe how much harder he or she is working.
4. *Leaving the Field*: Transfer to another department or quit the organization.
5. *Distorting the Inputs or Outcomes of the Comparison Other*: Describe the other person's job as routine and unchallenging.
6. *Changing the Comparison Other*: Find someone in the organization more like himself or herself—another high-performing worker.

Equity Theory does not predict which method the individual will select. The behavior chosen by the individual depends on the situation with the goal of maximum utility (see **Case Study 7-2**). According to Mowday (1983), the easiest method is trying to distort the other's inputs and outcomes. Leaving the organization will be considered only in extreme cases. Managers need to be aware of how employees perceive inequities in the work environment because individuals will respond to feelings of inequity in various ways. For instance, in general, the level of demotivation displayed by the person will be proportional to the perceived inequity with others. However, for some employees, the slightest indication of negative inequity between themselves and others may cause a high level of disappointment and a feeling of injustice, resulting in demotivation or hostile behavior toward others. Other employees may lower their level of productivity and become disruptive in the workplace, expressing negative attitudes toward management and/or their peers. Others may request additional compensation or more benefits to adjust their output upward or seek a new position that provides for higher levels of outputs. In conclusion, if subordinates perceive that they are not being dealt with fairly, it is difficult, if not impossible, to motivate them.

CASE STUDY 7-2 I Don't Know What to Do

Katie was disgusted with the situation she was in at work. She was seriously thinking about applying for the open RN position in the hospital's ambulatory surgery center just to get away from Beth. Katie has been employed at Good Point Hospital for 10 years. She started in the housekeeping department but knew she wanted more. So she took advantage of the hospital's tuition reimbursement program and returned to school to earn her nursing degree. Katie didn't care that she was 39 years old when she went back school and that it took her 3 long years to earn her associate of science degree. It was worth the time and effort, although it was stressful working full time during the day in the housekeeping department while going to school, especially with three small children at home. But Katie's husband Mike supported her, taking care

of the children and household chores at night and on weekends so that she could attend class or study at the library. She felt very blessed that she could set an example for her children by being the first person in her family to earn a college degree. It has been 4 years since Katie became an RN, and she has enjoyed working in the hospital's intensive care unit (ICU)—until Beth joined the ICU nursing staff last year.

Mike could see that she was very upset. When he asked her what was bothering her, Katie said, "Beth has been working at Good Point Hospital for 2 years and in the ICU for the past year. I am now convinced that she has absolutely no work ethic. Maybe it's part of her being in this new generation—her 24th birthday is next month. She spends half of her shift on the phone or texting with her friends. She calls in sick almost every other Monday or Friday when she is not scheduled for the weekend shift. She's always complaining about how busy she is and how can the hospital's administration think she can get all her work done in a 12-hour shift! Beth's workload is similar to mine. In fact, I have more responsibility than she does, but I always seem to get my work done. Because she never finishes her jobs, it causes more work for me. For example, Beth is always the first one off the floor at the end of our shift and never completes her patients' medical charts, so the nurses from the incoming shift have to ask me to bring them up to date on her patients before they start their shift. I don't mind helping them out, but it usually takes at least 30 minutes, and since the hospital froze overtime, I don't get paid to cover for Beth's laziness! Today she started whining that because I have seniority, I get first pick for vacation time and holidays. I tried to lighten the mood by saying that when I'm gone, she will have the seniority. I had to remind her that I've done my share of holiday shifts, and everyone has to work their way up the ladder. I've spoken to Terry, our manager, about Beth on numerous occasions, but I feel I'm wasting my time. He says he'll talk to Beth, but he never does. I think he's overwhelmed trying to manage the ICU along with the other two departments that were recently assigned to him. I just don't know what to do since I'm not Beth's supervisor. Beth has this attitude of 'I don't want to work, but pay me anyway.' I'm so frustrated with the situation, I'm ready to leave the ICU!"

Using Adams's Equity Theory, discuss Katie's motivation to quit the ICU.

Satisfaction–Performance Theory

One of the major criticisms of Expectancy Theory is that it does not take into account the relationship between employee performance and job satisfaction. Therefore, Lyman Porter and Edward Lawler (1968a) extended Expectancy Theory and incorporated Equity Theory into a model to reflect the relationship of an employee's performance to job satisfaction. Job satisfaction is related to both absenteeism and turnover. This is of great concern to organizations because turnover and absenteeism have a direct influence on an entity's effectiveness (Lawler, 1983). As Lawler points out,

> Absenteeism is very costly because it interrupts scheduling, creates a need for overstaffing, increases costs; turnover is expensive because of the many costs incurred in recruiting and training replacement employees. Because satisfaction is manageable and influences absenteeism and turnover, organizations can control them. By keeping satisfaction high and specifically by seeing that the best employees are the most satisfied, organizations can retain those employees they need the most. (p. 87)

Interestingly, prior to Porter and Lawler (1968a), no motivational model had directly dealt with the relationship between satisfaction and performance (Luthans, 2002). The Porter and Lawler model does not predict who is satisfied; it simply gives the conditions that lead to employees experiencing feelings of satisfaction or dissatisfaction (Lawler, 1983). The researchers believe that performance leads to satisfaction rather than satisfaction leading to improved performance.

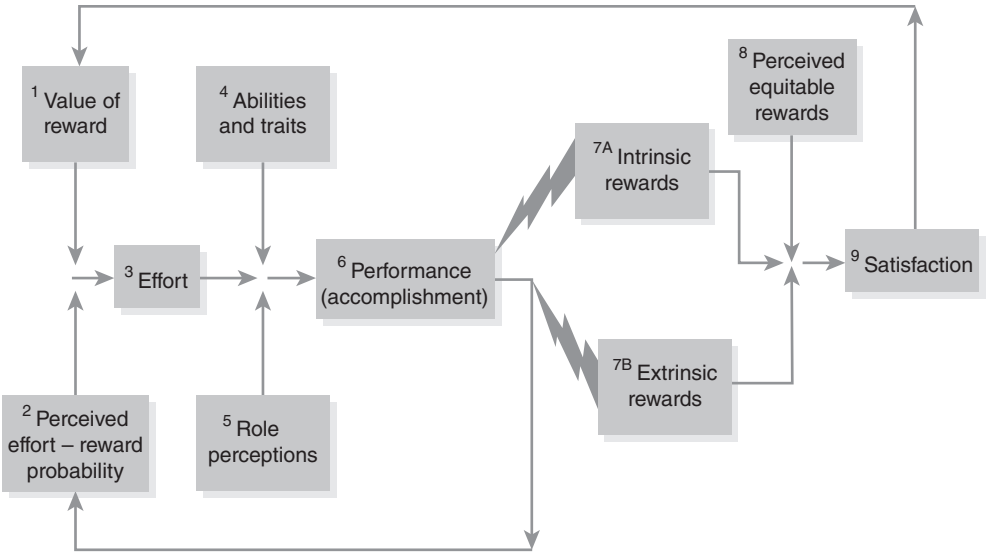

Figure 7-4 Porter–Lawler Satisfaction–Performance Model

The Porter and Lawler model reflects the idea that satisfaction results from performance itself, the rewards for performance, and the perceived equitability of those rewards (see **Figure 7-4**).

Porter and Lawler (1968a) stated that job satisfaction is generated when an employee receives rewards for their performance. These rewards can be intrinsic (e.g., sense of accomplishment) or extrinsic (e.g., bonus). An employee's degree of satisfaction will be proportionate to the amount of rewards they believe they are receiving.

An important aspect of Porter and Lawler's theory is the fact that the amount of the reward an employee receives may be unrelated to how well they have performed (e.g., pay increases based on seniority or labor union agreements). For employees whose rewards are tied to factors that are beyond their control versus receiving rewards based on how well they perform, there will be little or no correlation between satisfaction and job performance. However, if an employee holds a position (e.g., manager) in which rewards are received on the basis of the quality and quantity of the employee's performance, there would be a correlation between satisfaction and performance. Porter and Lawler's (1968a, b) research confirmed this hypothesis. The researchers found that managers who are ranked high by their supervisors report significantly greater satisfaction than do the low-ranked managers. More important is that, although the best-performing managers did not report receiving any greater extrinsic rewards (e.g., pay and security) as compared to their counterparts, they did report receiving greater intrinsic rewards (e.g., expressed autonomy and the ability to obtain self-realization in the job). Therefore, the question is, "Does the organization actively and visibly give rewards directly in proportion to the quality of job performance for all of its employees?" If the answer is yes, then high satisfaction should be more closely related to higher performance if the employees value the rewards distributed.

The Satisfaction–Performance Model tells us two things. First, if an individual is attracted by the value of the reward, if they perceive that a higher degree of effort on their part will lead to those rewards, and if the employee has the necessary abilities and accurate role perceptions, then

higher performance will result. Second, if the intrinsic and extrinsic rewards an employee receives for higher performance are perceived as equitable, then satisfaction will result—satisfaction being the difference between perceived equity and actual rewards.

Job satisfaction is a complex and multifaceted concept. It is circumstantial and subjective for each employee and situation being assessed.

Goal-Setting Theory

In the 1960s and 1970s, Gary Latham and Edwin Locke (1983) performed a number of laboratory and field research studies that determined that participants who were given specific, challenging goals outperformed those who were given vague goals such as "Do your best." For example, in a 1974–1975 study, Latham found that unionized truck drivers increased the number of logs loaded onto their trucks from 60% to 90% of the legal allowable weight as a result of setting goals. They saved the company $250,000 in 9 months. In 1982, another group of unionized drivers saved $2.7 million in 18 weeks by adhering to assigned goals of increasing their daily trips to the mill (Locke & Latham, 2002, p. 711). On the basis of their studies, Latham and Locke developed a goal-setting model. Although goal setting is a simple concept, it requires careful planning and forethought on the part of the manager (see **Figure 7-5**). A goal is the aim of an action or task that a person consciously desires to achieve or obtain (Locke & Latham, 2002, 2006). Goal setting involves the conscious process of establishing levels of performance in order to obtain desirable outcomes.

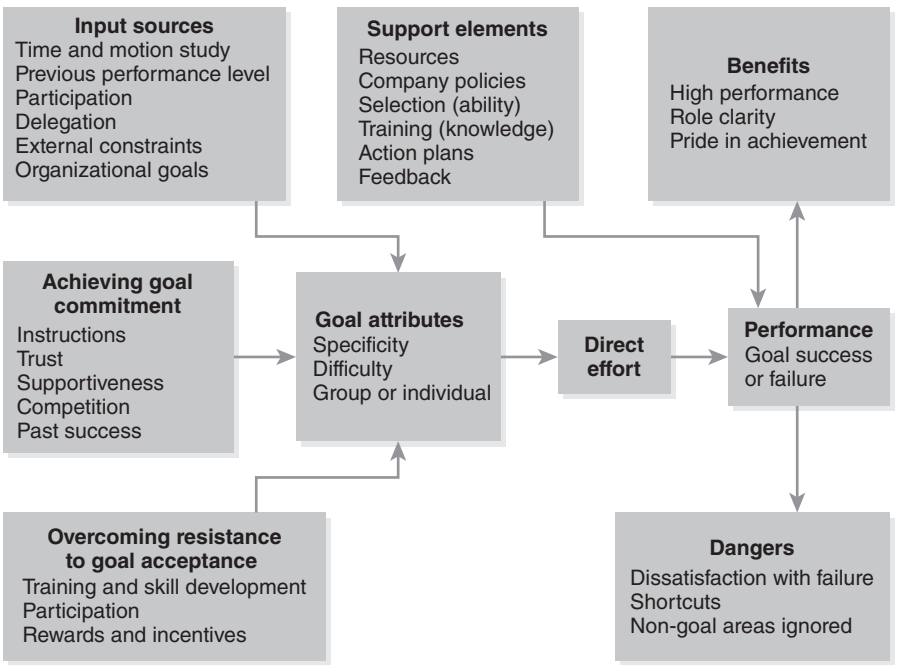

Figure 7-5 Latham and Locke's Goal-Setting Model

Reproduced from Latham, G. P., & Locke, E. A. (1979). Goal setting—A motivational technique that works. *Organizational Dynamics, 8*(2), 68.

Latham and Locke suggest that there are three steps to be followed in successful goal setting: (1) setting the goal, (2) obtaining commitment to the goal, and (3) providing support elements.

1. *Setting the Goal*: The goal that is set should have two main characteristics. First, it should be specific, rather than vague, and measurable. For example, a goal statement such as "Increase elective outpatient surgeries by 5% within the next 6 months" is specific, with a time limit for goal accomplishment. Second, the goal should be challenging yet reachable. Difficult goals lead to better performance. However, two points need to be made. For employees with low self-confidence or ability, goals should be set at a level that is easy and attainable. For employees with high self-confidence and ability, goals should be made difficult but attainable. In either case, if employees perceive the goals as unattainable, they will not accept them and performance will not improve. In fact, the employees will experience dissatisfaction and frustration. Managers need to be conscious that setting unattainable goals may cause employees to view management with suspicion and distrust.

   Latham and Locke stated that there are five possible methods, in addition to an employee's confidence and ability levels, that managers may use to determine goals for an employee. First, the manager could use time-and-motion studies to set an appropriate goal level. A second option, which would probably be more readily accepted, would be setting future goal levels on the basis of the average past performance of the employee. However, if the employee's past performance was unacceptably low, upward adjustments would need to be made. A third option would allow for the supervisor and subordinate to jointly set the goal. This participative approach has the advantages of being readily acceptable by both parties and promotes role clarity. The fourth method may be determined by external sources. This is very common in the health care industry; because third parties determine reimbursements, the goal is to deliver service at the lowest possible cost without reducing quality. The fifth method is determining individual goals that correspond to the long-term goals of the health services organization as determined by the organization's board of trustees.
2. *Obtaining Commitment to the Goal*: If goal setting is to be successful, the manager needs to ensure that subordinates will accept and remain committed to the goals. Appropriate pay (i.e., rewards) with the manager's supportiveness is usually sufficient for goal acceptance and commitment by the employee. Employees receive a feeling of satisfaction for reaching challenging, fair goals, which tends to reinforce acceptance of future goals.

   Generally, employees resist goals for two reasons. First, they might perceive themselves as being incapable of reaching the goals. To overcome this resistance, managers need to provide training to improve employees' skills and knowledge, thereby increasing their self-confidence that the goal can be achieved. Second, employees might not see any relationship between their personal benefits (i.e., feeling of accomplishment or external rewards) and attaining the goals. Managers may use a participative approach so that employees have a feeling of control over the situation. Reward systems must be in place to directly compensate employees for reaching the agreed-upon goals.
3. *Providing Support Elements*: Managers must ensure that employees have adequate resources (e.g., financial, equipment, time, assistance) to reach their goals. Furthermore, company policies and procedures must not create barriers to employees' goal attainment. Employees need to trust that managers are supporting, not undermining, their efforts. For example, perhaps the company's goal is to have employees trained in new safety protocols. However, the manager's bonus depends upon the organization's financial performance, not the employee's implementation of the safety procedures. Therefore, the manager might not be motivated to allow employees to stop their daily tasks to complete the training (Fusion, n.d.).

Managers need to provide employees with an action plan of agreed-upon goals and rewards so that there is no ambiguity in the process. In addition, feedback is essential. Employees must have access to information as to the status in their goal attainment. Finally, Latham and Locke point out that goal setting is not a solution for problems due to poor management or for poor compensation of employees.

Reinforcement Theory

Reinforcement Theory is based primarily on the work of B. F. Skinner (1953), who experimented with the theories of operant conditioning. Skinner's research found that an individual's behavior could be redirected through the use of reinforcement. Reinforcement Theory suggests that an employee's behavior will be repeated if it is associated with positive rewards and will not be repeated if it is associated with negative consequences. Although Reinforcement Theory is not a motivation theory (at least not in the context we have been discussing), it does help managers to understand and influence, when necessary, behavioral change by the reinforcements they use. Reinforcement is a behavioristic approach, which argues that reinforcement conditions behavior (Robbins, 2003). Since reinforcement is an important means of understanding what controls an individual's behavior, it is included in motivation discussions (see **Figure 7-6**) (Robbins, 2003; Tosi & Mero, 2003).

There are four types of reinforcement: positive, negative, punishment, and extinction.

Positive reinforcement occurs when a desirable outcome is associated with a behavior. Desirable outcomes can be simple and symbolic, such as words of praise, a certificate of accomplishment, or a month's use of the parking space directly outside the hospital's main entrance. To fully appreciate its effect, managers should use positive reinforcement only when an employee displays the desired behavior. For example, the director of nursing has attempted to reduce the turnover time (i.e., time required to set up an operating room [OR] after each surgical procedure) of the hospital's ORs to improve the efficiency of the department. The OR nurses formed a task group, and after many months and careful planning with full cooperation of the physicians and support

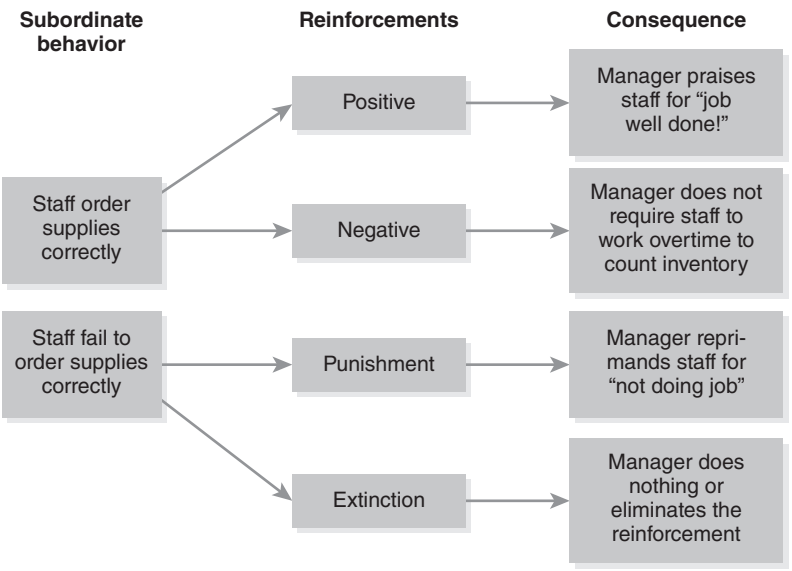

Figure 7-6 Reinforcement Theory and Types of Reinforcements

staff, the daily turnover time decreased by 15% within a 6-month period. The decrease in OR turnover time allowed for one additional case to be scheduled per day. The director of nursing recognized the team's accomplishment by publishing it in the health system's newsletter and hosting a thank-you lunch for the department.

Negative reinforcement occurs when an unpleasant effect is eliminated or avoided, which, like positive reinforcement, encourages repeated positive behavior. In our OR example, the nurse responsible for ordering surgical supplies, by working with the hospital's technology department, designed an inventory system using bar codes that alert her when supplies are at a reordering level. With the use of technology, the system automatically transmits a message that an order must be placed to the purchasing department. By designing and implementing the new inventory ordering system, the nurse has eliminated her need to work overtime counting inventory and has eliminated the negative consequences (e.g., unhappy patients and physicians, lost revenues) that occur when a surgery case has to be canceled and rescheduled because the hospital did not have the necessary supplies on hand.

Punishment can come in two forms: negative consequences and positive consequences, both undesirable. A negative consequence is an undesirable response to an employee's behavior that is intended to stop the behavior from being repeated. For example, an OR nurse who is responsible for ordering supplies was reprimanded by the department's manager when she failed to place an order for a required surgical instrument, causing an OR case to be canceled. (This reprimand motivated the OR nurse to design an inventory system so that the situation would not occur again.) A positive consequence occurs when something desirable is removed from the employee. For example, when the OR nurse failed to order the necessary surgical instrument, the department's manager required them to update the inventory supply list within 24 hours, which meant that they had to work on their scheduled day off and cancel their trip to Disney World.

Extinction is defined as the removal of an established reinforcement (positive or negative) that was previously used to reinforce an employee's behavior. This removal may weaken an employee's future behavior. For example, one hospital's OR department had a policy that if the room charge nurse's surgical cases started and ended on time (measured on a weekly basis), they would receive a $50 certificate to a local restaurant. When there was a change in the hospital's senior management, this positive reinforcement was abruptly eliminated and the following message was issued: "It is your job to make sure the OR is run efficiently, which includes having the cases start and end on time. Therefore, we are eliminating the previously awarded gift certificate. If you have any questions regarding this new policy, please contact your manager."

Managers need to be careful about the administration of punishment reinforcements. Unless it is done carefully and appropriately, the effects can cause long-term consequences for the organization. Punishment can cause employee resentment, hostility, and turnover. Managers should punish only undesirable behavior and be very clear as to what constituted the undesirable behavior when discussing the situation with the employee; give reprimands or discipline actions as soon as possible after the behavior has occurred; administer punishment in private; and, when possible, combine negative and positive reinforcements.

Reinforcement schedules refer to the timing and frequency with which the consequences are associated with behavior. The scheduling of the reinforcement is important because the frequency will determine the time it takes to learn a new behavior (Tosi & Mero, 2003). Reinforcement schedules can be continuous, fixed interval, variable interval, fixed ratio, or variable ratio.

- A *continuous* reinforcement schedule requires the specific employee's behavior to be reinforced each time it occurs (e.g., the chief executive officer rewards all employees every time the hospital passes its Joint Commission accreditation). Research suggests that continuous reinforcement is the fastest way to establish new behaviors or to eliminate undesired behaviors.

- In a *fixed-interval* reinforcement schedule, the reinforcement is administered at predetermined periods (e.g., annual performance appraisals, weekly paycheck). A fixed-interval reinforcement schedule does not appear to be a particularly strong way to elicit desired behavior, and behavior learned in this way may be subject to rapid extinction.
- A *variable-interval* reinforcement schedule allows reinforcements to be administered at irregular intervals (e.g., special recognition for successful performance, promotions to higher-level positions). This reinforcement schedule appears to elicit desired behavioral change that is resistant to extinction.
- A *fixed-ratio* reinforcement schedule requires the reinforcement to be administered after a predetermined number of behaviors have occurred (e.g., sales commission based on a number of units sold). Fixed-ratio reinforcement schedules can produce high rates of responses that continue as long as the reinforcement has value to the employee.
- A *variable-ratio* reinforcement schedule is evident when the number of behaviors necessary for reinforcement varies (e.g., bonuses or special awards that are applied after varying numbers of desired behaviors occur). Variable-ratio reinforcement schedules appear to produce desired behavioral change that is consistent and very resistant to extinction. (Tosi & Mero, 2003).

Consider the following scenario:

A hospital CEO is discussing his facility's experiences at trying to effectively manage the ordering and tracking of supplies in the hospital's OR department.

"We started looking at some product line assessments. As an example, a couple of years ago we met with two different groups of ophthalmologists to look at their costs on a case-by-case basis. We then compared what they used and might use, and determined the areas in which we might be able to standardize products and equipment… We had the ophthalmologists work with vendors and use a case supply cap, and we saved some money that way. Recently though, we've noticed that some of the ophthalmologists are drifting back to their old routines again, so I think this is something that you can't just do once and expect it to manage itself."

What reinforcement schedule would you advise the CEO to use in the future? Why?

Summary

In this chapter, we discussed various process theories of motivation. These motivation theories help health care managers to predict employee behavior. Managers can then effectively influence that behavior, achieving organizational success through increased job satisfaction.

Discussion Questions

1. Discuss the various components of Expectancy Theory.
2. Explain Newsom's Nine Cs.
3. Discuss the two components of Equity Theory.
4. Explain the methods of inequity resolution.
5. Discuss the significance of the Satisfaction–Performance Theory.

6. Explain how the Satisfaction–Performance Theory relates to Expectancy Theory and Equity Theory.
7. Discuss the three components of the Goal-Setting Theory.
8. Explain how goals can be determined under the Goal-Setting Theory.
9. Explain management's responsibilities under the Goal-Setting Theory.
10. Explain why we include Reinforcement Theory in motivation discussions.
11. Discuss the types of reinforcements that are available to managers for changing an employee's behavior.
12. Discuss the various reinforcement schedules and why their timing and frequency are important.

CASE STUDIES

Case Study 7-3 What Can Joe Do About Betty?

Just before quitting time, Joe, the hospital's health information department manager, watched his three new trainees struggling with the complicated electronic medical records software they had to learn to use to do their jobs. Across the room, Betty, who was an expert with the software, was preparing to leave for the day, her tasks done ahead of time as usual. Also as usual, she gathered up her belongings and left without saying good-bye to any of her coworkers. "There goes the answer to my problem," thought Joe, "if only I knew how to reach her." With her expertise and experience in using the system, Betty would seem to be an ideal coach for the new employees. However, she had begged off from taking on training duties when Joe had asked her. Her reasons were that she wasn't comfortable telling anyone else what to do, didn't want the responsibility for someone else's work, and preferred to work by herself at her own job.

Joe was stunned by her refusal. He enjoyed helping his coworkers and thought that it was why he had advanced to department manager last year instead of Betty, who had more seniority and experience with the company than he did. Since her work was excellent, Joe hesitated to make it an "either you do what I want or you're in trouble" situation; he believed that employees worked best at what they wanted to work at. But his problem still remained: There was no money in the training budget, and there were no other employees as skilled with the system as Betty was. Was there an approach he hadn't thought of that he could use to convince her to help?

As Betty walked to the hospital's parking lot, she thought, "How could Joe think I would lift a finger to help him? I should have been the one promoted to department manager last year, not him. I'm the one with seniority and the necessary experience. In fact, I was the one who trained Joe when he first joined the hospital! Just because he has a master's in health information management and I should not have been the determining factor, but obviously senior management thought so when they selected him over me. I could care less what happens from this point forward. I only have five more years until I can retire with my full pension. As long as my work continues to be excellent, there is no way Joe can upset my plans. Not that he could, since he hardly understands the complexity of the software we use. It requires a person with a lot of technology knowledge and experience."

Using Vroom's Expectancy Theory (VIE), explain Betty's lack of motivation.

Case Study 7-4 How Much Longer Can Alice Continue Working for MGM Healthcare?

Alice has been a business/finance trainer for MGM Healthcare Consulting Group's clients for 3 years. Until recently, she enjoyed her job responsibilities and coworkers, and although she would like to earn more money, she believes that her salary is fair compensation for her duties, experience, and education. Alice's first career choice was to be a teacher, so she especially likes the ability to teach others about her second passion: the business side of health care. She has an MHSA degree, certification as a health care

finance professional through HFMA, and a lean Six Sigma Green Belt. Alice has been recognized by her director for her excellent work each year.

As a trainer, Alice needs to travel extensively 8 months of the year to clients' facilities throughout the United States. During this period, Alice works 12-hour days, 6 days a week. During her nontraveling months, Alice is in the office preparing new training manuals and conducting educational webinars for existing and potential clients. During this period, she works three and half days a week but collects a full paycheck. Alice has been fine with this schedule because she enjoys what she does and she feels that, in the end, it all balances out. Also, although she has never requested time off during the traveling months, her director has said that she would cover for Alice if the need arose.

Just as Alice's latest traveling period began, she found out that her mother will need surgery next month, which will require a 2-day hospital stay and complete bed rest for a week. Alice's father is available to help with the situation, but Alice and her mother are very close, and Alice wants to be there to take care of her mother while she is recuperating. Alice tells her director immediately about her family situation, but her director refuses to accommodate her request, telling Alice that because the office is short staffed, there is no one to cover her clients' training requirements during that week. Alice becomes frustrated and angry because she has never asked for time off during her traveling period, and now she will not be able to help her mother.

Another issue that has frustrated Alice from the beginning is how her director micromanages her and other coworkers when they are in the office during the nontraveling period. All changes to the training manuals, the content of the educational webinars—essentially everything—has to be approved by the director before it can be finalized. This has caused deadlines to be missed, resulting in client complaints. Alice feels that this affects her reputation with existing clients in addition to affecting the bonus money she would have received for signing up new clients to participate in the educational webinars. She has also felt frustrated with the lack of growth opportunities within the consulting company. The organization is small, so after working for the company for 3 years, she has already reached the top position and pay scale below the director level.

Although Alice enjoys working with her clients and coworkers, she has become dissatisfied with her job and no longer feels committed to doing whatever it takes to get the job done. She is starting to resent having to give up her weekends for 8 months of the year, her director's delays that cause her to lose bonus money, and the lack of growth opportunities. She doesn't know how much longer she can continue working for MGM Healthcare Consulting Group.

Using Porter–Lawler's Satisfaction–Performance Theory, discuss Alice's job dissatisfaction and lack of motivation.

Case Study 7-5 Problems in the Purchasing Department

Employees in the purchasing department of a large hospital were suffering from lack of motivation. On the day shift, there had always been a few employees who were less productive than others. The other employees would have to pick up the slack to ensure that all supplies for the hospital were ordered on a timely basis. This would cause the departmental staff who were performing their jobs properly to become frustrated and angry because the other employees were not being held accountable for their low levels of productivity. There was clearly a disconnect between what was expected of all employees and what was actually being done.

Jack and Chris consistently worked hard and consistently exceeded the requirements of their jobs. They made sure that all daily requests for supplies were ordered so that there was not backlog to deal with at the beginning of each shift. However, they started to notice that Page and Betty were spending more time doing things other than their assigned jobs in the purchasing department.

Jack and Chris became less motivated to work as hard because they felt that they were picking up the slack for undeserving coworkers. The overperformance levels for the department began to fall. Backlogs started to increase, as did complaints from the other functional units of the hospital when requested

(continues)

Case Study 7-5 Problems in the Purchasing Department *(continued)*

supplies were not received in a timely fashion. Some surgical cases had to be canceled and rescheduled because the proper supplies were not available for the surgeons. Something had to be done!Using the Goal-Setting Theory, create a plan that will motivate all the departmental staff to work to their full potential and perform more efficiently.

Case Study 7-6 How to Motivate Physicians to Improve Compliance

A hospital, located within a highly competitive market, is concerned over a decline in its performance on national quality indicators. Although many members of the medical staff are cooperative and compliant with the required documentation, a group of physicians don't seem to understand the importance of these measures. When either the hospital administration or members of the medical staff leadership confront these physicians, they often state they will try harder to be compliant, but ultimately don't change their behavior. Others simply choose to ignore letters sent to them or any attempts to discuss their noncompliance. Frustrated by the lack of cooperation by these physicians, the hospital and medical staff leadership decide to get tough on enforcement. They design a tiered response system. Physicians who do not meet the documentation requirements will be sent a warning letter. Failure to improve or respond will result in temporary loss of privileges. Continued lack of compliance will lead to loss of privileges.

Will this punitive system work to motivate physicians to improve compliance? If not, why not? Develop recommendations as to how to motivate these physicians to improve their compliance.

Reproduced from Tarantino, D. P. (2008). If you want to motivate physicians, you have to understand and fulfill what drives human behavior. *Physician Executive, 34*(5), 84–85.

Case Study 7-7 All in a Day's Work

Sarah Goodman, senior manager of network development for the Holy Managed Care Company, has just returned from a lunch meeting with the adviser for the MHSA (Master's of Health Services Administration) program at State University, and now she is back on the job attending more meetings. At 1:30 P.M. she has a meeting to discuss pay issues. The Human Resources Department has evaluated the salary picture for the entire organization and is concerned that women are not being paid as well as men. They want input on a strategy to bring the pay issue into line so as to avoid a gender discrimination charge. Personally, Sarah wondered if she got paid as well as Dave, her counterpart in Tampa. Certainly she has been there as long and worked about twice as hard as he seems to! He does seem to benefit from the "good old boy network," however.

At 3:00 there is a performance appraisal Sarah had scheduled with her assistant Maria. Sarah wasn't sure what to do about Maria. Her work was terrific from the standpoint of accuracy and amount. As long as she got a pat on the back pretty frequently, Maria was an ideal employee in a lot of ways. Sarah knew that Maria would be prepared for the interview, including her goals for the next six months. The problem was that Sarah really wanted to get Maria more involved with others in the department. If she wasn't able to get Maria ready to assume her position, how could Sarah ever hope to be promoted? Productive as she was, Maria just wasn't a "people person."

Then at 4:00, there is another performance appraisal scheduled. This one was going to be difficult. Janine was a fairly new employee and Sarah loved the work she produced, but she didn't think she'd ever seen a more uptight person! She seemed to need to be told at each step what to do next and worried constantly about breaking the rules. Sarah had begun to think Janine had even invented some new rules! Last week, for example, Sarah had asked Janine to stay a little late to finish a project. She didn't discover until the next day that Janine had been late picking up her baby from the babysitter. Certainly overtime wasn't required, and Sarah felt bad about causing the problem. She could have asked someone else to do the work, but thought it might be a way of encouraging Janine to "get out of the box" a little.

By the time the meetings were over, Sarah figured she'd just have time to return her phone calls and scan the mail before it was time to go home. She'd promised Richard something special for dinner, mostly because she was planning to tell him about graduate school. The traffic would be awful, and she needed to stop by the store on the way. "Oh well! It's all in a day's work," she thought.

Discuss the various motivation theories reflected in this case study.

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Case Study 7-8 Why Aren't My Employees Motivated?

Roger Harris is the founder and managing partner of a large health management consulting firm that specializes in strategic planning for hospitals. The firm has six partners, including Roger, and 20 professional staff members (all with graduate degrees in health administration). The staff, which is evenly divided between males and females, consists of single and married individuals between 25 and 35 years of age. Of the 10 married staff members, two of their spouses work outside the home. All the married individuals have families of at least two children, and all the children are under 10 years old.

The philosophy of the firm is to serve the needs of its clients and have fun serving those needs, all while making a profit. Because of the tight labor market, the firm's salaries for its professional staff are well above the market rate in order to attract and retain the best talent. In addition, each employee has a private office, breakfast served daily, free weekly car washes, and their dry cleaning delivered to the office. The firm also offers the staff home computers if they prefer to work at home on weekends during the firm's busy time, which usually runs from October to May.

During the busy period, staff members are required to work approximately 55–60 hours per week. They receive 2 weeks of vacation annually, in addition to 1 week for continuing professional education and 1 week for personal time, which is utilized by 100% of the staff. Roger was concerned because, although the partners' billable hours (i.e., hourly rates charged to clients for services rendered) had increased 12% over the past 2 years, the staff's billable hours had decreased by 14%. In addition, the turnover rate (i.e., the percentage of the newly hired graduates who stay with the firm for approximately 3–4 years before taking a position in one of their client's hospitals) had increased to 50% (from 10% 5 years earlier).

In order to increase the firm's productivity and retention rate, Roger initiated a bonus program as follows: If a staff member billed out 2000 hours annually, they received a bonus equal to 5% of their annual salary. For every hour billed over the minimum 2000 hours, the employee would be paid twice the hourly rate.

Under the new program, all employees earned the 5% bonus, but no one's productivity increased over the minimum 2000-hour base.

Roger was concerned by this lack of improvement in productivity and the turnover rate. Thinking that the staff needed outside professional recognition, he encouraged everyone to publish articles for the various health management journals discussing aspects of their most interesting cases. All staff members were willing to do so, as long as the time required to develop the articles would be applied toward their minimum 2000 hours' bonus calculation.

Roger also told the staff that anyone who demonstrated technical competence and the ability to attract and retain clients to the firm would have the opportunity to become a partner. Even though individuals from the outside had filled the last two senior management-level positions, four of the six partners had been promoted from within (after 8–10 years of continuous employment with the firm). However, the most recent promotion to partner was made to an individual who had been hired from the outside after only 3 years of employment with the firm.

Roger thinks that the consulting firm is a great place to work, with interesting and challenging cases, an excellent compensation package, and growth opportunity. He cannot understand why the staff's productivity continues to decline and the turnover rate continues to increase.

Using Expectancy Theory, explain to Roger why nonpartner productivity level is low and why the firm is experiencing a high turnover rate among its professional staff.

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CHAPTER 8

Attribution Theory and Motivation

Paul Harvey, PhD, and Mark J. Martinko, PhD

LEARNING OUTCOMES

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

- The basic premises of attribution theory.
- The differences between optimistic, pessimistic, and hostile attribution styles.
- The role of attributions, emotions, and expectations in motivating employees.
- Techniques that managers can use to promote accurate and motivational attributions.

Overview

In this chapter, we discuss how attribution theory is used to provide managers with a better understanding of the highly cognitive and psychological mechanisms that influence employees' motivation levels. The chapter begins with an overview of attribution theory. We then discuss the different attribution styles that can bias the accuracy of causal perceptions, potentially undermining the effectiveness of motivational strategies. We then describe the impact of attribution-driven emotions and expectations on motivation. This is followed by an overview of techniques that health care managers can use to promote motivational attributions among employees.

Attribution Theory

Before we describe the basic tenets of attribution theory, it is useful to understand exactly what is meant by the term "attribution." An attribution is a causal explanation for an event or behavior. For example, a nurse who observes a colleague performing a procedure incorrectly is likely to try to form an attributional explanation for this behavior. The nurse might conclude that the

colleague is poorly trained; thus, the observer is attributing the behavior to insufficient skills. People also form attributions for their own behaviors and outcomes. For example, a physician might attribute their success in diagnosing a patient's rare disease to their intelligence and training or to good luck.

People typically engage in the attribution process countless times each day. For many of us, the process is so automatic and familiar that we do not notice it. However, a wide body of research indicates that the formation of causal attributions is vital for adapting to changing environments and overcoming the challenges that we confront in our daily lives. When we experience desirable outcomes, attributions help us to understand what caused those events so that we can experience them again. When we experience unpleasant outcomes, attributions help us to identify and avoid the behaviors and other factors that caused them to occur.

Fritz Heider (1958) argued that all people are "naïve psychologists" who have an innate desire to understand the causes of behaviors and outcomes. Attribution theory holds that attributions for these behaviors and outcomes ultimately help to shape emotional and behavioral responses (Weiner, 1985). A simplified depiction of this attribution–emotion–behavior process is shown in **Figure 8-1**. In order to understand these relationships, however, it is important to be familiar with the various dimensions along which attributions can be classified.

First, attributions can be classified along the dimension of *locus of causality*, which describes the internality or externality of an attribution. A physician who misdiagnoses a patient and attributes this medical error to their own carelessness (e.g., they overlooked one of the patient's symptoms) is making an internal attribution. If the misdiagnosis is attributed to faulty laboratory results, the physician is making an external attribution. The locus of causality dimension is particularly relevant to emotional reactions. Internal attributions for undesirable events or behaviors are frequently associated with self-focused negative emotions, such as guilt and shame. External attributions for the same behaviors and outcomes are generally associated with externally focused negative emotions, such as anger and resentment (Gundlach, Douglas, & Martinko, 2003; Weiner, 1985).

Attributions can also be categorized along the *stability* dimension. Stable causes are those that tend to influence outcomes and behaviors consistently over time and across situations. Causes such as intelligence and physical or governmental laws are generally considered relatively stable in nature because they are difficult, if not impossible, to change. Unstable causal factors, such as the amount of effort exerted on doing a task, are comparatively easy to change. Unlike the locus of causality dimension, which primarily influences emotional reactions to events and behaviors, the stability dimension affects individuals' future expectations (Kovenklioglu & Greenhaus, 1978). When an outcome such as poor performance is attributed to a stable cause, such as low intelligence, it is logical to expect that the employee's performance is not going to change in the future. If the same poor performance is attributed to a less stable factor, such as temporary illness or insufficient effort, we can expect that the employee could improve their performance in the future.

Researchers have also classified attributions in terms of the intentionality and controllability of the cause (Weiner, 1995). However, for the purposes of understanding the basic impact of attributions on motivation, we will limit our discussion to the dimensions of locus of causality

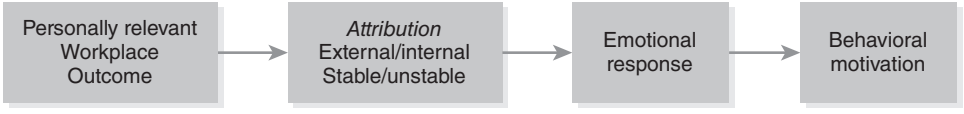

Figure 8-1 Attribution–Emotion–Behavior Process

and stability. Thus, we can consider attributions that are internal and stable (e.g., intelligence), external and stable (e.g., laws), internal and unstable (e.g., effort), or external and unstable (e.g., temporary organizational policies). Before examining the influence of these attributions on motivational states, however, it is useful to understand how attribution styles can bias and distort the attributions that individuals form.

Attribution Style

It is important to recognize that, as with all perceptions, attributions are not always an accurate reflection of reality. We can probably all think of an instance in which someone failed at a task because of their own actions but erroneously blamed the failure on other people or on circumstances. In fact, if we are totally honest with ourselves, we can each probably recall making such false attributions ourselves a time or two.

Astute observers may also notice that some people make these attributional errors more frequently than others do. These individuals are said to have a biased *attribution style*. An attribution style is defined as a tendency to consistently contribute positive and negative outcomes to a specific type of cause (e.g., internal or external, stable or unstable). The tendency to attribute negative outcomes to external factors is often coupled with a tendency to attribute positive outcomes to internal factors. This self-serving attribution style is referred to as an optimistic attribution style (Abramson, Seligman, & Teasdale, 1978; Douglas & Martinko, 2001). This term reflects the fact that people with an optimistic attribution style often feel good about themselves and their capacity for success. An obvious downside, however, is that this personal optimism may be unfounded and can set the individual up for disappointments in the future. Not surprisingly, employees with an unjustified sense of entitlement typically demonstrate high levels of this type of bias (Harvey & Martinko, 2009).

A second attribution style, known as a pessimistic attribution style, denotes the opposite tendency. Individuals who demonstrate this attributional tendency frequently attribute undesirable events to internal and frequently stable factors such as lack of intelligence while attributing desirable outcomes to external and frequently unstable factors such as good luck. As the name of this style suggests, people who exhibit this tendency often lack confidence in themselves and are pessimistic about their chances for success (Abramson et al., 1978). This tendency can also promote depression and learned helplessness.

A third attributional tendency, known as a hostile attribution style, also warrants discussion. This style is similar to the optimistic style in that it denotes a tendency toward external attributions for negative outcomes. However, the two styles differ in that the external attributions for undesirable events associated with a hostile style are also stable in nature. A study by Douglas and Martinko (2001) suggested that the stability of these attributions could promote anger toward the external entity (e.g., one's manager) and increase the likelihood of an aggressive response. It appears, for example, that a number of highly publicized incidents of workplace violence that have occurred in the United States were committed by individuals with a history of consistently external and stable causal explanations for the negative events in their lives. We can conclude that hostile attribution styles in the workplace are not only unproductive but can also be dangerous.

Before we discuss the implications of these attribution styles (see **Table 8-1**) and of attributions in general for employee motivation, one point should be clarified. In many situations, the causes of an event are perfectly clear. For example, a driver who is rear-ended at a traffic light well after coming to a complete stop is going to blame the other driver regardless of the first driver's

Table 8-1 Summary of Attribution Styles

Attributional Style	Impact on Attributions	Examples
Optimistic	Biased toward internal (often stable) attributions for positive outcomes and external (often unstable) for negative outcomes.	Successful diagnoses are attributed to personal ability; misdiagnoses are attributed to inadequate information from others.
Pessimistic	Biased toward internal (often stable) attributions for negative outcomes and external (often unstable) for positive outcomes.	Successful outcomes are attributed to good luck; poor outcomes are attributed to lack of personal ability.
Hostile	Biased toward external, stable attributions for negative outcomes.	Most workplace problems are attributed to a biased and vengeful manager.

attribution style. Because attribution styles are only tendencies to make certain types of attributions, they are unlikely to have an effect in situations where the causes of an outcome are obvious. However, when the causes are ambiguous, attribution styles are more likely to have an effect. A manager's goal, therefore, should be to make (as well as to encourage) accurate and unbiased attributions so that employees' successes can be repeated and the causes of problems can be rectified (see **Exhibit 8-1** at the end of the chapter).

Attributions and Motivational States

Our discussion of attributions and motivational states is divided into four sections, each of which describes a desirable or undesirable motivational state and the capacity of specific attributions and attribution styles to bring about these states. Two undesirable states, learned helplessness and aggression, are discussed first. We then discuss two desirable motivational states: empowerment and resilience.

Learned Helplessness

After repeated punishments and failures, a person may become passive and unmotivated and stay that way even after the environment changes so that personal or professional success is possible (Abramson et al., 1978; Martinko & Gardner, 1987). This phenomenon has been labeled "learned helplessness" because it describes a situation in which individuals come to believe that effort is futile because failure is inevitable. They have, in effect, learned to be helpless.

Learned helplessness is a consequence of the reinforcement process. When people see that behaviors lead to desired rewards and outcomes, they are motivated to repeat those behaviors. When specific behaviors do not achieve desired outcomes, the motivation to perform those behaviors is lost. Learned helplessness was first observed by Overmier and Seligman (1967) in dogs that had been placed in a shuttle box (a type of box used in animal learning experiments) with two sides. One side had an electric grid, and the other side was safe. Initially, the dogs were tethered to the electrified half of the chamber. Before administration of an unpleasant but nonlethal, shock, a light flashed. Because of classic conditioning, the dogs quickly learned to associate the flash of

light with the impending electrical shock. After the conditioning was complete, the experimenters removed the tethers that had previously made escaping to the nonelectrified side of the chamber impossible. However, instead of leaping to safety when the light flashed, most of the dogs froze, whimpered, and braced themselves for the shock. The researchers concluded that the dogs had learned to be helpless, believing that the shock was inevitable regardless of their efforts.

More recent research suggests that this tendency toward learned helplessness is also common in people and that organizational rules and norms can cause learned helplessness among employees (Martinko & Gardner, 1987). Specifically, organizational policies and norms and leaders' behaviors that cause employees to feel that success or recognition is unobtainable are likely to inhibit motivation. For instance, a manager who routinely takes credit for their subordinates' successes while blaming them for their failures may find themself with employees who see little reason to work any harder than is necessary to keep their jobs. Similarly, an organization that forces employees to follow outdated and ineffective procedures may find itself with employees who show little urgency or interest in their work, given that they expect the effort to fail. If you expect to fail, why bother trying?

The significance of organizationally induced learned helplessness is that, as Overmier and Seligman's experiments with dogs demonstrated, the helplessness often remains even when the barriers to success are removed. To continue the previous examples, if the unfair manager is replaced or restrictive policies are removed, we might expect employee motivation and performance to improve immediately. However, the reality is that employees who work under such conditions for an extended period of time often retain their learned helplessness and remain unmotivated even after the situation and conditions have changed.

This tendency can be explained by the attribution process. External barriers to success in the workplace can, ironically, promote internal and frequently stable attributions for failures while promoting external attributions for successes. Over time, these attributions can manifest themselves in the form of a pessimistic attribution style, causing employees to accept blame for failures they did not contribute to while attributing successes to their manager or to other external factors. To illustrate, a manager who consistently takes credit for departmental successes while blaming employees for failures can, over time, cause employees to believe and feel that they are incompetent at their jobs. This perception can remain even after the manager has been removed if proper steps to restore employees' confidence are not taken. This example also illustrates one of the downsides of the optimistic attribution style. Organizational leaders who demonstrate this tendency may feel good about themselves (at least in the short term), but their tendency to take credit for successes and attribute blame for failures to others may cause their employees to lose confidence and experience learned helplessness.

Aggression

Aggression, another undesirable motivational state, differs from learned helplessness in several ways. Perhaps most significantly, unlike the diminished motivation associated with learned helplessness, aggression refers to a state of heightened motivation. The problem is that this motivation is focused on an undesirable behavior or goal.

Instrumental aggression describes behaviors targeted at obtaining a goal that the employing organization is not providing. For instance, an employee who feels that they are underpaid and steals from their employer is performing instrumental aggression. Hostile aggression refers to behaviors aimed primarily at harming another person or entity. For example, an employee who physically attacks a manager probably does so not to get anything from the manager except the satisfaction of inflicting physical pain. Beyond the obvious surface-level differences in these forms of aggression, there are different underlying motivations (Martinko, Douglas, Harvey, & Joseph,

2005). Whereas instrumental aggression is motivated primarily by a desire to obtain something, hostile aggression is motivated by a desire to retaliate and harm others.

Both types of motivation may be sparked by the causal perceptions associated with hostile attribution styles. **Case Study 8-1**, at the end of the chapter, describes a study that indicated that individuals can more easily justify instrumental acts of deviance, such as forging paperwork or lying about their performance, in response to negative workplace events that were attributable to stable organizational factors (e.g., inadequate resources). Research has also shown that the attribution of undesirable workplace outcomes to external and stable causes can increase the likelihood of a hostile aggressive response. Similarly, research suggests that individuals with a hostile attribution style are more likely to engage in acts of hostile aggression than other people are (Douglas & Martinko, 2001). In addition to empirical research evidence, anecdotal reports suggest that a number of workplace shootings in the United States, such as those at several U.S. Post Office facilities, were perpetrated by individuals with external attributional tendencies.

Several studies have suggested that an employee with a hostile attribution style can pose dual problems for managers. In addition to having a heightened tendency toward aggressive behaviors, employees with hostile attribution styles appear to be prone to perceive that they themselves are victims of such behavior. One study found that employees with hostile attribution styles were significantly more likely than other employees to view their supervisors as abusive in their behaviors toward them (Martinko, Harvey, Sikora, & Douglas, 2011). Building on this finding, a later study compared pairs of employees who shared the same supervisor and found that employees with a stronger hostile bias consistently rated the shared supervisor as being more abusive than more objective employees did (Harvey, Harris, Gillis, & Martinko, 2014). Worse, this study also showed that although the perceptions of mistreatment in these employees may have been inaccurate, they were correlated with retaliatory behavior targeting the employees' supervisors.

From this evidence, we can conclude that employees who attribute negative events at work to external and stable causes are more likely than others to become motivated to engage in aggressive behaviors. A key element in determining which form of aggression will occur, or whether any aggression will occur at all, appears to be the perceived intent of the responsible party. When an undesirable workplace event is deemed to be caused by factors beyond the control of any specific party (e.g., an economic downturn), aggression becomes less likely (Harvey, Martinko, & Borkowski, 2007). However, there is some evidence that some individuals will remain motivated to engage in acts of instrumental aggression in these situations (see Martinko et al., 2005). When such individuals perceive that an external and stable factor caused a negative outcome and could have been prevented, hostile aggression toward the "guilty" party becomes more likely. This is probably due to the feelings of anger associated with such perceptions (Weiner, 1995). In other words, when causality and intent can be attributed to a specific person or entity, people often feel anger, which, in turn, frequently motivates acts of hostility.

Empowerment

Turning our attention to desirable motivational states, we first discuss the notion of empowerment. Empowerment refers to a heightened state of motivation caused by optimistic effort–reward expectations (Conger & Kanungo, 1994). Put differently, empowered individuals expect their efforts toward their goals to succeed and are therefore motivated to exert high levels of effort.

Empowerment is also associated with high levels of innovation and managerial effectiveness (Spreitzer, 1995).

Because empowerment among employees is generally good for overall organizational effectiveness, it is helpful to understand the cognitive processes that help foster this state of heightened motivation. Research has shown that the causal attribution process can tell us a lot about how employees become empowered. Unlike learned helplessness, empowerment appears to result from the attribution of negative workplace events to factors that either are internally controllable or are external, unstable, and uncontrollable. Thus, a physician who misdiagnoses a patient's disease but believes that the error was due to a factor that is under their control (e.g., "I didn't think to check for this disease, but I will know to do so in the future") is less likely to experience strongly negative emotions and learned helplessness than is a physician who attributes the error to their own incompetence. Similarly, a physician who attributes a similar error to an external, unstable, and uncontrollable factor (e.g., the patient gave incomplete information and there was not enough time to run a full battery of diagnostic tests) is likely to feel optimistic about their future chances for successful diagnoses.

Naturally, we can also expect individuals who attribute positive events to internal factors, such as their intelligence, skill, and effort, to experience empowerment (Martinko & Gardner, 1987). It follows that individuals with an optimistic attribution style are more likely to demonstrate empowerment than those with pessimistic or hostile attribution styles. Recall, however, that attribution styles can cause individuals to form inaccurate perceptions of causality. A caveat, therefore, is that people with an optimistic attribution style may feel empowered even when their skills and abilities are lacking. Therefore, as we discuss later in the chapter, it may be more important to promote attributions that are accurate than to encourage attributions that are optimistic.

Resilience

Resilience can be defined as a "staunch acceptance of reality … strongly held values, and an uncanny ability to improvise and adapt to significant change" (Coutu, 2002, p. 47). Research suggests that resilient people are relatively good at developing accurate attributions (Huey & Weisz, 1997). More specifically, it appears that people with low levels of resilience have a tendency to be overly external or internal in their attributions for negative outcomes. Thus, people who are nonresilient are likely to err in their attributions and are prone to blame others or themselves for their failures. As we have discussed, either of these attributional errors can promote negative motivational outcomes. High levels of resilience have the opposite effect, helping people to keep their attributions in line with reality. (Recall that resilience denotes a "staunch acceptance of reality.")

Resilience, then, can be thought of as a factor that helps individuals to avoid the attributional errors that can hurt motivation levels. By promoting accurate causal perceptions, resilience helps to keep people grounded in reality and helps to prevent pessimistic and hostile attributional tendencies. It is also likely that resilience can help to prevent overly optimistic attributions and the disillusionment and unfounded optimism noted in the previous section.

If we assume that resilience is good for promoting motivation through accurate attributions, the next logical question is, "Where does resilience come from?" We begin the next section by addressing this question, after which we discuss some additional techniques for promoting empowerment while discouraging learned helplessness and aggression (**Table 8-2**).

Table 8-2 Summary of Attributions Associated with Motivational States

Motivational State	Associated Attributional Tendency
Learned helplessness	Tendency to favor internal and stable attributions for failures, external attributions for successes
Aggression	Tendency to favor external and stable attributions for failures
Empowerment	Tendency to favor internal and stable attributions for successes, external and unstable attributions for failures
Resilience	Tendency to favor accurate attributions, not biased toward overly internal or external attributions for successes or failures

Promoting Motivational Attribution Processes

In this section, we summarize five techniques that managers can use to promote and maintain employee motivation. These techniques are grounded in the formation of accurate and empowering attributions.

Screening for Resilience

In the previous section, we discussed the benefits of resilience for forming attributions that are accurate and motivational. Individuals' baseline levels of resilience appear to form very early in life (Masten, 2001). With proper emotional support, children have shown remarkably high levels of resilience in dealing with undesirable circumstances, such as poverty and violence. Conversely, we are probably all familiar with both children and adults who break down in response to relatively minor problems. This suggests that resilience levels begin to form early in life. (Note that drastic events such as war and serious disease often result in increased resilience levels in adults, but these do not fall under the umbrella of "normal life events.")

Employers may determine that their organization requires that employees have a high level of resilience . Hospitals, for example, can provide a very stressful and emotionally draining working environment. If employees form overly hostile or pessimistic attributions in response to the negative events that are bound to happen in such settings, motivational problems are likely to arise. This type of organization will probably benefit from a resilient workforce. A less stressful organization, by contrast, might not require such resilience among employees.

Organizations such as hospitals that require high levels of resilience should try to attract and hire individuals who demonstrate high levels of resilience. Although it is unlikely that they can drastically increase their employees resilience levels in the short-term, managers can try to form a workforce that has high preexisting levels. This can be accomplished through the use of standardized measures of resilience (for an example, see Huey & Weisz, 1997) during the employee screening process or through simple interview questions. Asking potential candidates to describe past hardships and how they responded to those hardships is likely to shed light on both candidates' resilience levels and their attributional tendencies (Campbell & Martinko, 1998).

Attributional Training

Although resilience is a fairly stable and unchanging personal characteristic, accurate and optimistic attributional tendencies can be fostered in other ways. One technique for accomplishing this is attributional training (Martinko & Gardner, 1987). This can take several forms, one of which is measuring employees' attribution styles with an existing assessment device (for examples of these instruments, see Kent & Martinko, 1995; Lefcourt, 1991; Lefcourt, Von Baeyer, Ware, & Cox, 1979; Peterson, Bettes, & Seligman, 1985; Peterson et al., 1982; Russell, 1982) and discussing their attributional biases with them. Often, by simply realizing that they favor overly optimistic, pessimistic, or hostile attributions, individuals can begin to deliberately adjust their "perceptual lenses" to correct for their biases. Over time, this correction can become subconscious, allowing employees to form accurate attributions without additional cognitive effort.

A second form of attributional training is less formal and involves discussing the causes of employees' successes and failures on a case-by-case basis. This can help employees to understand both the internal and external factors involved with workplace outcomes by helping them to see the big picture in terms of the multiple personal and situational factors that are likely to contribute to positive and negative events. This promotes a more thorough causal search process and can help employees to avoid the cognitive shortcuts that enable overly optimistic, pessimistic, or hostile attributions.

Immunization

Another technique recommended by Martinko and Gardner (1987) is to immunize against demotivational attributions by enabling successes early in an employee's career or tenure with an organization. An employee who fails miserably at the first few tasks they are assigned in a new position may quickly decide that they lack the ability to succeed at the job (an internal and somewhat stable attribution). However, if they are allowed to tackle a number of more easily surmountable assignments before engaging in more difficult tasks, they are likely to see that they have the basic ability to succeed at the job. This will probably promote more optimistic attributions throughout the employee's tenure by providing a basic level of confidence at the beginning.

Increasing Psychological Closeness

In addition to individual attributional biases, employees can become the unwitting victims of their managers' inaccurate attributional tendencies (Martinko, 1995). Managers provide an important and often highly valued source of feedback for employees. If this feedback consistently attributes blame for negative outcomes to employees' internal characteristics, employees might accept the feedback as accurate even if it is not and might then experience organizationally induced learned helplessness (Martinko & Gardner, 1987).

Research suggests that people in observational capacities (which is often the case for managers) frequently tend to be overly dispositional in their attributions for others' performance (Jones & Nisbett, 1971). That is, they tend to focus on the influence of actors' effort and ability levels while overlooking situational factors that contribute to performance. In other words, managers can be overly hard on employees when their performance is low. Managers might also demonstrate an optimistic attribution style and take credit for the successes of their departments without giving credit to their subordinates while also blaming employees when the department's performance suffers. Again, these tendencies can be demotivational, particularly if employees believe their managers' attributional explanations for their performance.

One technique for avoiding this tendency is to promote psychological closeness. Psychological closeness describes the extent to which two or more people form the same perceptions of their situation. Research has shown that managers who have direct experience with the work their employees perform are less likely to form inaccurate attributions regarding employee performance. Managers who have little or no experience with their employees' tasks (or who have not performed them in a long time) appear to be less familiar with the situational challenges associated with the work and are more likely to blame employees' effort and ability levels when their performance is low (Fedor & Rowland, 1989).

To increase psychological closeness between managers and employees, organizations should work to ensure that managers have experience with the work their subordinates perform. This can be accomplished through internal promotions (i.e., selecting future managers from the pool of employees currently performing the job to be supervised) and by requiring existing managers to perform the jobs they are managing from time to time. These techniques will ensure that managers are familiar with both the internal and external factors associated with performance, allowing more accurate and motivational attributional feedback to be formed and communicated to employees.

Multiple Raters of Performance

A final recommendation for improving the accuracy and motivational capacity of employees' attributions is the use of multiple raters of performance when possible (Martinko, 2002). As mentioned previously, managers can demonstrate attribution styles that bias them toward demotivational explanations for employee performance. This tendency can be offset by the use of multiple performance raters.

An illustrative example of this style of judging performance is the use of multiple judges to evaluate figure skaters in the Olympics. This system is used to help ensure that potential biases held by one or more raters can be offset by the accuracy or counteracting biases of other judges. Similarly, organizations can use more than one individual to rate the performance of employees. An increasingly common example of this is the use of 360° evaluations, in which peers, managers, subordinates, customers, and the employees themselves rate performance. Although each of these parties may demonstrate some attributional inaccuracy, the hope is that through the use of multiple sources, an accurate picture of the causes of each employee's successes and failures will emerge. With this information, the proper steps can be taken to correct poor performance and encourage future successes, ultimately promoting empowerment among employees (see Case Study 8-1 at the end of the chapter).

Conclusion

Our overarching goal in this chapter was to illustrate the importance of attributional perceptions in predicting employee motivation. One of the key findings from research on this topic is that internal and stable attributions for successes in the workplace, as well as external and unstable attributions for negative workplace events, are associated with higher levels of empowerment. However, we have seen repeatedly that such attributions are desirable only when they are accurate. If an employee fails at a task because the employee is simply not cut out for the type of work being performed, it is generally better for the employee to realize that the task is too demanding. Similarly, if failures are caused by unstable internal factors such as insufficient effort, it is important for employees to make that attribution even if it is not the most desirable short-term

conclusion. These accurate attributions help to steer employees along the path toward empowerment, and managers can assist in the process by providing honest and accurate assessments of the causes of employees' performance.

Discussion Questions

1. What is an attribution?
2. Differentiate between optimistic, pessimistic, and hostile attribution styles.
3. Why might an optimistic attribution style be undesirable?
4. How can different types of attributions and attribution styles encourage high or low levels of learned helplessness, aggression, and empowerment?
5. How does resilience promote motivational attributions?
6. How can organizational leaders promote accurate and motivating attributions among their employees?

CASE STUDIES AND EXERCISE

Case Study 8-1 Managing Employees' Attributions

David, who was just promoted to manage a small medical transcription department, has inherited a problem. His predecessor recently completed the staff's annual performance evaluations, and it is now time to distribute annual raises based, in large part, on these evaluations. Of the seven employees whom David now manages, all received fairly strong evaluations, mostly in the "above average" range, although none received the highest rating of "excellent." The budget for David's department will not be growing much for the next few years, and there is very little room for salary increases. Had any of the employees achieved the highest performance level, David might have been able to apply for extra merit pay funding, but this does not appear to be an option.

Because all seven employees received relatively strong evaluations and there was not much difference between the highest and lowest performers, David has decided to allocate the raises equally among them. However, these raises will probably be disappointingly small. David is trying to decide how to break the disappointing news to his staff in the least demotivational way possible. He is weighing the following options:

1. Explain to the staff that they deserve larger raises but, given the long-term departmental budget, this was the best he could do for them.
2. Explain to the staff that he could have gotten them larger raises if their performance levels had been higher.
3. Explain to the staff that they deserve larger raises and that he, as their manager, failed them by not doing more for them.
4. Explain to the staff that these raises are fair, given their performance levels.

Discussion Questions

1. What attributions are being communicated in each of these explanations? Are they internal or external? Are they stable or unstable?
2. From a motivational standpoint, what potential pros and cons do you see for each of these explanations?
3. Which of these four options (or which combination of two or more) do you think would be the least demotivational for the staff? Why?

(continues)

CASE STUDIES AND EXERCISE *(continued)*

Case Study 8-2 "Unhealthy" Motivation: How Physicians Justify Deviant Behavior

We probably all know the feeling: something bad happens at work, and there are a few choices for dealing with it. You can go "by the book" and potentially suffer some unpleasant consequences, or you can bend the rules just a bit to make the whole thing go away. For example, suppose you miss a deadline by a few hours. You can choose to tell your manager or, because your manager happens to be in a long meeting, finish the job late and slip it under some paperwork on their desk, claiming that it has been there all day. You know what you *should* do, but you also know that the sneakier alternative is probably the path of least resistance. What would you do?

Your answer to this question would probably depend, at least in part, on why you missed the deadline in the first place. If you missed the deadline because you procrastinated all week and took an extended lunch break on the day the work was due, you might feel some guilt over lying to your manager. Attribution theory suggests that this is because you are attributing the missed deadline to an internal and unstable/controllable factor: insufficient effort. This guilt might, depending on other factors, such as your values and the consequences if your manager learns of the missed deadline, reduce your willingness to lie about finishing the work on time.

Your response might be different if you believe that you missed the deadline because the amount of time your manager gave you to complete the work was unreasonably short. If you worked late and skipped lunch all week but still needed a couple of extra hours to get the work done, you are much less likely to blame yourself. Instead, you will probably attribute the missed deadline to an external and relatively stable factor: your manager. Such attributions are associated with anger, which is a strong motivator of deviant behavior. This attribution-driven anger might help you feel justified in sneaking the work onto your manager's desk. After all, why should you get in trouble if the request was unreasonable?

To test the strength of attributions such as these to motivate deviant behaviors, Harvey et al. (2005) examined the relationship between attributions, emotions, and the justification of workplace deviance using a sample of physicians. The researchers gave the physicians a hypothetical scenario similar to the one just described and asked them whether they would feel comfortable altering dates on paperwork to disguise the fact that a nonlethal procedural mistake had been made in diagnosing a patient. Each physician was given the same hypothetical scenario with one difference: The cause of the mistake (i.e., the attribution) was varied so that in some cases the mistake was due to internal and stable or unstable factors (the physician has poor attention to detail or was distracted) and in other cases it was due to external and stable or unstable factors (the physician's department is chronically understaffed, or an emergency meeting was called and the required test could not be ordered on time).

As you might expect, physicians were more likely to say that they would alter the paperwork when the cause of the mistake was beyond their control and was stable (i.e., likely to occur again). Before taking an overly dim view of these physicians, remember that the hypothetical mistake described in the scenarios was deliberately designed to be minor and inconsequential. Still, this study provides some insight into the power of attributions to motivate behaviors that we might not normally consider.

This justification process is an almost unavoidable part of life. There are always going to be times when it is tempting to break the rules because we feel that it is a justifiable response to a wrongdoing we have suffered. Indeed, many timeless stories are based on the notion of justifiable wrongdoing—Robin Hood returning the king's wealth to the peasants, for example.

There is a decidedly darker side to the justification process, however. Perpetrators of many serious crimes throughout history have, at least at the time of the crime, convinced themselves that they were justified in their behavior. In many cases, the justification can be traced to a desire for revenge resulting from the attribution of negative events to externally controllable, stable factors. Thus, we can see that there is more at stake than productivity when it comes to forming accurate attributions.

Exhibit 8-1 Attribution Style Self-Assessment: Measure Your Attribution Style for Negative Events

To complete this assessment, begin by reading each of the hypothetical scenarios below and imagine them happening to you. Then, try to imagine what the most likely cause of each event would be if it *did* happen to you.

1. You recently received a below-average performance evaluation from your supervisor.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present
2. Today, you were informed that suggestions you made to your supervisor in a meeting would not be implemented.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present
3. You recently learned that you will not receive a promotion that you have wanted for a long time.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present
4. You recently discovered that you are being paid considerably less than another employee who holds a position similar to yours.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present
5. You recently received information that you failed to achieve all of your goals for the last performance reporting period.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present
6. You have a great deal of difficulty getting along with your coworkers.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present
7. You just discovered that a patient recently complained about the services you provided.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present

(continues)

Exhibit 8-1 Attribution Style Self-Assessment: Measure Your Attribution Style for Negative Events *(continued)*

8. A large layoff has been announced at your organization, and you are told that you will be one of those laid off.
   What is the most likely cause of this outcome? _____
   a. To what extent was this outcome caused by something about you?
      Nothing to do with me 1 2 3 4 5 6 7 Totally due to me
   b. Will this cause be present in similar future situations?
      Never present 1 2 3 4 5 6 7 Always present

Enter the sum of your **A** scores here:
Enter the sum of your **B** scores here:

Scoring Key

Your **A** score represents the *locus of causality* dimension of your attribution style for negative outcomes. A score above 28 represents an internal attribution style, with scores closer to the maximum of 56 indicating a relatively more internal style (i.e., a tendency to attribute negative outcomes to internal causes). A score below 28 represents an external attribution style, with scores closer to zero indicating a relatively more external style (i.e., a tendency to attribute negative outcomes to external causes).

Your **B** score represents the *stability* dimension of your attribution style for negative outcomes. A score above 28 represents a stable attribution style, with scores closer to the maximum of 56 indicating a relatively more stable style (i.e., a tendency to attribute negative outcomes to stable causes). A score below 28 represents an unstable attribution style, with scores closer to zero indicating a relatively less stable style (i.e., a tendency to attribute negative outcomes to unstable causes).

Discussion Questions

1. According to this test, do you have an attribution style that favors internal or external attributions for negative outcomes?
2. According to this test, do you have an attribution style that favors stable or unstable attributions for negative outcomes?
3. Would you characterize your attribution style as optimistic? Pessimistic? Hostile?
4. If you were managing an employee with the attribution style that you identified, how would you help them to stay motivated when negative events occur?

Modified from Kent, R. L., & Martinko, M. J. (1995). The measurement of attributio ns in organizational research. In M. J. Martinko (Ed.), *Attribution theory: An organizational perspective* (pp. 53–75). Delray Beach, FL: St. Lucie Press. Reprinted with permission.

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Other Suggested Reading

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PART III

Leadership

Power is the ability to influence other people's actions, thoughts, or emotions. When discussing power, the topic of leadership always enters into the conversation because the two terms are almost inseparable. In Part III, we attempt to answer the often-asked question, "What does it take to be an effective leader?" In Chapter 9, we provide an overview of the definition of power and the types, sources, and uses of power as well as organizational politics. In Chapter 10, we discuss the early theories of leaderships, such as the Great Man Theory and trait theory. In Chapter 11, we turn our attention to the next generation of leadership theories: contingency theories and situational models. These theories state that leaders apply different styles in different situations, depending on the factors involved. Chapter 12 provides insight into some of the contemporary theories in leadership, such as transformational, servant, and collaborative leadership. These contemporary theories of leadership look to the person and the organization's culture in the attempt to determine what it takes to be an effective leader.

CHAPTER 9

Power, Politics, and Influence

Power is the ability to define reality and have others accept that definition as if it were their own.

– Wade Nobles

LEARNING OUTCOMES

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

- Definition of power.
- Difference between potential and kinetic power.
- Different sources of power.
- Ways in which managers develop a power base.
- Definition of organizational politics and the various political behaviors.
- Definition of upward influence and the various influence tactics categories.

Overview

Since 2002, *Modern Healthcare* has annually published a list of the 100 most powerful people in health care. *Modern Healthcare*'s readers develop the list. The readers are asked first to nominate and then to vote for individuals they believe have the greatest power to influence the U.S. health care delivery system. Burda (2003) related that the one theme that caught his attention was control. He stated, "Controlling something of value makes you powerful, and that's what the people on the list have in common" (p. 36). It should be no surprise to learn that many of the top 100 powerful people each year are elected or appointed federal employees (with the President of the United States often taking the number-one position) who hold the purse strings on an annual budget in excess of $1 trillion or have the power to impose, delay, or eliminate costly regulatory requirements on health care providers.

Power has been defined in a variety of ways. Thibaut and Kelley (1959) defined power as having behavioral or fate control over the behavior of another person. Mechanic (1962) defined power as any force that results in behavior that would not have occurred if the force had not been present. Siu (1979) defined power as the influence over the beliefs, emotions, and behaviors of people, which is the definition adopted for our discussions.

Power exists only when there is an unequal relationship between two people and one of the two is dependent upon the other (Emerson, 1962). Using the example of the annual 100 most powerful people ranking in health care reflects these two components of power: unequal relationship and dependency. Health care providers depend on the federal government, specifically the Medicare and Medicaid programs, for reimbursements. Any change in the levels of reimbursement can have positive or negative effects on the industry. For example, the Affordable Care Act of 2010 transformed Medicare from a passive payer to an active purchaser of higher-quality, more efficient health care through the value-based purchasing (VBP) initiative. The Centers for Medicare and Medicaid Services rule that denies payment for hospital-acquired conditions referred to as "never events" strongly encouraged patient safety efforts. There is an unequal relationship because of the federal government's ability to enact new regulations that require major changes in how health care providers and suppliers conduct business (e.g., Affordable Care Act of 2010 and the Medicare Access & Chip Reauthorization Act of 2015).

Potential power exists when an individual has the ability to influence but does not use it (e.g., a supervisor sits at her desk completing paperwork but does not interact with staff). When the individual actually uses the power to influence, it is referred to as kinetic power (e.g., a supervisor awards a bonus to a subordinate for completing a challenging task on time and correctly) (Siu, 1979).

The concept of power is an integral part of organizational behavior. For example, power is central to the topics of attitudes, perception, and motivation as well as leadership, group dynamics, and change management.

Sources of Power

John French and Bertram Raven (1959) identified five bases or sources of social power: reward power, coercive power, legitimate power, referent power, and expert power. An individual is not limited to one source of power; individuals may hold and exercise multiple sources of power simultaneously.

1. *Reward power* is defined as the ability to give rewards, something that holds value to another individual. Reward power has two components. First, the individual (P) must perceive that the other person (O) has the ability to reward. Second, the reward must have some value to P. If O offers a reward to P and then fails to deliver, future attempts by O to change P's behavior by using reward power will have been diminished.
2. *Coercive power* is defined as the ability to punish either by administering a punishment or by withholding something that an individual needs or wants. Coercive power stems from P's expectation that O will administer a punishment if P fails to conform to the influence attempt. As with reward power, for coercive power to be effective, P must perceive that O has the ability to punish or sanction, and this negative valence must have some value (e.g., avoidance of punishment) to P.
3. *Legitimate power* is authority given to an individual on the basis of a given role or position. There are three bases of legitimate power: culture, social structure, and delegation of power. In some cultures, certain groups are granted the right to prescribe behavior for others. For

example, in some cultures, the elders or one sex is granted the power to demand conformity of behavior by others. Social structure is the second basis for legitimate power. In formal organizations, this power is granted by the position that someone holds in the company's hierarchy. The third base of legitimate power is delegation of the power by the legitimizing agent. For example, a department manager may accept the authority of a vice president in certain areas because the organization's president has specifically delegated the authority to the vice president. It is important to remember that O holds legitimate power only if P accepts O as holding a legitimate power position.

4. *Referent power* stems from P's affective regard (i.e., attraction) for, or identification with, O. Interestingly, O has the ability to influence P even though O may be unaware of this referent power. Also, because P desires to be associated with or identified with O, P will assume attitudes, beliefs, or behavior displayed by O. Therefore, the greater the attraction, the greater the identification and the greater the referent power.
5. *Expert power* exists when P awards power to O on the basis of P's perception of O's knowledge in a given area. P evaluates O's expertness in relation to their own knowledge as well as against an absolute standard. The expert is seen as having superior knowledge or ability in very specific areas. Therefore, the attempt to exert expert power outside of the specific area will reduce that expert power, and an undermining of confidence may take place.

Two other sources of power have been discussed: informational and connection (Hersey & Blanchard, 1982). A person who has access to valuable or important information possesses informational power. Connection power is related to who you know, vertically and horizontally, both within and outside the organization. These two sources of power are discussed further in the following sections.

Other Sources of Power in an Organization

David Mechanic (1962) found that employees without formally defined power positions exercise significant personal power within an organization by creating a sense of dependency. Employees create this dependency by controlling access to the following:

1. Instrumentalities, which includes any aspect of the physical plant of the organization or its resources (e.g., equipment, materials, budgets).
2. People, including anyone within the organization or outside the organization on whom the organization is in some way dependent.
3. Information, which includes knowledge of the norms, procedures, and techniques of doing business within the organization.

The most effective way for lower-level employees to achieve power is to have higher-ranking employees be dependent on them. Thomas Scheff's research (1961) provides us with an illustration of this dependency relationship and the power associated with it. Scheff's study involved a state mental hospital that failed to implement reforms because of the opposition of the hospital attendants. The failure was due largely to the ward physicians' dependency on the attendants. The dependency resulted from the physicians' short tenure, their lack of interest in administration, and the large amount of administrative responsibilities they had to assume. An implicit trading agreement developed between physicians and attendants whereby attendants would take on some of the responsibilities and obligations of the ward physicians in return for increased power in decision-making processes involving patients. Failure of the ward physician to honor their part

of the agreement resulted in information being withheld, disobedience, lack of cooperation, and unwillingness of the attendants to serve as a barrier between the physician and a ward full of patients demanding attention and recognition. When the attendants withheld cooperation, the physicians had difficulty in making graceful entrances and departures from the ward, in handling necessary paperwork (officially their responsibility), and in obtaining information needed to deal adequately with daily treatment and behavior problems. When the attendants opposed change, they could wield influence by refusing to assume responsibilities that were officially assigned to the physician.

Another example is new physician residents' dependency on the floor nurses in a large teaching hospital. These new physicians depend on the nurses to provide information that will help them maneuver through the hospital maze to obtain the necessary care for their patients. How are tests ordered? What paperwork must be completed? Does the patient need an authorization from their insurance company? The new residents depend on the nurses' goodwill. If the nurses withhold their cooperation, the physicians have little or no alternative but to attempt to decipher the hospital's policies and procedures by themselves, which would be a very time-consuming process.

Increasing complexity in organizations has made the expert or staff person more powerful as a result of the organization's dependency on their specialization, knowledge, and skills. Experts have tremendous potential for power by withholding information or providing incorrect information. For example, Mechanic (1962) discusses the situation of a lay hospital administrator (in contrast to a hospital administrator who is also a physician) who makes an administrative decision that physicians oppose on the basis of medical necessity. A lay administrator is not in a position to contest these claims independently. To evaluate these claims, the administrator would need to engage medical consultants to serve as a buffer between the medical staff and the lay administration.

Employees also form coalitions that demonstrate the power to get things done in a highly functionally structured organization such as a hospital. Hospitals are complex entities organized into functional units such as medical, nursing, administration, and physical plant, which are controlled at high levels of authority. It is not unusual for coalitions to form at the intermediate and lower levels that overlap the functional units. For example, the hospital's orthopedic unit secretary knows the person in patient support services who schedules patient transport or the person in the centralized supply unit who coordinates deliveries to the various departments. The secretary can handle informally what would be very time consuming if handled formally. Thus, managers become dependent on employees who know how to get around the system, which gives those employees power.

Employees also gain power because others have delegated responsibilities to them that the others do not want to do themselves but that bring with them a certain amount of power. For example, a physician usually delegates the responsibility of scheduling their appointments to a secretary. The secretary schedules both patient and nonpatient appointments and therefore wields an enormous amount of power in terms of who will or will not see the physician during any given time period. Ask any pharmaceutical representative trying to schedule an appointment to discuss a new drug with a physician! An administrative assistant in a primary care physician's (PCP's) office who issues patient referrals has the power to select what specialists the physician's patients will be referred to within the managed care network. A specialist could experience a decrease in their patient referrals by not cooperating with the PCP's administrative staff's requests (e.g., seeing referred patients in a timely fashion).

Uses of Power

Recall that McClelland (1985) relates that a high need for power may be expressed as personalized power or socialized power. Individuals with a high need for personalized power tend to display impulsive aggressive actions, to abuse alcohol, and to collect prestige "toys" such as fancy cars. They seek to control others for their own benefit. Their attitude is "I win, you lose." Individuals with a high need for personalized power demand personal loyalty from staff, not loyalty to the organization. Yukl (2001) points out that when a high personalized power leader leaves an organization, the result tends to be chaos, loss of direction, and low morale.

Socialized power need is associated with effective leadership. These leaders direct their power in ways that benefit others and the organization rather than for their own personal gain. As McClelland (1985) and Yukl (2001) relate, these leaders are interested in seeking power because it is through power that they can influence other people to accomplish tasks. They empower others who use that power to enact and further the leader's vision for the organization.

Magee and Langner (2008, p. 1548) provides the following example of individuals' use of personalized and socialized power. Three individuals decide to pursue a career in politics. One of them, who is high in socialized power motivation but not personalized power motivation, pursues this career to improve the welfare of a constituent group. Another, who is high in personalized power motivation but not socialized power motivation, seeks political office to achieve recognition and to coerce others into benefiting them. The third, who is high in both types of power motivation, is motivated both by the promise of helping others and by the trappings of political office.

Developing a Power Base

Managers are dependent on others because of two organizational factors: division of labor and limited resources (Kotter, 1977). Managers are dependent on subordinates, peers, supervisors, other units within the organization, outside suppliers, and many others. Managers are sensitive to this issue, and they cope with their dependency by eliminating it, limiting it, or establishing power over others (Kotter, 1977). Kotter describes four ways in which managers have been successful in developing a power base:

- *Creating a Sense of Obligation*: Managers will go out of their way to do favors for people who they expect will feel an obligation to return those favors.
- *Building a Reputation as an Expert in a Certain Area*: Managers will establish themselves as experts in one or more areas so that others will defer to them on those matters. This can be accomplished through visible achievement (e.g., professional reputation and track record, executing a successful high-profile project).
- *Identification*: Managers will try to foster other people's unconscious identification with them or ideas for which they stand. Managers try to look and behave in ways that others respect. They go out of their way to be visible to their employees and give speeches about their organization's goals, values, and so on.
- *Perceived Dependence*: Managers will attempt to have other people believe that they are dependent on the manager for either help or not being hurt. The manager can accomplish this by securing resources that an employee requires to perform their job. At the same time, the manager makes it known that they can also have the same resources removed. Managers may also resort to influencing others' perception of the manager's available resources, which

may be more than they possess in reality. In trying to influence people's judgments, managers pay attention to the trappings of power and to their own reputations and images. They associate with people and organizations that are known to be powerful.

Kotter (1977) notes that managers who build their power based on perceived expertise or on identification can often use it to influence attitudes as well as someone's immediate behavior, which would result in a lasting impact.

Organizational Politics

Allen, Madison, Porter, Renwick, and Mayes (1979, p. 77) describe organizational politics as the intentional acts of influence to enhance or protect the self-interest of individuals or groups. On the basis of their research, eight types of political behaviors were identified:

- *Attacking or Blaming Others*: Attacking or blaming others is often associated with scapegoating—blaming others for a problem or failure. It may also include trying to make a rival look bad by minimizing their accomplishments.
- *Using Information as a Political Tool*: Using information as a political tool may include withholding important information when doing so might further an employee's political interests. This type of behavior can also include information overload—for example, by burying or obscuring among other information some important (but potentially damaging) details that the employee hopes will go unnoticed.
- *Creating and Maintaining a Favorable Image*: Creating and maintaining a favorable image include drawing attention to one's successes and the successes of others, creating the appearance of being a player in the organization, and developing a reputation of possessing qualities considered to be important to the organization (i.e., impression management). The behavior also includes taking credit for the ideas and accomplishments of others.
- *Developing a Base of Support*: Examples of developing a base of support include getting prior support for a decision before a meeting is called and getting others to contribute to an idea to secure their commitment.
- *Ingratiation/Praising Others*: Ingratiation/praising includes praising other people and establishing good rapport for self-serving purposes. Organizational jargon for this behavior includes buttering up the boss, apple polishing, and brown-nosing.
- *Developing Allies and Forming Power Coalitions*: Developing allies and forming power coalitions include developing networks of coworkers, colleagues, and/or friends within and outside the organization for purposes of supporting or advocating a specific course of action.
- *Associating with Influential People*: Associating with influential people includes developing professional connections with organizations and people that are known to be powerful.
- *Creating Obligations and Reciprocity*: Creating obligations and reciprocity includes performing favors to create obligations from others, commonly known as "you scratch my back and I'll scratch yours."

From an organizational perspective, withholding and distorting information are the most dysfunctional and should be safeguarded against by the company. Note the similarities between Kotter's power bases and Allen et al.'s types of political behavior: creating a favorable image, developing allies and forming power coalitions, creating obligations, and associating with influential people. Although Kotter and Allen et al. developed their arguments 40 years ago, they are still valid today.

Upward Influence

There has been a growing recognition among organizational behavior researchers that a political influence perspective is a useful way to examine the effectiveness of managers (Falbe & Yukl, 1992; Farmer & Maslyn, 1999; Pfeffer, 1992). This perspective has focused on employees' influence tactics directed upward at those higher levels in the formal organizational structure. Kipnis, Schmidt, and Wilkinson (1980), on the basis of their research, grouped influence tactics into various categories, of which six relate to upward influence:

- *Assertiveness* includes such influence tactics as demanding compliance, ordering, and setting deadlines, as well as nagging and expressing anger.
- *Ingratiation* includes behaviors such as praising, politely asking, acting humble, making the other person feel important, and acting friendly.
- The *rationality tactic* consists of using reason, logic, and compromise in attempting to influence others. This also includes attempts to convince others that certain actions are in their own best interests.
- The *exchange category* refers to such behavior as offering to help others in exchange for reciprocal favors.
- *Upward appeal* is indicated by behavioral attempts to gain support from superiors in an organization.
- *Coalition formation* refers to attempts to build alliances with others.

Kipnis and Schmidt (1988) assessed the use of upward influence with hospital supervisors, clerical workers, and chief executive officers. Using the tactics of the six categories of upward influence, Kipnis and Schmidt identified four clusters:

- *Shotguns*: Individuals who use all tactics but especially assertiveness and higher authority.
- *Tacticians*: Individuals with a high use of reason or rationality but average use of other tactics.
- *Bystanders*: Individuals with lower than average scores on all tactics.
- *Ingratiators*: Individuals with the highest use of friendliness or ingratiation tactics but average use of other tactics.

In the early stages, this research stream has been productive. There is growing knowledge of how various tactics that employees use to influence behaviors of those in higher positions in the organization work or do not work under certain circumstances and in different cultures (Farmer & Maslyn, 1999; Ralston, Hallinger, Egri, & Naothinsuhk, 2005; Ralston et al., 2001).

A study by Carney, Cuddy, and Yap (2010) explored the use of body language to increase one's power position. The researchers found (p. 1) that

> posing in high-power nonverbal displays (as opposed to low-power nonverbal displays) would cause neuroendocrine and behavioral changes for both male and female participants: High-power posers experienced elevations in testosterone, decreases in cortisol, and increased feelings of power and tolerance for risk; low-power posers exhibited the opposite pattern. In short, posing in displays of power caused advantaged and adaptive psychological, physiological, and behavioral changes, and these findings suggest that embodiment extends beyond mere thinking and feeling, to physiology and subsequent behavioral choices.

Reproduced from Carney, D. R., Cuddy, A. J. C., & Yap, A. J. (2010). Power posing: brief nonverbal displays affect neuroendocrine levels and risk tolerance. *Psychological Science, 21*(10), 1363–1368.

In other words, Carney et al. (2010) showed that an individual's nonverbal displays can govern how the person thinks and feels about themselves and that a person's body movements can change their mind. The technique study is referred to as the "power pose."

Conclusion

In this chapter, we discussed what is meant by power and how individuals can use it to influence others. As was noted in the chapter, the concept of power is an integral part of organizational behavior. Power is central to the subject of leadership.

Discussion Questions

1. Discuss what is meant by the term "power."
2. Explain the difference between potential and kinetic power.
3. Describe the different sources of power.
4. Explain what is meant by a manager's power base and the ways in which managers develop it.
5. Describe organizational politics and the resulting political behaviors.
6. Discuss what is meant by upward influence and the various influence tactics categories associated with it.

CASE STUDIES

Case Study 9-1 What Can Joe Do About Betty?

Just before quitting time, Joe, the hospital's health information department manager, watched his three new trainees struggling with the complicated electronic medical records software they had to learn to use to do their jobs. Across the room, Betty, who was an expert with the software, was preparing to leave for the day, her tasks done ahead of time as usual. Also as usual, she gathered up her belongings and left without saying good-bye to any of her coworkers. "There goes the answer to my problem," thought Joe. "If only I knew how to reach her." With her expertise and experience in using the system, Betty would seem to be an ideal coach for the new employees. However, she had begged off from taking on training duties when Joe had asked her. Her reasons were that she wasn't comfortable telling anyone else what to do, didn't want the responsibility for someone else's work, and preferred to work by herself at her own job.

Joe was stunned by her refusal. He enjoyed helping his coworkers and thought that it was why he had advanced to department manager last year instead of Betty, who had more seniority and experience with the company than he did. Since her work was excellent, Joe hesitated to make it an "either you do what I want or you're in trouble" situation; he believed that employees worked best at what they wanted to work at. But his problem still remained: There was no money in the training budget, and there were no other employees as skilled with the system as Betty was. Was there an approach he hadn't thought of that he could use to convince her to help?

As Betty walked to the hospital's parking lot, she thought, "How could Joe think I would lift a finger to help him? I should have been the one promoted to department manager last year, not him. I'm the one with seniority and the necessary experience. In fact, I was the one who trained Joe when he first joined the

hospital! Just because he has a master's in health information management and I don't should not have been the determining factor, but obviously senior management thought so when they selected him over me. I could care less what happens from this point forward. I only have 5 more years until I can retire with my full pension. As long as my work continues to be excellent, there is no way Joe can upset my plans. Not that he could, since he hardly understands the complexity of the software we use. It requires a person with a lot of technology knowledge and experience."

Describe French and Raven's five sources of power. In this case, who has power(s) and why?

Case Study 9-2 Scott's Dilemma

Scott is a licensed physical therapist who works for a national rehabilitation company. The rehabilitation facility in which Scott works is located in an urban Southwest city. He has worked at this facility for 4 years and, up until recently, was satisfied with his working environment and the interactions he shared with his coworkers. In addition, Scott received personal fulfillment from helping his patients recover from their disabilities and seeing them return to productive lives.

Last year the health system went through reorganization, with some new people being brought in and others reassigned. Scott's new boss, George, was transferred from one of the system's Midwest facilities. Almost immediately upon taking his new position, George began finding fault with Scott's care plans, patient interactions, and so on. Scott began feeling as if he couldn't do anything right. He was experiencing feelings of anxiety, stress, and self-blame. Although his previous performance evaluations had been above average, Scott was shocked by his first performance review under George's authority—it was an extremely low rating.

Scott began trying to work harder, thinking that by working harder he could exceed George's expectations. Despite Scott's long hours and addressing George's critiques, George continued to find fault with Scott's work. Staff meetings began to be a great source of discomfort and stress because George would belittle Scott and single him out in front of his colleagues.

Scott began to feel alienated from his family, friends, and colleagues at work. His eating and sleeping habits were adversely affected as well. Scott's activities held no joy for him any more, and the career that he had once loved and been respected in became a source of pain and stress. He began to call in sick more often and started visualizing himself confronting and even hurting George, which created even more guilt and anxiety for Scott.

As time went on, George encouraged Scott's coworkers to leave Scott alone to do his work. The perception of the coworkers became more sympathetic to George's point of view. Scott's coworkers mused that perhaps Scott really was a poor worker and that George knew better because of his position as the supervisor of the rehabilitation department. Eventually, Scott's coworkers began to distance themselves from him, in order to protect their own interests. They began to see Scott as an outsider, with whom it was unsafe to associate.

In an effort to resolve the situation, Scott spoke to George directly, stating his feelings and expressing an interest in how they might improve the situation. Rather than making the situation better, what George perceived as Scott's insubordination served to enrage George, and the personal attacks against Scott intensified. Feeling frustrated and helpless, Scott then decided to take his problem to the Human Resources Department (HRD). A human resources manager listened to Scott's complaints and suggested that Scott return with documented evidence of what Scott perceived to be George's mistreatment. In an effort to help ease the situation, the HRD manager discussed the issue with George, which only stirred the flames of George's anger and his negative behavior toward Scott.

As a last resort, Scott decided to go to George's boss, Rebecca. Rebecca met with George to get his side of the story. George portrayed Scott as an unproductive employee with no respect for authority. The result was a strong letter of reprimand in Scott's file for insubordination.

Describe French and Raven's five sources of power. What power(s) do the individuals in Scott's dilemma hold?

Reproduced from Pinto, J., Vecchione, M., & Howard, L. (2004, October). *Case discussion: Workplace bully*. Presented at the 12th Annual International Conference of the Association on Employment Practices and Principles, Ft. Lauderdale, FL.

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CHAPTER 10

Trait and Behavioral Theories of Leadership

LEARNING OUTCOMES

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

- Difference between leaders and managers.
- Importance of early behavioral and trait studies.
- Role of behavioral and trait theories in the evolution of leadership research.
- Contributions of the early leadership studies at Ohio State University and the University of Michigan.
- Design and application of Blake and Mouton's Managerial (Leadership) Grid.

Overview

What is leadership? *Leadership* can be described as a complex process by which a person sets direction and influences other people to accomplish a mission, task, or objective and directs the organization in a way that makes it more cohesive and coherent (Winder, 2003). What makes an individual a leader? What makes a leader effective? The answers to these questions have been the focus of organizational researchers for nearly a century. In this chapter, we discuss some of the earlier studies in leadership, referred to as the trait and behavioral theories, that laid the foundation for other leadership theories such as contingency theories and contemporary or transformational theories.

Often, in exploring leadership in organizations, the first question asked is, "Are managers leaders?" or "Is there a difference between managers and leaders?" Kotter (1988) believes that managers and leaders perform two different but complementary activities. Winder (2003) and Hellriegel, Slocum, and Woodman (1995) point out that a manager is a person who directs the work of employees and is responsible for results. By contrast, a leader inspires employees with a vision and helps them to cope with change. Leaders make people want to achieve an organization's goals and objectives, while managers direct people to accomplish a particular task or objective. In the words of Peter Drucker and Warren Bennis, "Management is doing things right; leadership is doing the right things." Khan (2010) emphasizes that organizations need both strong

Table 10-1 Leaders Versus Managers

Leaders	Managers
Inspire employees with a vision.	Direct the work of employees and devise systems to monitor employees' progress toward achieving preset goals.
Help employees to cope with change.	Determine how to achieve preset goals and be responsible for achieving them.
Make people want to achieve high goals and objectives.	Tell employees to accomplish a particular task or objective.
Articulate a direction or vision of what the future might look like.	Handle activities through planning and budgeting.
Develop strategies for producing changes needed to move in a new direction.	Achieve preset goals by organizing and staffing.
Recruit and keep employees who understand and share their visions.	Create an organizational structure and sets of jobs for accomplishing the organization's strategies.

leadership and strong management for optimum effectiveness. Robbins relates (as cited by Khan, 2010, p. 2) that in today's dynamic world, organizations require leaders who can challenge the status quo, create the needed vision, and motivate followers toward achieving that vision. To achieve the vision, leaders need strong managers who can successfully develop the plans, create the structure and processes, and efficiently handle the daily operations.

Management and leadership are two separate behaviors, but both are necessary for an organization to achieve its goals (see **Table 10-1**). Note that the distinctions in the table are based on behaviors—that is, what an individual does—and not on particular characteristics, personality, or traits. Therein, we begin to discover the distinct contributions and applications of the theories presented in this chapter: trait and behavioral.

Trait Theory

The belief that innate traits could be found and be the basis for identifying leaders is illustrated by the following quote from Henry Ford: "The question 'who ought to be boss' is like asking 'who ought to be the tenor in the quartet?' Obviously, the man who can sing tenor." One might conclude that not all of us are born to sing tenor, and not all of us are born to lead. Similar thoughts were expressed by sociologist Jerome Dowd. In the early 20th century, many people accepted his belief that individuals possess different degrees of intelligence, energy, and moral force and that the masses of society, in whatever direction they may be influenced, are always led by the superior few (Bass, 1990). Leaders, it was believed, were born with personality, social, and physical characteristics that set them apart—traits that made them distinct from nonleaders.

The earliest trait studies of leadership reflect the social and psychological context of their times. These studies generally assumed that leaders were born—the Great Man Theory—and that these born leaders possessed specific characteristics or traits that set them apart. More than 100 studies summarized by Stogdill (1948) and Mann (1959) sought to distinguish leaders from

nonleaders on the basis of personality characteristics and individual traits, including intelligence, initiative, understanding of the task, and preference for a position of control and dominance. Early trait theorists suggest that characteristics such as intelligence, maturity, inner motivation, achievement drive, and employee centeredness are more likely to be found in middle-level and top managers than in team leaders or first-line supervisors. Leaders tend to be emotionally mature, have a broad range of interests, and are high achievers. They are able to work effectively with employees in a variety of situations, and they respect other people and realize that to accomplish tasks, they must be considerate of others' needs and values (Stogdill, 1974).

As research on leadership traits continued, a review by Geier (1967) of 20 different studies demonstrated the wide variance in the leadership traits chosen for investigation. Nearly 80 different traits were identified across the 20 studies, and only five traits were common to four or more of the investigations. Thus, no clear set of traits by which we can distinguish great leaders emerged. Despite the difficulties in linking traits to successful leaders, evidence based on observed characteristics of both successful and unsuccessful leaders does reveal that many successful leaders share some basic traits (see **Exhibit 10-1**). Other studies established differences in drive (achievement, ambition, energy, tenacity, and initiative), cognitive ability, honesty and integrity, self-confidence, knowledge of business, and desire to lead (Kirkpatrick & Locke, 1991). However, as Robbins (2005) notes, the power of these traits to predict leadership was modest. No consistent patterns between specific traits and effective leadership materialized. Lussier and Achua (2012) note that no universal list has emerged of traits that all great leaders possess or that will guarantee leadership success in all situations. Leadership emerges from the combined influence of multiple traits (Zaccaro, Kemp, & Bader, 2004). This is consistent with research from the GLOBE study, which involved over 200 researchers across 62 cultures over the course of more than 20 years. This study found that although some elements of leadership were universally valuable, some elements of desirable leadership are culturally contingent and cannot necessarily be translated across cultures. Furthermore, this research found that leaders who acted in accordance with the cultural

Exhibit 10-1 Trait Theory

One researcher studied a large number of North American organizations and leaders and concluded that there are some common traits that leaders possess. Leaders who possess these traits are able to lead in a variety of situations:

- Physical vitality and stamina
- Intelligence and action-oriented judgment
- Eagerness to accept responsibility
- Task competence
- Understanding of followers and their needs
- Skill in dealing with people
- Need for achievement
- Capacity to motivate people
- Courage and resolution
- Trustworthiness
- Decisiveness
- Self-confidence
- Assertiveness
- Adaptability/flexibility

Data from Gardner, J. (1989). *On leadership.* New York, NY: Free Press.

values and expectations of leaders in their specific context tended to be more effective (Dorfman, Javidan, Hanges, Dastmalchian, & House, 2012; Hernandez, O'Connor, & Meese, 2018).

Winder (2003) points out another criticism of early trait theory related to its reference to leaders' physical characteristics such as appearance, physique, energy, and health. This is not surprising when one considers that the early leadership studies were conducted in the 1930s. Leaders during that period would have typically been male, Caucasian, authoritarian, and educated. Aside from these traits, it would have been difficult to find more than minor differences from one organizational leader to the next. However, as we recognize today, physical characteristics are not requirements for leadership.

The failure of early studies to determine a clear set of leadership traits led a number of researchers to question the value of trait leadership theory and to explore another area of distinction: leader behavior. Rather than asking what traits distinguish leaders, behavioral theories of leadership ask, "How do leaders act or behave differently than nonleaders?" The underlying assumption or hypothesis shifts from being born with innate leadership abilities to being able to acquire leadership behaviors. Can we identify and teach particular behaviors that promote effective leadership? Many researchers would support the position that leadership can be learned, cultivated through work experience, training, education, opportunity, motivation, and even a little luck (Kotter, 1988).

Lewin's Behavioral Study

One of the earliest studies to examine the effect of leadership behavior was performed in the 1930s under the direction of Kurt Lewin, who is recognized as the father of group dynamics. Lewin (1951) and his colleagues observed the behavior of children under different leadership styles used by the adult participants. The study involved 10-year-old boys who were participating in an arts and craft club. The boys were placed into groups that were matched on personal characteristics (e.g., IQ, popularity), and all groups worked on the same project (producing the same item). Each group was exposed to three types of leadership styles:

- *Authoritarian*: The authoritarian leader remained aloof and used orders (without consultation) in directing the group's activities.
- *Democratic*: The democratic leader offered guidance and encouraged the children while actively participating in the group's activities.
- *Laissez-Faire*: The laissez-faire leader gave the children knowledge but did not direct the activities; nor did this leader become involved or participate in the group's activities.

The researchers measured and recorded both the amount of work produced and the levels of aggression displayed by the children. The results established that leadership style had clear impacts on group productivity and on the behaviors and interpersonal relationships among group members. Under the democratic leadership style, group morale was high, and relationships between the group members and leader were friendly. When the group leader was absent, the children continued with their work. The group's work reflected levels of originality and quality. However, members of the group did not produce as many items as did the group under the authoritarian leader. Under authoritarian leadership, the group displayed two types of behaviors: aggressive and apathetic. The aggressive children were defiant and continually wanted the leader's attention. They blamed one another when anything went wrong within the group. Although the apathetic children placed fewer demands on the leader, they displayed outbursts of aggression when the leader was absent. Under the laissez-faire leadership style, the children displayed low levels of satisfaction

and a low tendency or ability to work independently. In addition, group members displayed little cooperation. The group produced the least number of items, and the items were of low quality.

Overall, the democratic leadership style appeared to be the most successful. However, some of the children reported that they preferred the authoritarian style. Thus, this study not only provided us with our initial examination of leadership behavior but also alerted us to the possibility that followers may exhibit a preference for specific leadership styles. Gladding (1995) suggested that different types of groups prefer specific styles of leadership. He contended that members' preference would be based on the leadership style that they perceived as right or natural according to their personal socialization process.

Comprehensive research projects conducted at Ohio State University and the University of Michigan during the 1940s focused further attention on the identification of leader behaviors. These foundational studies had a significant impact on future conceptualizations and the research leadership theorists.

Ohio State Leadership Studies

The focus of the researchers at Ohio State University in the late 1940s was on the identification of independent dimensions of leadership behavior. The researchers developed an assessment tool, the Leader Behavior Description Questionnaire, which was used to discover how leaders carry out their activities. Leaders from the military, educational, manufacturing, and other sectors were included in the research project. The researchers found that two dimensions of leadership were consistent among the studied groups: consideration for people and initiating structure.

The dimension of consideration for people was focused on the human side of the business and was also called relationship behavior. This dimension recognized that individuals have needs and require relationships. The initiating structure dimension put an importance on tasks and goals. These findings were important to the study of organizational behavior and leadership by not only identifying these concepts but also recognizing that the two dimensions were independent. In other words, consideration for workers and initiating structure existed simultaneously and to different degrees. A matrix was created that showed the various combinations and quantities of the elements (see **Figure 10-1**).

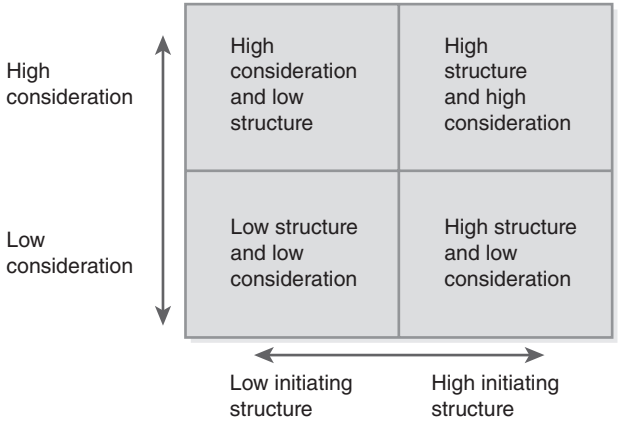

Figure 10-1 Ohio State Studies

Leaders who ranked high on both dimensions were more likely to influence the workforce to higher levels of satisfaction and performance. A weakness that was noted in the Ohio State studies was that situational factors were absent from the research. Although a combination of the dimensions was developed, the effectiveness of each combination in relation to workplace situations was not identified. Not all workplace situations require an emphasis on initiating structure. For example, health care professionals who are intrinsically motivated and highly skilled might not require initiating structure from their manager.

University of Michigan Studies

During the same period of time as the Ohio State studies, researchers at the University of Michigan were conducting research in an attempt to determine the most effective style of leadership based on two dimensions of leadership behavior: an employee-centered focus or a production-centered focus. Employee-centered leaders emphasized interpersonal relations, took a personal interest in the needs of their subordinates, and accepted individual differences among members. Production-centered leaders emphasized the technical aspects of the job, focused on accomplishing the tasks, and saw the members as a means to an end—that is, achievement of the tasks. The researchers found that general supervision (i.e., providing support and direction without being authoritarian) created higher levels of productivity than did production-centered supervision and that low-producing supervisors placed an emphasis on production, displaying little concern for their employees. Years of research have confirmed the University of Michigan studies (Luthans, 2002). A particular point of interest from these studies is that productivity is not directly related to employee satisfaction.

Likert (1961) expanded on the Michigan studies with extensive research into what differentiates effective managers from ineffective managers. Likert related that job-centered managers were found to be the least productive, while employee-centered managers were found to be the most effective. In addition, effective managers set specific goals but gave employees freedom in the way they achieved those goals (i.e., empowerment).

Blake and Mouton's Leadership Grid

During the 1960s, Blake and Mouton reexamined the two dimensions of leaders that were identified in the Ohio State studies, that is, consideration for people and initiating structure. Their work developed a two-factor framework (Razik & Swanson, 1995, p. 53). The Leadership Grid (formerly referred to as the Managerial Grid) is based upon the assertion that one best leadership style exists. The Leadership Grid provides the manager with a conceptual assessment as to what their current leadership style is and, theoretically, provides an avenue of development in becoming an ideal manager.

Although there is a possibility of being categorized in one of 81 possible positions on the grid, we will examine five positions to assist our understanding of the Leadership Grid. The Leadership Grid (see **Figure 10-2**) identifies a vertical axis, on a scale from one to nine, describing a concern for people. A horizontal axis, also on a scale from one to nine, identifies a concern for production or results. The five notable positions are: impoverished management (1,1); authority-compliance (9,1); middle-of-the-road management (5,5); country club management (1,9); and team management (9,9).

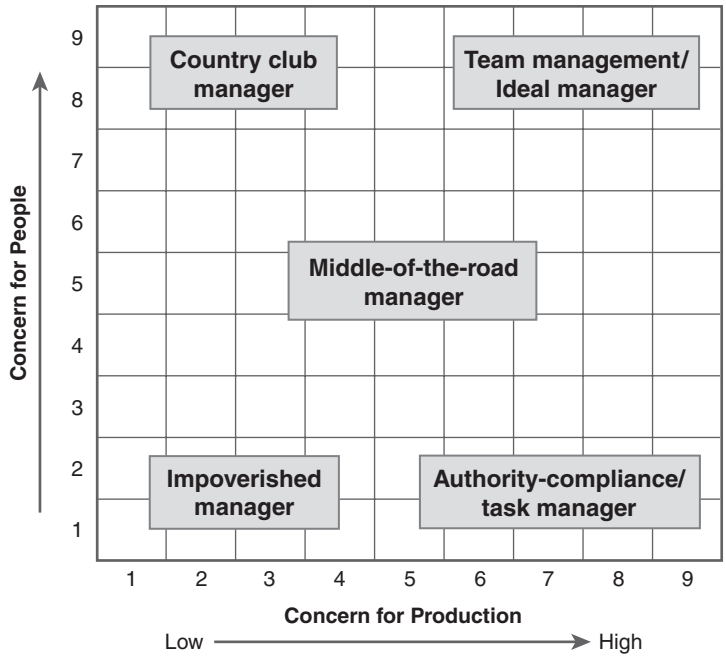

Figure 10-2 Blake and Mouton's Leadership Grid

Let us examine leadership characteristics in each one of the five quadrants to better understand how the grid functions. At the lower left position on the grid (1,1), the impoverished manager (also referred to as laissez-faire type leader) exercises minimal effort on getting the task accomplished, doing only the amount of work that is required to sustain their position within the organization. Additionally, the impoverished manager is much more focused on their own well-being than on the subordinates they supervise. This manager has a low concern for people and a low concern for production. Such managers do just enough to get by, avoiding conflicts, having little social contact with subordinates, and so on.

The authority-compliance/task manager is positioned at the lower right on the grid (9,1). This manager exhibits a true autocratic presence and is often referred to as a dictator. The managerial focus in this quadrant is efficiency, with an ongoing effort to improve work processes to increase production. There is, at best, negligible concern for people. These managers consider staff to be a means of production. The task manager is unconcerned by the potential negative impact their leadership style might have on staff, such as conflict or stress.

Located directly in the middle of the grid, at the (5,5) position, is the middle-of-the-road manager. This manager appears to balance the concern for task and the concern for people in an effort to boost morale and satisfaction. On the surface, this may seem to be a very effective approach to management, but this balancing act is often difficult to sustain over time. One might consider the middle-of-the-road manager the perfect politician. These managers play both sides of the field, depending upon situational factors. They will tell you exactly what they think you want to hear and then tell someone else exactly what they want to hear, even if this contradicts what they told you. This is not to suggest that the middle-of-the-road manager operates exclusively

on political alliances, but it should be clear that under the best of circumstances, it is difficult to balance an equal concern for people and an equal concern for production.

At the upper left on the grid (1,9), we find the country club manager. This individual is most concerned with ensuring that employees' needs are met and that the work environment is comfortable and friendly. The lack of focus on production diminishes the overall capacity for employees to meet or exceed organizational goals. This style of management will probably not lead to many successful ventures based upon production expectations.

The final quadrant is found in the upper right corner of the grid (9,9). Blake and McCanse (1991) labeled this position team management (formerly the ideal manager). As this label suggests, the team manager develops a sense of purpose and accomplishment in both concern for people and concern for task. This is not a balancing act as was described for the middle-of-the-road manager; it is a theoretically perfect combination of concern for people and concern for task. Khan (2010, p. 12) relates that the ideal [team] manager "works to motivate employees to reach their highest level of accomplishment. They believe in creating a situation whereby people can satisfy their own needs by commitment to the objectives of the organization." One might ask, "What is the likelihood of scoring a 9,9 on Blake and Mouton's Leadership Grid?" Although possible, it is very unlikely. One should presume that there is always room for improvement, thereby diminishing the possibility of attaining the elusive 9,9 score.

Blake and McCanse added two more styles in 1991: the opportunistic management style and the paternalistic management style. The opportunistic management style refers to a manager who uses any combination of the five basic styles for personal reward and advancement. The purpose of the opportunistic manager's performance and effort is to realize personal gain.

The paternalistic management style refers to a manager who uses both 1,9 and 9,1 styles but does not integrate the two. In other words, the person acts fatherly or motherly toward their subordinates but is the key decision maker, and this manager rewards loyalty but punishes noncompliance.

The grid is a useful tool for identifying leadership style, both perceived and real. Managers are often surprised at where they score on the grid. Scores may lead to self-reflection and increased understanding of their management style, which then provides opportunities for increasing managerial effectiveness.

Conclusion

Trait and behavioral theories focused attention on the individual. Were differences found? Yes. Were the researchers able to produce a clear set of traits or behaviors that can be used to definitely distinguish leaders? No. Examining the findings across numerous studies, we uncover a lack of consistency and modest relationships. However, it is important not to diminish the importance of the early leadership research or of the contribution these efforts made as traits and behaviors have reemerged in contemporary leadership theories and behavioral competencies.

The theoretical evolution of leadership has led us to the next generation of research: contingency theories. Some researchers suggest the questionable reliability and disputed validity of early leadership research efforts may be attributed to the absence of a single important dimension known as the contingency factor. The term "contingency" refers to the leader's contextual situation. "Effective leaders analyze the factors pertaining to the situation, task, followers, and the

organization, and then choose the appropriate style" (Osland, Kolb, & Rubin, 2001, p. 290). The leadership and management traits and behaviors that work in one organizational context might not be effective in another. Factors both internal and external to the organization change, and leaders and organizations must change in response, particularly in health care. Consider a few of the impetuses that are dramatically reforming the health care system, such as the call for quality and performance in concert with cutting costs and the economic, social, technological, and political environments in context with a newly emerging diverse workforce. All of these factors (and more) provide compelling reasons to incorporate the application of contingency leadership theory in attaining organizational goals.

Discussion Questions

1. Is leadership synonymous with management, or is leading just one of the many things that a manager does? In what ways are they the same or different?
2. Explain the findings of Lewin's behavioral studies on leadership styles and behaviors.
3. Discuss the contributions and the weaknesses of trait theory.
4. Discuss the results of the Ohio State studies in terms of their significant impact on leadership research.
5. Explain the difference between the University of Michigan studies and the Ohio State studies.
6. Explain Blake and Mouton's Leadership Grid in relationship to previous leadership research.

CASE STUDY AND EXERCISES

Case Study 10-1 Leadership Style

A small group of nurses at a large community hospital were unhappy about their work environment and met daily during lunch to discuss the situation. A recent change in the hospital's senior management was causing a high level of uncertainty and anxiety among the nursing staff. The nurses felt overworked as a result of the industry's current nursing shortage. Their wages and benefits had been stagnant, with no salary market adjustments for the past 2 years. The nurses saw the situation as management requiring them to do more work with fewer resources and with no appreciation or recognition of their efforts. Whenever the nurses approached management about these matters, they perceived their concerns as falling on deaf ears, since no changes were ever made.

Feeling that they had no other choice, the nurses contacted a labor union. The labor union began an organizing effort in the hospital shortly thereafter, waging an aggressive campaign over a 6-week period. There was tremendous peer pressure, as some of the well-respected members of the nursing staff became active leaders for unionization, although they had not been among the initial group of nurses who had contacted the union. The election was held, and the union was voted in by two-thirds of the nursing staff. In the weeks that followed, the original group of nurses remarked that they were surprised by the union's victory; they had only wanted to scare management into making changes to their work environment.Using Blake and Mouton's Leadership Grid, explain the leadership style displayed by management to the nursing staff.

Exercise 10-1

Write a description of an effective manager. Write words that you would use to describe an effective leader. When you review your list, consider the differences and similarities in your adjectives. How did the review of the concepts in the chapter influence your word choices? Are you comfortable distinguishing the roles? To what degree, if at all, do you believe that a manager should also be a leader or that a leader should also be a manager?

Exercise 10-2

Think of some individuals who you believe to be really exceptional leaders. What, if anything, do they have in common?

Think of some individuals who you believe to be truly poor leaders. What, if anything, do they have in common?

Do your answers identify traits or behaviors? Which do you personally view as dominant in effective leadership: traits or behaviors?

Exercise 10-3

Have you ever known people who were successful leaders in one situation and failures in another? Why do you think this happened?

Exercise 10-4

On a blank piece of paper, draw a picture of a leader. Once your picture is complete, answer the following questions:

- What does this picture say about you?
- What does this picture say about what traits you associate with leadership?
- How might implicit biases be a part of your conceptualization of a leader?

Exercise 10-5 Leadership Questionnaire

Objective: To determine the degree that a person likes working with tasks and other people.
Time: 45 Minutes

Instructions

1. Complete the 18 items in the Questionnaire section.
2. Transfer your answers to the two respective columns provided in the scoring section. Total the score in each column and multiply each total by 0.2. For example, in the first column (people), if you answer 5, 3, 4, 4, 3, 2, 5, 4, 3, then your final score is 5 33 3 0.2 5 6.6.
3. The total score for the first column (people) is plotted on the vertical axis in the matrix section, and the total score for the second column (task) is plotted on the horizontal axis. Intersect the lines to see which leadership dimension you normally operate out of:
   - Task manager (authoritarian)
   - Impoverished manager
   - Ideal manager (team leader)
   - Country club manager

Questionnaire

Below is a list of statements about leadership behavior. Read each one carefully, then, using the following scale, decide the extent to which it actually applies to you. For best results, answer as truthfully as possible.

Never			Sometimes		Always
0	1	2	3	4	5

1. _____ I encourage my team to participate when it comes decision-making time and I try to implement their ideas and suggestions.
2. _____ Nothing is more important than accomplishing a goal or task.
3. _____ I closely monitor the schedule to ensure a task or project will be completed in time.
4. _____ I enjoy coaching people on new tasks and procedures.
5. _____ The more challenging a task is, the more I enjoy it.
6. _____ I encourage my employees to be creative about their job.
7. _____ When seeing a complex task through to completion, I ensure that every detail is accounted for.
8. _____ I find it easy to carry out several complicated tasks at the same time.
9. _____ I enjoy reading articles, books, and journals about training, leadership, and psychology; and then putting what I have read into action.
10. _____ When correcting mistakes, I do not worry about jeopardizing relationships.
11. _____ I manage my time very efficiently.
12. _____ I enjoy explaining the intricacies and details of a complex task or project to my employees.
13. _____ Breaking large projects into small manageable tasks is second nature to me.
14. _____ Nothing is more important than building a great team.
15. _____ I enjoy analyzing problems.
16. _____ I honor other people's boundaries
17. _____ Counseling my employees to improve their performance or behavior is second nature to me.
18. _____ I enjoy reading articles, books, and trade journals about my profession; and then implementing the new procedures I have learned.

Scoring Section

After completing the questionnaire, transfer your answers to the spaces below:

People	**Task**
Question	**Question**
1.	2.
4.	3.
6.	5.
9.	7.
10.	8.
12.	11.

People	Task
Question	**Question**
14.	13.
16.	15.
17.	18.
Total	Total
× 0.2 =	× 0.2 =
(Multiply the total by 0.2 to get your final score)	(Multiply the total by 0.2 to get your final score)

Matrix Section

Plot your final scores on the graph below [**Figure 10-3**] by drawing a horizontal line from the people score (vertical axis) to the right of the matrix, and drawing a vertical line from the task score on the horizontal axis to the top of the matrix. The area of intersection is the leadership dimension that you operate out of.

The Results

This chart will give you an idea of your leadership style.

However, like any other instrument that attempts to profile a person, you have to take in other factors, such as how your manager and employees rate you as a leader, do you get your job done, do you take care of your employees, or are you are helping to "grow" your organization.

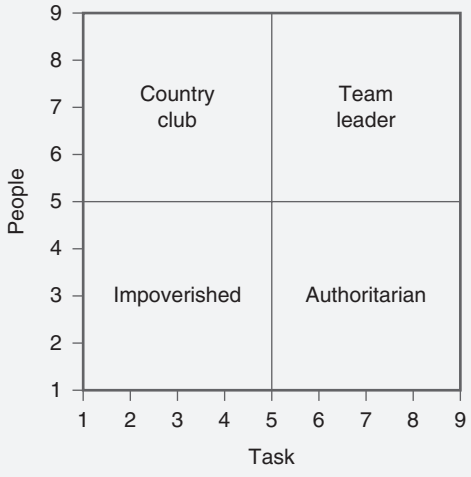

Figure 10-3

You should review the statements in the survey and reflect on the low scores by asking yourself, "If I scored higher in that area, would I be a more effective leader?" And if the answer is yes, then it should become a personal action item.

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CHAPTER 11

Contingency Theories and Situational Models of Leadership

LEARNING OUTCOMES

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

- Appreciate the contributions of contingency theories in understanding leadership.
- Distinguish between the various contingency theories.
- Apply the various contingency theories of leadership to today's work environments.

Overview

Leadership is truly a complex concept involving a multitude of factors that extend beyond the individual to include situational factors. The simplicity of examining leadership on the basis of individual traits and behaviors gives way to a more complex situation as we add the interrelationships of leadership style, personal and professional values, one's ability to control by means of influence, subordinate relationships, subordinate development, and the variability of other situational factors. In contingency theories, the critical component becomes the characteristics of the situation rather than those of the individual. Analyzing contingent factors and properly matching leadership style to the situation can allow an individual, in the right context, to effectively move an organization toward its strategic goals by influencing other organizational members to participate in the collaborative effort to achieve corporate success and economic sustainability.

Understanding the development and application of leadership theory prepares the health care manager to fulfill three explicit administrative responsibilities: predict, explain, and control. Successful leaders must have the capability to predict how, when, where, and why things happen. Prediction permits the leader to enhance opportunities and diminish threats, which constantly arise in the workplace. The ability to explain these occurrences instills a sense of confidence on the part of peers and subordinates, further augmenting the legitimacy of the manager's ability to

lead in a variety of situations. Finally, a leader recognizes and accepts the role of control, whereby individuals are influenced to participate in the achievement of strategic goals and organizational sustainability.

A contingency is an event that may occur but is not likely or intended. It is a possibility that must be prepared for, and it is dependent on chance or uncertainty. As such, contingency leadership is about possessing the knowledge, skills, and abilities to respond to a changing situation. Analyzing and responding to the contingencies that influence leader effectiveness may provide one with the ability to succeed in an ever-changing health care environment. Health care leadership is about stepping up in times of uncertainty and moving forward to minimize potential threats and exploit opportunities to benefit the organization.

In this chapter, we discuss the various contingency leadership theories and their implications for the leader, the employee, and the health care organization. To maximize your understanding of these theories, consider how they apply to you and your work environment. Developing knowledge and a working application of contingency theories will enhance your ability to successfully accomplish your managerial responsibilities to predict, explain, and control.

Fiedler's Contingency Theory

In studies of the relationship between leadership style and situation variables, Fiedler and his associates (1965, 1967, 1974) posit that individuals have dominant leadership characteristics that are well established and generally inflexible. In Fiedler's theory, leaders are characterized as either task-oriented (active, controlling, and structuring) or human relations–oriented (passive, permissive, and considerate). Fiedler believed that an individual's leadership style was grounded and somewhat inflexible; therefore, leaders would improve their overall effectiveness by being placed in situations that best suited their orientation. Situations that display more variability and provide contingencies are analyzed across three dimensions:

- *Leader–Member Relations*: The degree of certainty, trust, and deference between the subordinate and the leader. This factor addresses the manager's perception of their cooperative relations with subordinates. In other words, is the cooperation between the manager and subordinates good or poor? (Rating: good or poor.)
- *Task Structure*: The extent to which job assignments are clear through the implementation of formalization and policy. This factor relates to whether the work task is highly structured, subject to standard procedures, and subject to adequate measures of assessment. Certain tasks are easy to structure, standardize, and assess, such as the operation of an assembly line. (Rating: high or low.)
- *Leader Position Power*: The degree of control and influence the leader legitimately possesses in dealing with organizational activities. This factor, which is highly dependent on the support the leader receives from senior management, asks whether the manager's level of authority is based on punishing or rewarding behavior. For example, does the manger derive authority from providing bonuses profitability goals or terminating employees for failure to meet the goals? (Rating: strong or weak.)

A leader's contribution to successful performance by their group is determined by the leader's style (i.e., task or relations) in conjunction with situation variables (i.e., relationships, task structure, and power position). Effective leaders seek or are placed in situations that best match their leadership style.

Fiedler's research and the identification of leadership styles were based on a questionnaire known as the Least Preferred Coworker (LPC) Scale. Fiedler (1970) developed the LPC by asking the participants to describe their most- and least-preferred coworkers. Each participant was asked to think of all others with whom they had ever worked and then to describe the person with whom they had worked best (i.e., most-preferred coworker) and then the person with whom they had worked least well (i.e., least-preferred coworker [LPC]). From the items identified, Fiedler created a scale that contains contrasting adjectives (such as pleasant/unpleasant, supportive/hostile, considerate/inconsiderate, and agreeable/disagreeable) to measure whether a person was task-oriented or relations-oriented. Fiedler believed that the ratings individuals ascribed to their least-preferred coworker reflected more about themselves than about the person whom they least enjoyed working with. Thus, individuals who scored the LPC in relatively positive terms were labeled "relations-oriented," while individuals who scored the LPC in relatively unfavorable terms were labeled "task-oriented."

In assessing the three situational dimensions (leader–member relations, task structure, and position power), four levels of situational favorableness can be determined. **Figure 11-1** identifies these four levels in a continuum of situational favorableness, from Very Unfavorable to Unfavorable and Favorable to Very Favorable. Fiedler's research suggests that aligning the leadership style with the favorableness of the situation determines the effectiveness of the leader regarding a group's performance. If the leader is generally accepted and trusted by subordinates (good leader–member relations), the tasks for which individuals are responsible are clear and fully understood through formalization and direction (high task structure), and the leader's power is recognized (strong position of power), then the situation is very favorable. On the opposite side of the coin, if the leader lacks acceptance or trust by subordinates (poor leader–member relations), the tasks for which individuals are responsible are unclear and not fully understood because of a lack of formalization and an absence of direction (low task structure), and the leader's power is not recognized (weak position power), then the situation is very unfavorable. In either scenario, the leader with a task-oriented leadership style would be the most effective. When the situation variables are determined to be mixed (i.e., moderately unfavorable or moderately favorable), the human relations–oriented leadership approach would be most effective.

In a very unfavorable situation (i.e., leader–member relations are poor, there is low task structure, and the leader has little position power), one can understand the importance of a task-oriented leadership approach. But why would a task-oriented leadership approach be best suited for a very favorable situation? In a very favorable situation, the leader–member relationship is good, the task structure is high, and the position power is strong. This combination

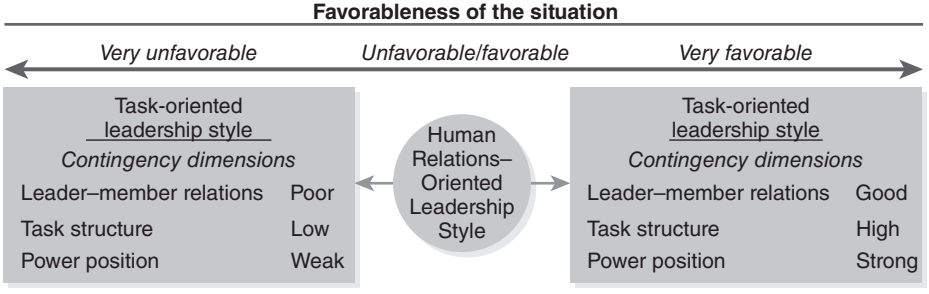

Figure 11-1 Fiedler's Contingency Theory

provides an environment in which individuals are prepared to be guided and expect to be told what to do. For example, Fiedler suggests considering the captain of an airliner during its final landing. We would hardly want the captain to turn to the crew for a discussion on how to land the plane!

Fiedler's Contingency Theory made a tremendous contribution toward contingency theories for three reasons. It was the first theory to systematically account for situational factors (i.e., relationships, task structure, and position power). Second, the theory considers the leader's dominant orientation (i.e., a function of a leader's needs and personality), not the leader's behavior (Tosi & Mero, 2003). As Tosi and Mero (2003) point out, although this orientation may affect the leader's behavior, it is the leader's orientation toward their group that determines how effective the group will be. Third, because the leader's orientation is relatively stable, it is not likely that a leader will change orientations when confronted with different situations, though the leader can change their behavior when necessary and when the leader wants to (Tosi & Mero, 2003). Fiedler believed that it would be easier to change the situation (i.e., work environment) to fit the leader's style. However, organizational and situational change may be difficult to achieve or may occur very slowly. Therefore, an organization should not choose a leader who fits a situation but should change the situation to suit the style of its leader, since the leader's personality is not likely to change (Fiedler, 1970) (see **Case Study 11-1**). This concept is a major criticism of Fiedler's theory, because it is difficult to enact in reality.

In further work, Fiedler and colleagues introduced other variables into the original Contingency Theory (Fiedler, 1995; Fielder & Garcia, 1987; Fiedler, Potter, Zais, & Knowlton, 1979). Fiedler (1996) suggests that when leaders are under stress, their intelligence and experience tend to interfere with each other, diminishing the leader's ability to think rationally, logically, and analytically. Fiedler and Garcia (1987) refer to this reconceptualization as cognitive resource theory.

This theory describes how group performance is a construct of a complex interaction between (1) two leader traits—intelligence and experience, (2) one type of leader behavior—directive leadership, and (3) two aspects of the leadership situation—interpersonal stress and the nature of the task (Yukl, 1998, p. 286). In other words, cognitive resource theory states that (1) a leader's intellectual abilities correlate positively with performance under low stress but negatively under high stress and (2) a leader's experience correlates negatively with performance under low stress but positively under high stress (Fiedler, 2008, p. 99). For example, leaders under stress will fall back on their previously learned knowledge and behavior (e.g., relying on intuition and hunches); therefore, the greater the range of their experience, the better their performance will be. Under low-stress conditions, more experienced leaders are not challenged and tend to get bored and cut corners (Fiedler, 1996).

House's Path–Goal Leadership Theory

Path–Goal Leadership Theory was introduced by Evans (1970) and further developed by House (1971). House (1971) suggests that effective leaders provide the path, the support, and resources to assist subordinates in attaining organizational goals. This theory combines elements of the Ohio State studies (i.e., consideration and initiating structure) with expectancy theory of motivation.

Four separate but fully integrated components make up House's Path–Goal Leadership Theory: Leadership Behaviors, Environmental Contingency Factors, Subordinate Contingency

CASE STUDY 11-1 The New Chief Safety and Compliance Officer Position

Ben Allrod, chief executive officer of a 300-bed community hospital located in Midwest suburbia, received a call from the hospital's director of nursing, Paul Muir, to ask whether they could meet immediately to discuss a problem. It was unlike Paul to make such a request, so Ben agreed to meet immediately.

When Paul arrived, Ben could see that he was distressed. His face was pale and he appeared nervous. Ben asked, "What's up?" Paul related, "A few hours ago a patient received the wrong blood type during a transfusion. The nurse realized something was wrong when the woman began reacting adversely to the transfusion. Although this type of mistake is not automatically fatal, the patient died a few minutes ago. However, we cannot be certain that the wrong blood type was the cause of her death because 60% of people who receive the wrong blood type would not exhibit any symptoms of the problem. The patient may have expired because of other reasons. She was very sick with multiple diagnoses." Paul reminded Ben that, in addition to the family, the state's Medical Error Oversight Board would need to be notified of this medical error.

Ben was shocked to hear this news, considering that 2 months ago the hospital had had to report to the state's Medical Error Oversight Board that a metal clamp had been left inside a patient after surgery because the surgeon forgot to order a postsurgical X-ray. Fortunately, the patient was not injured. At that time, the hospital's chief operating officer, Harry Benson, stated that new procedures would be implemented, so the problem should not happen again.

Ben thanked Paul for the information, instructed him to notify the state's Medical Error Oversight Board, and said that he, Ben, would personally meet with the family to express his sympathy for the loss of their loved one and inform them that "we" will be looking into the matter.

After Paul left, Ben knew that he had to do something immediately. Although Harry Benson had been responsible for developing and implementing all the necessary policies and procedures to prevent medical errors, he was not doing enough, and things were going to have to change—now! He would deal with Harry later. His first priority was creating a new position: Chief Safety and Compliance Officer. This new position would report directly to Ben and would have full authority to do whatever was needed to ensure that no further problems of this kind would occur. Ben immediately drafted the job description.

> The selected candidate will play a key role in the development of the organization's compliance culture with a focus on prevention. This position will be responsible for developing, implementing, and communicating the organization's compliance and safety standards, policies, and procedures. The position will oversee the design, organization, and implementation of systemwide compliance education and training programs. The position is responsible for monitoring and evaluating compliance activities to ensure program goals are being met across all functional areas. The position is responsible for establishing and participating in internal disciplinary actions for compliance violations.
>
> The candidate must have an MHA or related degree and 10 years of experience in the safety and compliance area, including 7 years in the health care industry and 5 years in a managerial role. The position offers a competitive compensation package with excellent benefits.

Using Fiedler's Contingency Theory, analyze the situational factors and determine what type of individual would be the most effective for Ben Allrod to hire. Could he change situational factors instead of hiring a new leader? If so, what changes would you recommend?

Factors, and Outcomes (see **Figure 11-2**). The first component, Leadership Behavior, identifies four specific leadership styles:

1. The *directive* leader provides employees with a detailed understanding of expectations, a plan to accomplish those expectations, and the resources to achieve the tasks. The directive leadership style can increase employees' motivation and satisfaction where role ambiguity exists.

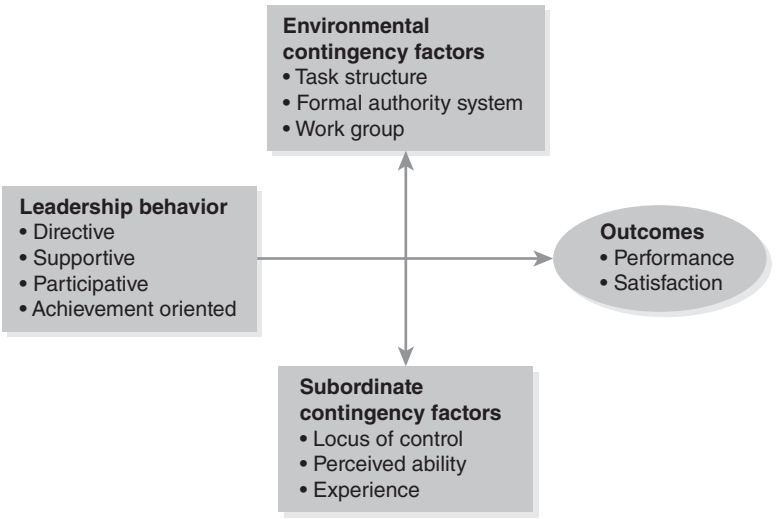

Figure 11-2 House's Path–Goal Leadership Theory

Reproduced from Robbins, S. P. (2003). *Organizational behavior* (10th ed., p. 326). Upper Saddle River, NJ: Prentice Hall.

2. The *supportive* leader shows concern for people, ensuring that the work environment does not impede specific tasks that lead toward organizational goals, and creates a supportive atmosphere. The supportive leadership style may increase employee motivation and satisfaction where tasks are routine or stressful.
3. The *participative* leader seeks input from a multiplicity of internal sources, including the technical core of employees, to assist in the decision-making process. The participative leader maintains responsibility for the final decision but includes the workforce in the process, ultimately enhancing buy-in from affected parties. The participative leadership style can improve motivation and satisfaction in environments that are uncertain or in the process of change.
4. The *achievement-oriented* leader establishes stimulating goals and expects high levels of performance in achievement of the stated goals. The achievement-oriented style of leadership creates an environment of trust, in which the leader acknowledges the workforce's abilities to accomplish organizational goals.

Whereas Fiedler proposed that leadership styles were grounded and inflexible, House proposed that leadership styles are adaptable and that managers may be called on to utilize any one of the four identified styles of leadership, depending on the situation (Razik & Swanson, 1995; Robbins, 2005).

Leadership style depends on two contingency factors: environmental and subordinate. House considered external dynamics, which are referred to as environmental contingency factors. These factors include (1) clarity of the task to be performed, (2) hierarchical authority systems, and (3) group dynamics (i.e., workgroup members' relationships). These factors are generally considered to be outside the control and influence of the worker and the manager. The second set of contingency factors, considered internal dynamics, are referred to as subordinate contingency factors. These factors include the employee's locus of control; knowledge, skills, and abilities (real or perceived); and experience. Subordinate contingency factors are characteristics exhibited by the employees (Robbins, 2005).

The integration of leadership style, environmental contingency factors, and subordinate contingency factors leads to outcomes (performance and satisfaction). According to House and Mitchell (1974), a leader's role is to influence subordinates' perceptions and motivate them toward achieving the desired outcomes. To be effective, managers should do the following:

1. Increase personal payoffs to subordinates for work goal attainment,
2. Provide coaching and direction when needed.
3. Clarify expectations of workers.
4. Reduce frustrating barriers.
5. Increase opportunities for personal satisfaction contingent on effective performance.

The appropriate leadership style that a manager should use is the one that compensates for any quality that the employee lacks (e.g., experience, ability) or the work setting (i.e., task structure). The leadership style should not duplicate what is already available to the employee. For example, the nurse manager should not provide direction (i.e., directive leadership style) on how to complete a patient's history and physical to a nurse who has 20 years of experience. However, the nurse manager should provide direction and/or training when a nurse with 20 years of clinical experience but little or no experience with technology must use an electronic medical records system for the first time to document a patient's history and physical.

Tannenbaum and Schmidt's Continuum of Leadership Behavior

Tannenbaum and Schmidt (1958, 1973) conducted one of the first studies that indicated a need for leaders to evaluate the situational factors before implementing a particular leadership style (Ott, 1996). The Continuum of Leadership Behavior model is based on the variety of behaviors noted in earlier leadership studies, particularly the distinction of task versus human relations orientation. This model identifies two styles of leadership, which occur across a continuum from boss-centered (task) through subordinate-centered (relationship).

As **Figure 11-3** illustrates, the Tannenbaum and Schmidt (1958) model covers a range of leadership behaviors. The model identifies the amount of authority (boss-centered) used by the manager and the amount of freedom afforded to employees (subordinate-centered). At one end of the continuum (boss-centered), the manager takes complete control of the situation, makes a decision, and announces it to the employees. There is no effort to solicit feedback, ideas, or input. At the other end of the continuum (subordinate-centered), the manager and employees collaboratively make decisions within clearly defined organizational constraints. Within the two extremes of the continuum lie a multitude of managerial options to either include or exclude employee involvement in decision-making processes. The appropriateness of the behavior depends on situational (contingent) factors.

How do managers determine where on the continuum they should position themselves? Determinants may include (1) the manager's style of leadership, (2) the culture of the organization, (3) the complexity of the task at hand, or (4) the relationship between the manager and the employee, specifically the level of confidence the manager has in the employee and the manager's level of comfort in delegating a task or seeking participation in the decision-making process. Another important situational factor is the employee's level of acceptance of this participation and acknowledgment of responsibility for delegated tasks. When an employee conveys a desire to participate, the subordinate-centered leadership is appropriate. Conversely, when an employee avoids involvement beyond what is minimally expected, the boss-centered leadership style would be the more suitable approach.

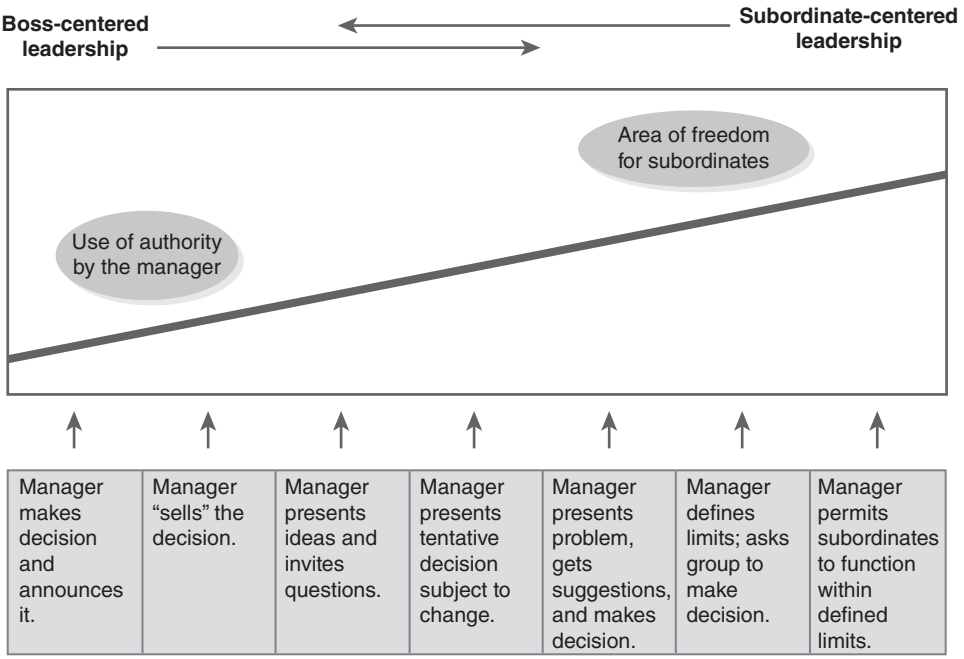

Figure 11-3 Tannenbaum and Schmidt Continuum of Leadership Behavior

Reproduced from Tannenbaum, R., & Schmidt, W. H. (1958, March–April). How to Choose a Leadership Pattern. *Harvard Business Review* (p. 96). Used with Permission.

One approach is not universally preferred over the other. Situational factors will determine which is appropriate. Today's health care managers are faced with an onslaught of ongoing critical decisions for which they are accountable and responsible. With this in mind, it is imperative that managers function effectively at each place on the leadership continuum. Attempts to maintain a subordinate-centered position on the continuum will not meet the needs of the organization when a manager must make a decision that requires information that employees might not possess or when the situation is so critical that there is no time to collaborate with employees.

Given appropriate time to seek involvement in a decision, the subordinate-centered approach is preferred for obvious reasons. Employees who are permitted to participate in the decision-making process tend to be less threatened by the impending change because they feel that they are part of the solution rather than being observers who have no control over what may or may not happen. Unnecessary exclusion from a participatory effort can create an environment of distrust, fear, hopelessness, and anger. A manager's decision as to where on Tannenbaum and Schmidt's continuum they should be positioned is critical to both the task and how the manager is perceived by the people who are affected by the positioning.

Hersey and Blanchard's Situational Leadership Model

The work of Hersey and Blanchard (1988) suggests that leaders should adapt their leadership style along three dimensions (1) task behavior, (2) relationship behavior, and (3) level of maturity of the subordinate. *Task behavior* refers to a leader's clear definition of work roles and responsibilities while ensuring task clarity. *Relationship behavior* refers to the development of personal

relationships as well as emotional and psychological contracts between the leader and the subordinates. These two dimensions, task behavior and relationship behavior, are shaped by the final dimension: the level of maturity of the subordinate, which is characterized by three specific criteria:

1. The level of motivation exhibited by the subordinate.
2. The willingness of the subordinate to assume responsibility.
3. The experience and educational level of the subordinate.

According to Hersey and Blanchard's Situational Leadership Model (see **Figure 11-4**), as the employee cultivates the knowledge, skills, and abilities to perform at increasing levels of expectations, the manager modifies their leadership style. As the subordinate passes through different

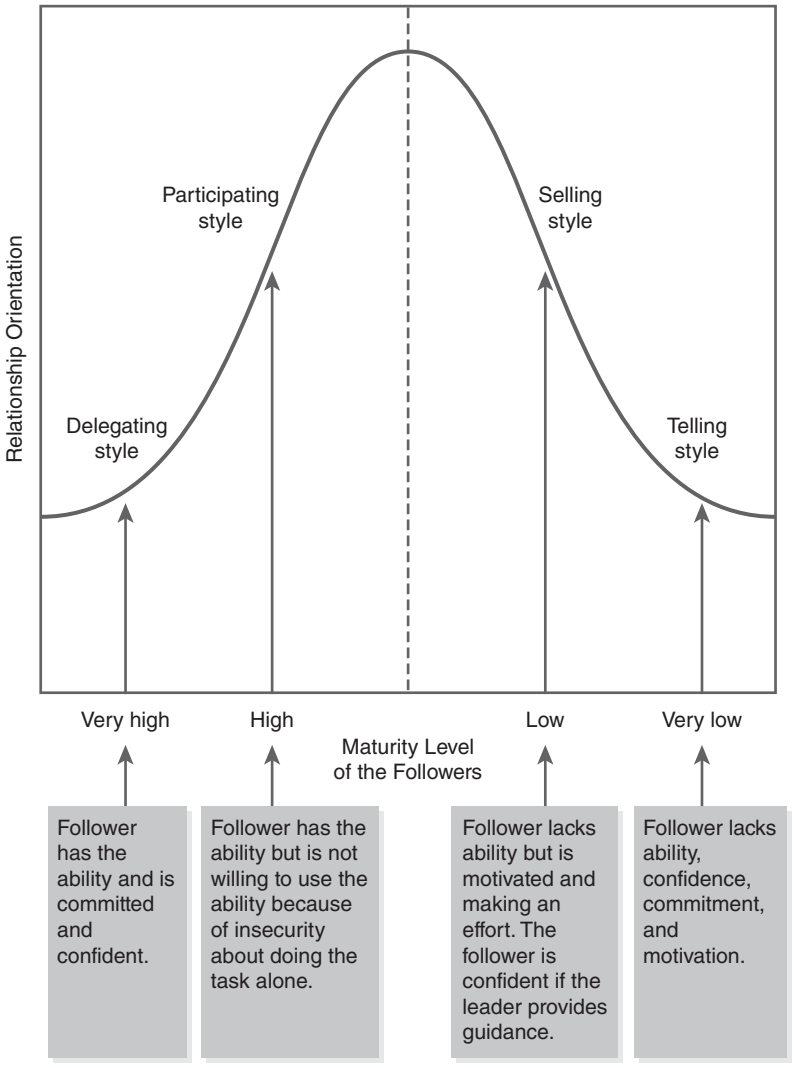

Figure 11-4 Hersey and Blanchard's Situational Leadership Model

Reproduced from Luthans, F. (2002). *Organizational behavior* (9th ed., p. 616). Boston, MA: McGraw-Hill.

stages of commitment and competence, the leader varies the amount of direction and support given. The leader plays various roles of directing, coaching, supporting, and delegating as the subordinate's level of maturity increases and the employee becomes able to perform more activities. The varying amounts of direction and support given are conceptualized into four leadership styles: Telling, Selling, Participating, and Delegating.

- Telling: The Situational Leadership Model identified that when the subordinate's level of maturity is very low, a high-task, low-relationship style of leadership is most effective. For example, this situation occurs when an employee is new to an organization, attempting to learn task expectations while assimilating into a new culture. The employee seeks direction by being told what to do; hence, the effective leader uses a telling style of leadership.
- Selling: As the new employee develops knowledge, skills, and abilities, thereby increasing their level of performance, the leader can incorporate a selling style of leadership. This method of leadership (high-task, high-relationship) is effective when the employee becomes increasingly confident and is willing to accept additional responsibilities. The leader no longer merely directs the employee as to what must be done but makes the effort to tell the employee what to do and how their role contributes to achieving departmental objectives and organizational goals. It is important that the leader recognize the importance of both the task behavior and the relationship behavior at this stage of maturity development.
- Participative: As the employee's maturity level continues to rise, the leader is required to place less of an emphasis on the task but continues to advance the relationship (low-task, high-relationship). At this level of maturity, the employee has demonstrated the ability to perform to organizational expectations with minimal managerial influence, allowing the leader to function most effectively using a participative style of leadership. In this stage of the model, the leader seeks input from the subordinate in areas concerning processes, tasks, and productivity concerns. The leader still makes the decision and ensures compliance, but the employee participates in the decision-making process through an exchange of information between the leader and the employee.
- Delegating: When the employee has fully developed, exhibiting an unquestionable ability to perform expected tasks, the subordinate's maturity level is very high (low-task, low-relationship), creating an environment that is conducive to a delegating style of leadership. At this point in the model, the leader modifies their own behavior to a level at which the leader is comfortable not only delegating, but also allowing the employee to identify innovative ways to accomplish the task.

Other empirical leadership studies research have not fully supported the Situational Leadership Model. Critics question the coherence of the results of the model, in which a questionnaire identifies 12 situations that are supposed to represent levels of subordinate maturity, and the premise that managers have only one of four styles of leadership. Hersey and Blanchard admit that the model may be oversimplified, yet one can clearly apply the model in a practical workplace environment (Luthans, 2002).

Leader–Member Exchange Theory

Whereas the contingency theories discussed thus far relate leadership style to general situational and subordinate factors across a group of employees, Leader–Member Exchange Theory (LMX) directs us to the differentiated relationships that arise between individual subordinates and their supervisors.

The foundation for LMX comes from the work of George Graen and James Cashman (1975), who coined the phrase Vertical Dyad Linkage (VDL) to describe how leaders develop dyadic

(two-person) relationships with subordinates that affect the behavior of both the leader and the subordinate. Over time and through a process of role-taking, role-making, and routinization (see **Exhibit 11-1**), the leader cognitively assigns subordinates to an in-group or an out-group. Individuals who are assigned to the in-group are perceived by the leader as being more committed to organizational goals and more likely to fulfill responsibilities with higher levels of performance.

Exhibit 11-1 The Three Phases of LMX

The Leader–Member Exchange Theory states that all relationships between leaders and subordinates go through three stages. These are:

1. Role-Taking.
2. Role-Making.
3. Routinization.

1. Role-Taking

Role-taking occurs when team members first join the group. Leaders use this time to assess new members' skills and abilities.

2. Role-Making

New team members then begin to work on projects and tasks as part of the team. In this stage, leaders generally expect that new team members will work hard, be loyal and prove trustworthy as they get used to their new role.

The theory says that, during this stage, leaders sort new team members (often subconsciously) into one of two groups.

- **In-Group**—if team members prove themselves loyal, trustworthy and skilled, they're put into the In-Group. This group is made up of the team members that the leader trusts the most. Leaders give this group most of their attention, providing challenging and interesting work, and offering opportunities for additional training and advancement. This group also gets more one-to-one time with the leader. Often, people in this group have a similar personality and work-ethic to their leader.
- **Out-Group**—if team members betray the trust of the leader, or prove that they're unmotivated or incompetent, they're put into the Out-Group. This group's work is often restricted and unchallenging. Out-Group members tend to have less access to the leader, and often don't receive opportunities for growth or advancement.

3. Routinization

During this last phase, routines between team members and their leaders are established.

In-Group team members work hard to maintain the good opinion of their leaders, by showing trust, respect, empathy, patience, and persistence.

Out-Group members may start to dislike or distrust their leaders. Because it's so hard to move out of the Out-Group once the perception has been established, Out-Group members may have to change departments or organizations in order to "start over."

Once team members have been classified, even subconsciously, as In-Group or Out-Group, that classification affects how their leaders relate to them from then on, and it can become self-fulfilling.

For instance, In-Group team members are often seen as rising stars and the leader trusts them to work and perform at a high level. This is also the group that the leader talks to most, offering support and advice, and they're given the best opportunities to test their skills and grow. So, of course, they're more likely to develop in their roles.

This also holds true for the Out-Group. The leader spends little, if any, time trying to support and develop this group. They receive few challenging assignments or opportunities for training and advancement. And, because they're never tested, they have little chance to change the leader's opinion.

Mind Tools.com, Available at: http://www.mindtools.com/pages/article/leader-member-exchange.htm Reprinted with permission

The in-group is "rewarded with more of the leaders' positional resources (i.e., information, confidence, and concern) than individuals assigned to the out-group" (Luthans, 2002, p. 583). For example, a group of early careerists are enrolled in the hospital's management development program, in which they must interact with the vice president of human resources, the facilitator of the program. The young careerists who are considered to be in the in-group may have a higher number of interactions with the vice president than do young careerists who are considered to be in the out-group. For instance, if Valerie's personality is similar to the vice president's personality, then the vice president may spend extra time meeting with and coaching Valerie regarding her career development. This high level of interaction will increase the likelihood that Valerie will be in the vice president's in-group and that Valerie and the vice president will develop a high-quality relationship. Additionally, Valerie may be given special projects during the development program that will further enhance her career opportunities within the hospital because she is in the vice president's in-group. Bob, another of the young professionals, may have relatively little interaction with the vice president outside of the program's scheduled training time because the vice president dislikes Bob's communication style. Therefore, Bob would be in the vice president's out-group, and Bob and the vice president would have a low-quality relationship.

Not surprisingly, in-group members report fewer problematic issues with leader–member interactions and higher levels of responsiveness with the leader than do members of the out-group. Additionally, in-groups are more often led with less emphasis on formal authority to control and influence, while out-groups are more often supervised with a much stronger emphasis on formal authority to control and influence. The mere nature of the high quality of the leader–member relationship that occurs with the in-group generates individuals who accept greater responsibility and exhibit higher levels of contribution to organizational goals (Graen & Ginsburgh, 1977; Liden & Graen, 1980).

The Leader–Member Exchange (LMX) theory takes VDL one step further. LMX examines the characteristics of individuals who belong to the in-group, noting similarities that exist between in-group members and the leader in the dyadic relationship. Individuals with high self-efficacy will tend to form in-group relationships with the leader. In this dyadic relationship, the leader perceives the follower to be more friendly, approachable, and similar in personality to the leader themselves. The perception of similarity becomes a very important factor for inclusion in the in-group and the resultant development of relationships and contributions to task accomplishment. However, this can have the effect of leaders developing and promoting people within the organization who look and think like themselves. This may lead to reduced diversity of managers and leaders within the organization, which can lead to groupthink and discrimination. Leaders must be aware of their own internal biases when investing time and resources in developing their employees. Are only employees who look, act and think like the leader getting fair opportunities?

According to Robbins (2005, p. 163), "Studies confirm many of the LMX predictions that leaders do differentiate among followers and those with in-group status have higher performance ratings, lower turnover intentions, and higher satisfaction with superiors than those in the out-group."

Conclusion

Contingency theories provide us with the understanding that one leadership style is not effective across all the variable situations that exist in organizations. The leader who is able to respond to ever-increasing levels of environmental uncertainty through the utilization of more than one style

of leadership will be most likely to increase employees' levels of motivation, satisfaction, and productivity. Managers should not underestimate the importance of the interrelationship of applying the appropriate leadership style based on the accurate analysis of situational factors.

Discussion Questions

1. Describe Fielder's Contingency Model. What is the impact of his assumption that leadership style is fixed?
2. Summarize Path–Goal Leadership Theory. What theories of motivation can you tie to the assumptions of the model?
3. Identify health care situations in which Tannenbaum and Schmidt's Continuum of Leadership Behavior would suggest the autocratic leadership style as the most appropriate.
4. Discuss the role of leadership style in response to employee maturity (development) as presented in the work of Hersey and Blanchard.
5. What impact does the assignment of employees to the in-group or out-group (LMX) have on workers' performance and satisfaction?
6. Apply the contingency theories discussed in this chapter as they relate to your work environment to assess the appropriate style of leadership and the implications for motivation, satisfaction, and productivity.

Exercise 11-1

Write a brief description of a personal experience as either the leader or follower when:

- A telling style of leadership was used.
- A selling style of leadership was used.
- A participating style of leadership was used.
- A delegating style of leadership was used.

Examine the effectiveness of the style by answering the following questions:

1. Did it work?
2. Could a different style have worked better?
3. Which style do you prefer your supervisor to use with you?
4. Which style are you most comfortable using yourself? Why?

Form a group of three or four individuals, and share and discuss your questions with your group.

CASE STUDY 11-2 What Can Joe Do About Betty?

Just before quitting time, Joe, the hospital's health information department manager, watched his three new trainees struggling with the complicated electronic medical records software they had to learn to use to do their jobs. Across the room, Betty, who was an expert with the software, was preparing to leave for the day, her tasks done ahead of time as usual. Also as usual, she gathered up her belongings and left without saying good-bye to any of her coworkers. "There goes the answer to my problem," thought Joe. "If

(continues)

CASE STUDY 11-2 What Can Joe Do About Betty?

(continued)

only I knew how to reach her." With her expertise and experience in using the system, Betty would seem to be an ideal coach for the new employees. However, she had asked not to take on training duties when Joe had asked her. Her reasons were that she wasn't comfortable telling anyone else what to do, didn't want the responsibility for someone else's work, and preferred to work by herself at her own job.

Joe was stunned by her refusal. He enjoyed helping his coworkers and thought that it was why he had advanced to department manager last year instead of Betty, who had more seniority and experience with the company than he did. Since her work was excellent, Joe hesitated to make it an "either you do what I want or you're in trouble" situation; he believed that employees worked best at what they wanted to work at. But his problem still remained: There was no money in the training budget, and there were no other employees as skilled with the system as Betty was. Was there an approach he hadn't thought of that he could use to convince her to help?

As Betty walked to the hospital's parking lot, she thought, "How could Joe think I would lift a finger to help him? I should have been the one promoted to department manager last year, not him. I'm the one with seniority and the necessary experience. In fact, I was the one who trained Joe when he first joined the hospital! Just because he has a master's in health information management and I should not have been the determining factor, but obviously senior management thought so when they selected him over me. I could care less what happens from this point forward. I only have 5 more years until I can retire with my full pension. As long as my work continues to be excellent there is no way Joe can upset my plans. Not that he could, since he hardly understands the complexity of the software we use. It requires a person with a lot of technology knowledge and experience."

Using Fiedler's Contingency Theory, explain what style of leadership Joe should use with Betty, given the current situation in his department (**Case Study 11-2**).

CASE STUDY 11-3 A New Employee Scheduling System

You are the director of human resources of Baptist Health System, an integrated network of nonprofit hospitals, physician clinics, and home medical services with over 4000 employees. You plan to implement a new software application to upgrade and automate employee-related scheduling. You estimate that replacing the organization's antiquated system and automating this labor-intensive, time-consuming task will save the health system thousands of dollars each year. Frank is an employee in the organization's Office of Technology (OT) who has the skill set you need. However, Frank does not report to you, and you know that the OT is understaffed and overworked. You have permission from Frank's boss, Jane, to use some of his time but only if it does not interfere with his regular duties.

Scenario One

On obtaining Jane's permission, you send Frank an email stating, "I need you to assist staff in my department with the implementation of a new software application to upgrade and automate the organization's employee-relateaccad scheduling. This needs to be completed within 2 weeks. My assistant will contact you tomorrow to discuss the specific details of this project so you can start immediately."

Scenario Two

You schedule a meeting with Frank for the next day to discuss your situation. "Frank, I want to talk to you about this project I am working on because I understand that you have experience with database conversions, and Jane told me that you were the best person to talk to about this subject. This project is very important to the organization because, like most health care organizations, we are facing ongoing

challenges of labor cost control and maintaining the appropriate staff levels necessary to maintain high levels of patient care. Baptist has been using an antiquated application to manage staffing and scheduling for several years. The software is outdated and no longer fulfills the needs of the organization. We need a new employee scheduling system that is flexible and scalable enough to accommodate continued organizational growth. Let me tell you what I'm trying to accomplish in the next 30 days. The system has to integrate with our existing time and attendance system so that information can be shared between our facilities. We also want to get a handle on our data in real time, not 14 days after the pay period. Additionally, The Joint Commission has high levels of tracking and reporting, so the organization has to find a way to deal with these reporting expectations. Frank, how can you help us reach our goal?"

Using Hersey and Blanchard's Situational Leadership Model, discuss how Frank will react in each of these scenarios. Why?

Exhibit 11-2 Leadership Style Survey

Directions

This questionnaire contains statements about leadership style beliefs. Next to each statement, circle the number that represents how strongly you feel about the statement by using the following scoring system:

- Almost Always True: 5
- Frequently True: 4
- Occasionally True: 3
- Seldom True: 2
- Almost Never True: 1

Be honest about your choices, as there are no right or wrong answers—this is only for self-assessment.

Leadership Style Survey

1.	I always retain the final decision-making authority within my department or team.	5	4	3	2	1
2.	I always try to include one or more employees in determining what to do and how to do it. However, I maintain the final decision-making authority.	5	4	3	2	1
3.	I and my employees always vote whenever a major decision has to be made.	5	4	3	2	1
4.	I do not consider suggestions made by my employees, as I do not have the time for them.	5	4	3	2	1
5.	I ask for employee ideas and input on upcoming plans and projects.	5	4	3	2	1
6.	For a major decision to pass in my department, it must have the approval of each individual or the majority.	5	4	3	2	1
7.	I tell my employees what has to be done and how to do it.	5	4	3	2	1
8.	When things go wrong and I need to create a strategy to keep a project or process running on schedule, I call a meeting to get my employees' advice.	5	4	3	2	1
9.	To get information out, I send it by email, memos, or voicemail; very rarely is a meeting called. My employees are then expected to act upon the information.	5	4	3	2	1

10. When someone makes a mistake, I make a note of it and tell them not to ever do it again.	5	4	3	2	1
11. I want to create an environment where the employees take ownership of the project. I allow them to participate in the decision-making process.	5	4	3	2	1
12. I allow my employees to determine what needs to be done and how to do it.	5	4	3	2	1
13. New hires are not allowed to make any decisions unless it is approved by me first.	5	4	3	2	1
14. I ask employees for their vision of where they see their jobs going and then use their vision where appropriate.	5	4	3	2	1
15. My workers know more about their jobs than me, so I allow them to carry out the decisions to do their job.	5	4	3	2	1
16. When something goes wrong, I tell my employees that a procedure is not working correctly and I establish a new one.	5	4	3	2	1
17. I allow my employees to set priorities with my guidance.	5	4	3	2	1
18. I delegate tasks in order to implement a new procedure or process.	5	4	3	2	1
19. I closely monitor my employees to ensure they are performing correctly.	5	4	3	2	1
20. When there are differences in role expectations, I work with them to resolve the differences.	5	4	3	2	1
21. Each individual is responsible for defining their job.	5	4	3	2	1
22. I like the power that my leadership position holds over subordinates.	5	4	3	2	1
23. I like to use my leadership power to help subordinates grow.	5	4	3	2	1
24. I like to share my leadership power with my subordinates.	5	4	3	2	1
25. Employees must be directed or threatened with punishment in order to get them to achieve the organizational objectives.	5	4	3	2	1
26. Employees will exercise self-direction if they are committed to the objectives.	5	4	3	2	1
27. Employees have the right to determine their own organizational objectives.	5	4	3	2	1
28. Employees seek mainly security.	5	4	3	2	1
29. Employees know how to use creativity and ingenuity to solve organizational problems.	5	4	3	2	1
30. My employees can lead themselves just as well as I can.	5	4	3	2	1

On the fill-in lines, mark the score of each item on the questionnaire. For example, if you scored item one with a 3 (Occasionally), then enter a 3 next to Item 1. When you have entered all the scores for each question, total each of the three columns.

Item	Score	Item	Score	Item	Score
1	_____	2	_____	3	_____
4	_____	5	_____	6	_____
7	_____	8	_____	9	_____

10	_____	11	_____	12	_____
13	_____	14	_____	15	_____
16	_____	17	_____	18	_____
19	_____	20	_____	21	_____
22	_____	23	_____	24	_____
25	_____	26	_____	27	_____
28	_____	29	_____	30	_____
TOTAL	_____	TOTAL	_____	TOTAL	_____
Authoritarian Style (autocratic)		Participative Style (democratic)		Delegative Style (free reign)	

This questionnaire is to help you assess what leadership style you normally use. The lowest score possible for a leadership style is 10 (Almost never), while the highest score possible for a stage is 50 (Almost always).

The highest of the three scores indicates what style of leadership you normally use. If your highest score is 40 or more, it is a strong indicator of your normal style. The lowest of the three scores is an indicator of the style you use least. If your lowest score is 20 or less, it is a strong indicator that you normally do not use this leadership style.

If two of the scores are close to the same, you might be going through a transition phase, either personally or at work, except:

If you score high in both the participative and the delegative, then you are probably a delegative leader.

If there is only a small difference between the three scores, then this indicates that you have no clear perception of the leadership style you use, or you are a new leader and are trying to feel out the correct style for you.

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CHAPTER 12

Contemporary Leadership Theories

Leaders would sooner sacrifice what is theirs to save what is ours.

And they would never sacrifice what is ours to save what is theirs.

This is what it means to be a leader.

It means they choose to go first into danger, headfirst toward the unknown.

And when we feel sure they will keep us safe,

We will march behind them and work tirelessly to see their visions come to life and proudly call ourselves their followers.

—Simon Sinek, *Leaders Eat Last*

LEARNING OUTCOMES

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

- Define transformational leadership.
- Identify the similarities and differences between transformational and transactional leadership approaches.
- Discuss the appropriate application of transformational leadership style in the contemporary work environment.
- Examine transformational leadership in the health management setting.
- Define charismatic, servant, and collaborative leadership.
- Identify characteristics common to charismatic, servant, and collaborative leaders.
- Describe the effect of charismatic, servant, and collaborative leadership on organizational outcomes and the attainment of strategic organizational goals.
- Discuss the development of behavioral competencies for health care leaders.

Overview

In this chapter, we examine various contemporary leadership theories, including transformational, charismatic, servant, and collaborative leadership approaches. These theories build on both individual trait and behavior theories as well as contingencies theories of leadership. When one first attempts to examine leadership, the focus is typically on an individual who has sufficient sources of power to exert influence and control over members of the organization in the effort to achieve organizational goals. The flaw in using this approach is the narrow focus on the individual. A more appropriate assessment of leadership includes the characteristics of the leader as well as subordinates, peers, supervisors, and the organization itself. This broader perspective provides a more detailed examination of the leader, the external environment, and the situation—all factors that determine appropriateness of leadership style. Contemporary theories also emphasize emotion, vision, and values.

While contemporary theories recognize the complexities of leadership and expand the multiplicity of variables that affect it, they also return us to the examination of individual characteristics and behaviors. Novick, Morrow, and Mays (2008) suggest that transformational leadership seemingly involves the reemergence of trait-based theories. Indeed, numerous studies in the past few decades have focused on personality traits of effective transformational, transactional, and charismatic leaders (DeHoogh, Den Hartog, & Koopman, 2005). Many researchers credit this resurgence to the work of Judge, Bono, Ilies, and Gerhardt (2002), who group the numerous traits identified in leadership studies into a "Big Five" personality framework. When similar traits were organized into five categories (Extroversion, Agreeableness, Conscientiousness, Emotional Stability, and Openness to Experience), stronger and more consistent relationships emerged. This five-factor view of personality provided a new framework for linking personality and leader behavior and effectiveness in studies on charismatic, transformational, and transactional leadership (Bryman, 1992; Den Hartog & Koopman, 2001; Digman, 1990). A second individual trait that has received considerable attention is emotional intelligence (EI). Emotional intelligence involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions (Salovey & Mayer, 1990).

While innate personality traits play a role in leadership, the variance explained by personality remains limited. A leader may have intrinsic traits that enhance or allow leadership to emerge, but they must also have knowledge, skills, vision, and values to effectively influence followers and facilitate individual and organizational performance. Therefore, we will conclude this chapter with a brief review of the development of behavioral competencies for health care leadership.

Transformational Versus Transactional Leadership

It is helpful to define the terms "transactional leadership" and "transformational leadership" to establish a foundation for how each approach is appropriate and vital to an organization's success.

In general terms, transactional leadership is directed toward task accomplishment and the maintenance of good relations between the leader and subordinates through consideration of performance and reward. The transactional leadership model has been considered the most prevalent leadership model used in health care (Schwartz & Tumblin, 2002). In contrast, transformational leadership is directed toward the influence and management of institutional change and innovation through revitalization and vision (Dessler, 1998, p. 350).

Leader behaviors include characteristics identified as consideration and initiating structure. *Consideration* is the recognition that individuals have needs and require relationships; *initiating structure* denotes an emphasis on tasks and goals. Burns (1978) reported that transactional leadership style is based on both consideration and initiating structure. Transactional behaviors are "largely oriented toward accomplishing the task at hand and maintaining good relations with those working with the leader by exchanging promises of rewards for performance" (Dessler, 1998, p. 350). Transactional leaders seek to maintain the status quo and reward subordinates for doing what is expected from them. Expectations of performance and the resultant rewards are clearly identified and delivered on completion of the agreement. As DeHoogh et al. (2005, p. 840) put it, "[T]ransactional leaders influence followers through task-focused behaviors; they clarify expectancies, rules and procedures, emphasizing a fair deal." Trastek, Hamilton, and Niles (2014) relate that the transactional leadership model is unable to account for the complex motivations of health care providers, and it fails to build trust between the leader and followers.

In contrast to the transactional leadership model, the transformational style of leadership incorporates emotion, values, and vision to motivate individuals and seeks to change the status quo. Transformational leadership is all about change, innovation, improvement, and entrepreneurship through vision and inspiration. Osland, Kolb, and Rubin (2001, p. 297) state that "transformational leaders are value-driven change agents who make followers more conscious of the importance of task outcomes. They provide followers with a vision and motivate them to go beyond self-interest for the good of the organization."

Transformational leadership establishes subordinate effort and performance that extends beyond that which occurs as a result of transactional leadership. These two approaches to leadership are not mutually exclusive; most leaders exhibit both transactional and transformational behaviors in different intensities and amounts (Bass, 1990b; Luthans, 2002). According to Bass (1990b) and Luthans (2002, p. 592), each leadership approach differentiates itself in the identification of four specific characteristics that are unique to each style.

Transactional Leadership

- *Contingent Reward*: Contracts exchange of rewards for effort; promises rewards for good performance; recognizes accomplishments.
- *Management by Exception (an active approach)*: Watches and searches for deviations from rules and standards; takes corrective action.
- *Management by Exception (a passive approach)*: Intervenes only if standards are not met.
- *Laissez-Faire*: Abdicates responsibilities; avoids making decisions.

Transformational Leadership

- *Charisma*: Provides vision and a sense of mission; instills pride; gains respect and trust.
- *Inspiration*: Communicates high expectations; uses symbols to focus efforts; expresses important purposes in simple ways.
- *Intellectual*: Promotes intelligence, rationality, and careful problem solving.
- *Individualized Consideration*: Gives personal attention; treats each employee individually; coaches; advises.

Transformational leadership elevates the level of insight about the importance and value of outcomes through the growth of subordinates by encouraging followers to question their own

way of doing things. Transactional leadership constitutes behavior that operates through consideration and covenants between the leader and the follower.

Transformational Leadership: A Contradictory View

Kotter (1995) provided a contradictory view as to the success of incorporating transformational efforts. Kotter noted that transformational change (through transformational leadership) is conducted under many banners: cultural change, reengineering, and total quality management, to name a few. The purpose of transformational leadership is to address the essential changes necessary to respond to an ever-changing, globally competitive environment.

Kotter (1995) added that transformational leadership resulting in successful change is best executed in phases and that failure to address each phase to the fullest significantly diminishes the capacity to succeed. As illustrated in **Table 12-1**, Kotter identified eight transformational phases and associated errors and provided strategies to enhance the success of the leader by addressing

Table 12-1 Eight Specific Errors That Diminish the Transformational Effort

Phase	Transformational Errors	Processes to Enhance Transformational Success
1	Failure to create a true sense of urgency	Establish a sense of urgency by examining market/competitive realities and conducting a SWOT analysis (strengths, weaknesses, opportunities, and threats)
2	Failure to create a powerful guiding coalition	Form powerful coalitions by assembling groups of teams with the power to effect change
3	Failure to create a clearly understood vision	Create a vision with direction and focus consistent with organizational strategies
4	Failure to adequately communicate the vision	Use all available channels of communication to convey the change and lead by example
5	Failure to remove obstacles in moving toward transformational change	Remove obstacles, change systems and structures, encourage creativity and innovation through empowerment
6	Failure to systematically plan for or create short-term successes	Plan for and recognize visible, short-term improvements through established reward systems
7	Proclaiming success prematurely	Utilize credibility to change systems, structures, processes, and policies to arrive at the vision
8	Failure to anchor the transformational change	Institutionalize the change by infusing appropriate behaviors that will lead to development and succession in the organizational culture

Kotter, J. P. (1995). Leading change: Why transformational efforts fail. *Harvard Business Review, 73*(2), 61.

the errors. Tichy and Devanna (1986), cited by Luthans (2002, pp. 591–592), found that transformational leaders shared the following seven characteristics:

1. They identified themselves as change agents.
2. They exhibited courage.
3. They trusted people.
4. They were value driven.
5. They valued lifelong learning.
6. They had the capability to face complexity, ambiguity, and uncertainty.
7. They were imaginative, creative, innovative, and visionary.

The Implications of Transformational Leadership for the Health Care Industry

Because of regulatory changes, financial pressures, and evolving care delivery models, health care organizations will be transformed in many ways in the years to come. The health care manager must acquire the skills, abilities, and knowledge to understand effective leadership processes and anticipate environmental change. Changes facing the health care manager necessitate a stronger focus on results, creativity, and innovation (Gummer, 1995). The health care manager will experience increasing demands to demonstrate high performance and quality outcomes while reducing costs in the midst of decreasing revenues. Leaders must increase their transformational skills while balancing the requirements of transactional management.

Despite the importance of transformational leadership, the transactional leadership model has been considered the most dominant leadership model actually used in health care (Schwartz & Tumblin, 2002). A 2003 study by Thyler provides interesting insight into the hold of the transactional approach to health care leadership and its impact on nursing care. Thyler reported that the transactional leadership style may be causing nurses to leave the profession because they struggle ideologically with the system in which they work. Numerous other studies have been conducted on the relationship between leadership style and job satisfaction (or dissatisfaction). For example, Medley and Larochelle's (1995) research reported that staff nurses view behaviors associated with transactional leadership (e.g., negative feedback) unfavorably in relation to their jobs. This study indicated that head nurses with high transformational scores were more likely to have staff nurses with higher job satisfaction scores and longer association with their staff nurses than transactional leaders have. These results provide strong support for the idea that a transformational leadership approach advances retention efforts and diminishes turnover rates—a conclusion that has significant fiscal implications for health care facilities.

Chaffee (2001) addressed the implications of transformational leadership in a military health care environment. The purpose of Chaffee's study was to identify the ideal characteristics of a Navy health care executive of the future. Sixty-seven respondents reported most frequently the following characteristics of an ideal, transformational leader:

- Possesses an ability to organize teamwork.
- Possesses a clear vision.
- Teaches others to succeed and mentors others.
- Takes risks and encourages others to do so.
- Develops and maintains excellent interpersonal relationship skills.

- Possesses credibility, honesty, and integrity.
- Embraces and drives change.
- Strives for excellence and continuous improvement.
- Has excellent communication skills.
- Exhibits a passion for work.
- Maintains a focus on the organizational mission.

As Chaffee (2001, p. 241) points out, "The characteristics identified by respondents describe leadership traits rather than management skills. None of the respondents identified the traditional managerial skills of planning, organizing, coordinating, directing, and controlling. Additionally, the most frequently identified characteristics fit the definition of transformational leadership."

These leadership characteristics support four managerial competencies sustained by successful leaders (Bennis, 1984; Chaffee, 2001):

1. *Management of Attention*: The ability to get the attention of a group through a compelling vision that brings others to a place they have not been before.
2. *Management of Meaning*: The ability to make a vision clear to others and the ability to communicate ideas and create meaning.
3. *Management of Trust*: The ability to inspire trust through reliability and constancy.
4. *Management of Self*: Knowing one's skills and deploying them effectively.

Transformational leadership is, without question, very well suited to today's economic, social, political, and technological conditions. Transformational leadership thrives on change and innovation. Transformational leadership provides the knowledge, skills, and abilities to facilitate innovation and transformation, beyond those that are available in a traditional approach. Doing things because that is the way they were always done is being replaced by dynamic solutions to old and new problems (Sofarelli & Brown, 1998; Trofino, 2000).

Bennis and Nanus (1985), while noting the importance of both management and leadership, recognized a philosophical dissimilarity between the two approaches: "Managers are people who do things right and leaders are people who do the right things" (p. 21). Lieutenant General George J. Flynn of the U.S. Marine Corps noted, "I know of no case study in history that describes an organization that has been managed out of a crisis. Every single one of them was led" (Sinek, 2017 p. xi). The implications of these statements provoke questions as to how the health care industry will respond to an environment in which leadership focuses less on managing technical skills and more on managing knowledge processes. Technical skills are controlled through clearly stated goals and measurable performance objectives. Mental processes have replaced the mechanistic tasks that must be carefully monitored and managed, meaning that critical decisions are arrived at through cognitive processes, not controlled through clearly stated goals and measurable performance objectives. The transformational leadership approach is well suited to serve this new health services environment (Trofino, 1995).

Other Contemporary Leadership Approaches

More than 70 years ago, the Office of Strategic Services published a book titled *The Assessment of Men*, in which two types of leaders were described: (1) the leader in articulation, who was forceful and inspirational in expression and who spelled out clearly what was needed and how it was to be accomplished, and (2) the leader in action, who, by setting themselves in motion, demonstrated how to accomplish a goal and whose successes encouraged others to join in the pursuit of

the goal. In either case, "the leader—by words or action—inspired others to achieve something beyond the ordinary by appealing to a goal worthy of human effort" (Curtin, 1997, p. 7).

Although the primary topic of this chapter is transformational leadership, other leadership styles and their respective characteristics also focus on transformation or change. Recall that transactional leadership is directed toward task accomplishment and good relations between the leader and subordinates through consideration of performance and reward, while transformational leadership is directed toward the influence and management of institutional change and innovation through revitalization and vision (Dessler, 1998). Here, we examine some other change styles and their conceptual similarities.

Bolman and Deal (1997) offer for consideration the *symbolic leader*. Symbolic leaders interpret and reinterpret experiences, developing the capacity to impart purpose and meaning. Symbolic leaders use symbols to seize attention. They frame experiences in an uncertain environment, providing a reasonable interpretation and understanding of events. Symbolic leaders disseminate information through persuasive communication, especially through the use of stories, rites, and rituals, both current and past. Symbolic leaders are consistent in their use of rules and customs (Bolman & Deal, 1997).

Another contemporary view of leadership is the *superleadership* perspective. Because today's leaders are required to function effectively in an ever-changing, fast-paced global environment, traditional leadership approaches lack the depth of knowledge, skill, and ability required of today's leaders. As contemporary work environments increasingly develop and implement new and innovative structural designs, there is an unprecedented level of employee participation, and the myriad of prevailing management practices make it difficult, at best, to identify an appropriate leadership approach. In response to these issues, the superleader willingly shares power and control with the employees and instills in them a sense of empowerment that redirects the basis of vision and direction from the leader to the follower. Like transformational leadership, superleadership encourages followers to do or become more—to discover, use, and maximize their abilities. The superleader continues to lead but recognizes the value of vision and direction that can be assembled by individuals at all levels of the organization. The superleadership approach is effective in that the leader creates a positive atmosphere, promotes self-leading teams, provides appropriate reward and constructive reprimand, and fosters a corporate culture that contributes to high levels of performance (Osland et al., 2001).

The Charismatic Leader

> Charisma is a tricky thing. Jack Kennedy oozed it—but so did Hitler and Charles Manson. Con artists, charlatans, and megalomaniacs can make it their instrument as effectively as the best CEOs, entertainers, and Presidents. Used wisely, it's a blessing; indulged, it can be a curse. Charismatic visionaries lead people ahead and sometimes astray. (Sellers, 1996, pp. 68–72)

Charismatic leaders are individuals who exhibit high levels of self-confidence and trust in subordinates, high expectations for subordinates, and an ideological vision and purpose that are enacted through personal example. In return, followers of charismatic leaders demonstrate loyalty to, confidence in, and trust in the charismatic leader's values, behaviors, and vision. The relationship and connectedness are critical elements between the followers and the charismatic leader. The effect is profound, often producing performance results that exceed established expectations (Luthans, 2002). Followers will transcend their own self-interests for the sake of the team, department, or organization (Bass, 2008).

In light of the high esteem in which the charismatic leader is held, one would expect the charismatic leader to exhibit high ethical standards. This presumption, in most cases, is correct. The ethical charismatic leader will, in general, use their power in socially constructive ways to serve others (e.g., Mother Teresa and Martin Luther King, Jr.). Yet not all charismatic leaders are ethical (e.g., Adolf Hitler and Osama bin Laden). Howell and Avolio (1992) noted that charismatic leaders "deserve this label only if they create transformations in their organizations so that members are motivated to follow them and to seek organization objectives not simply because they are ordered to do so, and not merely because they calculate that such compliance is in their self-interest, but because they voluntarily identify with the organization, its standards of conduct and willingly seek to fulfill its purpose" (Luthans, 2002, p. 590).

Although the components of transformational leadership and charismatic leadership differ somewhat (Yukl, 1999), these theories are often seen as equivalent. As we discussed earlier, research supports the position that transformational leadership qualities can be learned as long as the individual is comfortable and confident in the controlling and influencing roles. Thus, by combining the desire to lead with learning and understanding the position and responsibility of a transformational leader, a person may develop the capacity to transform organizations. Given this supposition and the close association of transformational leadership and charismatic leadership, the question is "Can an individual acquire charismatic characteristics sufficient to develop a following based on trust, expectations, and purpose?"

Benton (2003) describes a six-step plan for developing executive charisma. She suggests that many people, who might otherwise be change agents, accept the fact that, given organizational constraints and the competition among organizational leaders, they will achieve only a certain level of success. She also suggests that the one missing component to assuming charismatic positioning—beyond one's exemplary character, instincts, judgment, integrity, and positive energy—is executive charisma. Benton (2003, p. 10) defines executive charisma as "the ability to gain effective responses from others by using aware actions and considerate civility in order to get useful things done." Benton's six steps to developing executive charismatic qualities are as follows:

Step 1: Be the first to initiate

Step 2: Expect and give acceptance to maintain esteem

Step 3: Ask questions and ask favors

Step 4: Stand tall and straight, and smile

Step 5: Be human, humorous, and hands-on

Step 6: Slow down, shut up, and listen

It is important to recognize that being the first to initiate action establishes one's willingness to accept uncertainty head-on, to acknowledge that a situation can be either a problem or an opportunity to initiate transformation. This first step requires a consistent willingness to act. Recognition, as both a giver and a receiver, fulfills the second step of the plan: to provide a sense of esteem to oneself and others. This provision of esteem provides a cycle of optimism that can pervade the organization, affecting the other people who are involved in the transformative effort.

The third step provides for an exchange of information as required to meet organizational objectives. Choosing one's words and tone carefully while being specific and concise is important to ensuring that information is timely, relevant, and accurate. Do not be too timid to ask questions or solicit favors. Be mindful to recall favors provided and extend thanks in return. Perception is important when one is exhibiting charismatic qualities. Step four demands that the executive

leader not only play the role, but also look the role. Standing tall with a relaxed confidence enhances one's charismatic appearance.

Interestingly, step five mandates that charismatic leaders take on responsibilities that others will not—but without overdoing it. By this, Benton means that being human is imperative to being charismatic, but don't be too human. Be humorous with a sense of appropriateness. Do not cross social, ethnic, or gender boundaries. Stepping across acceptable boundaries into indefinable territory can quickly extinguish one's effort to create charismatic leadership qualities.

The final step involves maintaining a pace that permits decision making, implementation, and focus. Not talking (shutting up) allows one the opportunity to listen. Listening allows one to hear what others have to say, develop a response to the information, and gain the trust necessary to initiate transformational efforts. "Executive charisma isn't as much about you as about your effect on others and that comes not just from what you say and do but from what you don't say and don't do" (Benton, 2003, p. 153).

Servant Leadership

Some scholars in the leadership area, such as Peter Senge, Warren Bennis, Peter Block, and Margaret Wheatley, see servant leadership as the emerging leadership paradigm for the 21st century for all corporations and institutions. The concept of servant leadership is captured in the following quote from Disraeli: "I must follow the people. Am I not their leader?"

The term "servant leadership" was first used by Robert K. Greenleaf in 1969 as a way to describe a type of leadership that focuses on serving the highest needs of other people in an effort to help the others to achieve their goals. Servant leadership is an approach to managing people that "begins with a clear and compelling vision that excites passion in the leader and commitment in those who follow" (Blanchard & Hodges, 2003). A servant leader values others' strengths and talents and encourages the use of these strengths and talents for the betterment of the organization.

Servant leadership focuses on the leader's development through awareness and self-knowledge. Spears (2004) identified the qualities and characteristics of servant leadership: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community. These characteristics, along with a moral core, drive servant leaders to help people meet their goals and overcome challenges (Trastek et al., 2014).

Servant leadership recognizes the importance of performance coaching while acknowledging that individual development and performance are strongly related. According to Blanchard and Hodges (2003, p. A2), instrumental to the implementation of servant leadership are three components of performance coaching:

1. *Performance Planning*: The setting of goals and objectives.
2. *Day-to-Day Coaching*: Providing the resources and an environment conducive to the accomplishment of established goals.
3. *Performance Evaluation*: The timely and relevant evaluation of individual performance and the identification of professional developmental needs.

Anderson (2003) believes that servant leadership can build effective hospital–physician relationships. He states that servant leaders accept as their responsibility the need to invest in the lives of their followers, believing that they are "not superior to the follower and also know that on any given day or in a given circumstance the follower may become the leader. It is the servant leader's hope that the follower will indeed one day become a servant leader and, therefore, will

make an investment in the follower's career to better ensure that indeed this happens" (Anderson, 2003, p. 45).

Although empirical research in the area of servant leadership in the health care industry is still somewhat limited, Ornelas (2003) found a positive correlation between organizational outcomes and perception of servant leadership characteristics among departmental leaders in a large health system. The results of Ornelas's study showed that employees working in departments that had managers with servant leadership characteristics reported lower turnover rates, higher job satisfaction, and increased commitment to the organization than did employees working in departments whose managers did not embrace the servant leadership philosophy. Jenkins and Stewart (2010) reported similar results. The researchers found a positive impact on individual nurse employees' job satisfaction in departments where the nursing staff perceived that their managers had a stronger servant leadership orientation.

In their studies of health care leadership, Pelote and Route (2007) concluded that the most successful leaders, whom they refer to as masterpiece leaders, displayed a form of servant leadership. These leaders viewed themselves as the leader-coach first and the leader-expert second. "Masterpiece leaders create, energize, and motivate the health care climate; exhibit a high level of passion, excitement, and drive to perpetuate their success" (p. 282).

Many people equate servant leadership with transformational leadership; however, there are differences. The primary difference between the two leadership styles is the focus of the leader (Stone, Russell, & Patterson, 2003). Stone et al. (2003, p. 1) explain that

> the transformational leader's focus is directed toward the organization, and his/her behavior builds follower commitment toward organizational objectives, while the servant leader's focus is on the followers, and the achievement of organizational objectives is a subordinate outcome. The extent to which the leader is able to shift the primary focus of leadership from the organization to the follower is the distinguishing factor in classifying leaders as either transformational or servant leaders.

Collaborative Leadership

Ibarra and Hansen (2011, p. 73) define collaborative leadership as the "capacity to engage people and groups outside one's formal control and inspire them to work toward common goals—despite differences in convictions, cultural values, and operating norms." Collaborative leadership is complex because it requires a leader to achieve success by motivating individuals in multiple groups and/or organizations in addition to bringing together and aligning the goals of many stakeholders (Borkowski & Deppman, 2019). Al-Sawai (2013) states that collaborative health care leadership requires a synergistic work environment in which multiple parties are encouraged to work together toward the implementation of effective practices and processes. Such collaborations promote understanding of different cultures and facilitate integration and interdependency among multiple stakeholders who are unified by shared visions and values.

Borkowski and Deppman (2019) point out that as health care reform moves the industry from segment-based delivery models to integrated systems such as accountable care organizations (ACOs), collaborative leadership becomes critical to organizational success. The leader of an ACO is expected to integrate and coordinate the various component parts of health care, such as primary care, specialty services, hospitals, and home health care, and to ensure that all parts function well together to deliver efficient, high-quality, and cost-effective patient-centered care.

Managers of 21st-century health care organizations must be able to lead diverse groups of people and facilitate their professional efforts and problem solving both within an organization and across formal organizational boundaries.

According to Carter (2006), the collaborative leader should demonstrate:

1. The confidence that the goals and objectives are achievable.
2. The skills to clearly communicate with the stakeholders about the issues that need to be addressed and the potential approaches to problem solving.
3. The ability to serve as an active listener.
4. The ability to share knowledge and authority with the collaborators.
5. The ability to assess and handle varying levels of risk in decision making and implementation.

The good news is that these behaviors and the required skill set (see **Appendix 12-A**) can be learned by dedicated leaders who commit the necessary time and effort (Borkowski & Deppman, 2019). The Turning Point Leadership Development National Excellence Collaboration has identified six key practices that are unique to leading a collaborative process and the necessary steps for leaders to guide successful collaborations (see **Appendix 12-B**).

Another Look at Traits and Behavior

As was mentioned at the beginning of the chapter, contemporary theories of leadership indicate a resurgence of interest in individual traits and behaviors. Two such theoretical constructs that are receiving considerable attention are the Big Five personality factors (Judge et al., 2002) and emotional intelligence (EI) (Salovey & Mayer, 1990). Following an examination of these constructs, we return to behaviors. Bass (1990a, b) emphasized that leadership can be learned and suggested that one of the most significant applications of transformational theory is in the training of individuals to become transformational leaders. The success of transformational leadership training appears to be based on actual increases in leader uses of transformational behaviors. Identification of behaviors that define competent transformational health care leaders has captured the attention of both scholars and practitioners.

Big Five Personality Factors

The Big Five personality framework posits that the multitude of personality characteristics identified in theory and research can be organized into five factors that underlie all others (DeHoogh et al., 2005; Robbins, 2005):

Extroversion: Extroverts tend to be social, assertive, active, and gregarious.

Agreeableness: Agreeable individuals are warm, generous, cooperative, and trusting.

Conscientiousness: Conscientious individuals are dependable, responsible, achievement oriented, organized, and proficient.

Emotional Stability: This dimension captures an individual's ability to withstand stress. People with positive emotional stability are calm, self-confident, and secure. Some researchers measure this factor as *neuroticism*, which reflects the tendency to be anxious, insecure, and defensive.

Openness to Experience: Individuals who are open to experience are characterized by imagination, unconventionality, a range of interests, and fascination with novelty.

Robbins (2005) suggests that the studies of the Big Five approach resulted in consistent and strong support for traits as predictors of leadership. A different conclusion is drawn by DeHoogh et al. (2005). These authors suggest considerable variability in both the strength and direction of the relationships between the personality factors and transformational and transactional leadership. Such variances, they conclude, result in weak support for the Big Five factors.

The inconsistency of findings led DeHoogh et al. (2005) to suggest that it is not personality itself that is important in leadership style, but the interaction of personality characteristics and the context. Their research examined both the direct measure of the Big Five personality factors and interactive relationship with emphasis on perceived leader effectiveness (transformational and charismatic leader styles were considered equivalent and contrasted with transactional). The context variable—the work environment—was defined as either dynamic (i.e., characterized by a high degree of challenge and opportunities for change) or stable (i.e., more structured, and orderly). Results from this study established that the relationships between personality and leadership style did indeed differ depending on the context.

Emotional Intelligence

The concept of emotional intelligence (EI) is relatively new in the field of organizational behavior. Emotional intelligence involves assessing one's own feelings, as well as the feelings of others, then using those assessments to guide personal thought and action. EI has five distinct characteristics:

1. Self-awareness
2. Self-management or regulation
3. Self-motivation
4. Empathy or social awareness
5. Social skills

Goleman (1998, p. 318) describes self-awareness as involving self-understanding and knowledge of one's true feelings at any given moment. Self-management ensures that a manager can control their emotions to assist with the task at hand while focusing on the problem's solution. Self-motivation allows the manager to stay focused on the goal and desired outcome, overcoming negative emotional stimulus and accepting delayed gratification. Empathy is having a sense of what others feel and want while being sensitive to their needs. Finally, social skills relate to one's ability to read and react to social situations while interacting with other people and guiding and influencing the behavior of others.

Goleman (1998), as cited by Luthans (2002, p. 306), noted that EI is not the "end all" in determining leadership characteristics and competencies, but nonetheless, he concludes:

- At the individual level, elements of EI can be identified, assessed, and upgraded.
- At the group level, EI means fine-tuning the interpersonal dynamics that make groups smarter.
- At the organizational level, EI means revising the value hierarchy to make emotional intelligence a priority—in the concrete terms of hiring, training and development, performance evaluation, and promotions.

Goleman (1998) believes that EI is more important than IQ, proposing that EI is a better predictor of success in both personal and professional endeavors. Gibbs (1995) provided the following evidence as to the importance of EI: "IQ gets you hired, but EI gets you promoted" (p. 64).

Druskat and Wolff (2001) have extended the concept of individual emotional intelligence to teams. The members of creative, productive teams demonstrate mutual trust, a sense of group identity, and a sense of group efficacy. These emotional components enable effective participation, cooperation, and collaboration. They state (p. 83):

> Group emotional intelligence … [is] about bringing emotions deliberately to the surface and understanding how they affect a team's work. It is also about behaving in ways that build relationships both inside and outside the team and that strengthen the team's ability to face challenges.

Health care organizations are just beginning to recognize the importance of developing employees' EI (Grossman, 2000). Only some progressive health care facilities have recognized the value of EI training and have incorporated programs that emphasize its principles. However, as Freshman and Rubino (2002) point out, the applications of EI fit well within the industry, as reflected in **Table 12-2**.

Table 12-2 Emotional Intelligence Components Applied to Healthcare Administration

Component	Definition	Examples in Healthcare Administration
Self-awareness	Self-understanding and knowledge of one's feelings, strengths, weaknesses, and motivations at any given moment.	1. Knowing that you have a tendency to interrupt others and insist on your own way 2. Understanding what types of work arrangements will interfere with your family life
Self-regulation	Self-management to ensure that one can control their emotions to assist with the task at hand while focusing on the problem's solution	1. Able to maintain composure when an angry or aggressive patient wants a resolution to a problem with their experience 2. Learning how to work well with a new boss 3. Recognizing your contribution to an argument with a colleague
Self-motivation	Staying focused on the goal and desired outcome, overcoming negative emotional stimulus and accepting delayed gratification	1. Pursuing excellence in your work even if you think nobody else will notice 2. Looking at challenging assignments as opportunities to grow and learn 3. Taking on new projects
Social awareness	Having a sense of what others feel and want while being sensitive to their needs	1. Considering the perspective of doctors and nurses when making a decision that will impact them

(continues)

Table 12-2 Emotional Intelligence Components Applied to Healthcare Administration *(continued)*

Component	Definition	Examples in Healthcare Administration
		2. Understanding that a colleague's emotions and performance at work may be related to challenges in their personal lives
Social skills	Relating appropriately to social situations while interacting with others and influencing their behavior accordingly.	1. Getting department leaders on board to support a project being implemented across the hospital system 2. Helping motivate employees to work in a manner that supports the mission and vision of the organization

Behavioral Competencies

In general, behavioral competencies define the skills, knowledge, abilities, and actions that distinguish superior performance. Spencer and Spencer (1993) describe a competency as "what outstanding performers do more often, in more situations, with better results, than average performers." There has been growing interest in the development of competencies since McClelland (1961, 1985) published his work on achievement and motivation. In the past 10 or 15 years, leadership competency models have proliferated in health care education and professional development. Numerous consulting organizations, professional associations, health care organizations, and educational programs have created leadership competency lists (Hernandez, O'Connor, & Meese, 2018; Dye & Garman, 2006). The acceptance and implementation of competency-based education and training across health care systems may be viewed as acknowledgment that at least a significant portion of leadership may be learned and as the desire to ensure exceptional leadership and performance in health care.

The large numbers of competency models preclude an exhaustive review. However, students in health care management programs should examine the competencies incorporated into their programs of study. The National Center for Healthcare Leadership (NCHL) in conjunction with the Robert Wood Johnson Foundation has developed a framework to implement competency-based learning and assessment curricula in health care management education. The NCHL project relies on academics and experts in the field to define the technical and behavioral characteristics that leaders must possess to be successful across the health professions. The full model, which may be found on NCHL's website (www.nchl.org), contains levels for each competency that distinguish leaders at each career stage (early careerist, midcareerist, and senior executive). Future and current health care executives may be guided by the competencies set forth by the American College of Healthcare Executives (ACHE), the international professional organization for the more than 30,000 health care executives who lead hospitals and health care organizations around the world (see www.ache.org). ACHE offers a Healthcare Executive Competencies Assessment Tool derived from the Healthcare Leadership Alliance (HLA) (see www.healthcareleadershipalliance.org). The competencies were developed by HLA through job analyses and research. Three hundred competencies are categorized under five major domains: (1) leadership, (2) communications and relationship management, (3) professionalism, (4) business knowledge and skills, and (5) knowledge of the health

care environment. The ACHE self-assessment is designed to assist executives in identifying areas of strength as well as areas in which they might want to improve their performance. The International Hospital Foundation (IHF) took a similar approach to identify a global competency directory to be used by health care leaders across countries and continents (Hernandez et al., 2018).

Do competencies create effective leaders? Dye and Garman (2006) suggest that competency is most accurately described as the *capacity* to perform (p. xxxi). Translating competency into success requires both motivation and opportunity. Furthermore, competencies are not just learned but "are more accurately described as improving slowly over time as a result of mindful practice, feedback, and more practice" (p. xx). Pelote and Route (2007) also present a broader view of leadership competencies in the Healthcare Causal Flow Leadership Model. As the model demonstrates, individual characteristics do not exist in a vacuum and, of themselves, are not a source of success. Leadership competencies are viewed as being among the variables within a context (e.g., health care climate) that ultimately affects performance outcomes (i.e., patient outcomes, patient satisfaction, and financial results).

Lieutenant General George J. Flynn remarked, "In short, professional competence is not enough to be a good leader; good leaders must truly care about those entrusted to their care." (Sinek, 2017, p.xii). Therefore, leaders must create an organizational culture in which other people feel safe and protected, not only from the outside world, but also from each other. When leaders create an environment in which others feel safe to innovate, take risks, and work for the benefit of the group, organizational and group performance improves, innovation goes up, and organizational learning increases (Edmondson & Lei, 2014).

Summary

Contemporary theories recognize the complexity of leadership yet also bring us back to examining the role of traits and behaviors that were the focus of the more simplistic, traditional leadership theories of the past. Today, leadership theorists acknowledge the presence of a symbiotic relationship between the leader's traits and behaviors, the follower, the environment, the situation, and the strategic organizational objectives. In response to an ever-changing external environment, contemporary leadership approaches allow interactions between the leader and the follower that are not possible with traditional leadership approaches. A common thread among contemporary leadership models is an integration of ideological, moral, and value applications.

It is important to recognize that organizations require both transactional and transformational styles of leadership if strategic goals are to be met. One approach is not necessarily preferred over the other. Imagine an organization that has only transactional leaders. Tasks and processes would be accomplished, but it is unlikely that the organization would have the ability to transform itself to respond to an ever-changing environment or redirect its efforts into new markets. At the same time, an organization that had only transformational leaders would certainly have the vision to change and innovate but would not have the capacity to do so because of an absence of transactional agreements between managers and employees. This scenario is unlikely, but it does portray the importance of balance of leadership styles within organizations.

It is essential to create a blend of leadership that is flexible and adaptable to differing situational factors. The formula for balance is difficult. In a time of crisis, which style of leadership is most important: transactional or transformational? There is no simple answer to this question

because of the multitude of situational factors. One could argue that in a time of crisis, transactional leadership would be more effective if control and efficiency were the primary concerns. Likewise, transformational leadership would be more effective in a time of crisis if change and innovation were the dominant interest.

There is supportive research that suggests that transformational, charismatic, and other contemporary leadership attributes can be learned. This finding is valuable to individuals who find that they have reached a plateau in their professional development plan. Leaders at all levels of an organization can enhance, modify, and develop leadership skills to increase their ability to influence, control, and manage by identifying personal leadership strengths and weaknesses.

Today's health care managers can move beyond transactional leadership into areas that create opportunities for ever-increasing levels of performance and connection to the workforce through visionary and servant approaches to leadership. Contemporary managers should look closely within themselves to determine appropriateness of leadership styles on the basis of situational, environmental, and personal factors. Leaders in the turbulent health care environment must help their followers feel safe, not only from outside threats, but also from other people within the organization. Understanding the need for aligning one's leadership approach with these factors can generate higher levels of workplace commitment and performance.

Discussion Questions

1. Identify the similarities and differences between transactional and transformational leadership. Discuss the appropriateness of each style depending on situational factors.
2. Discuss the type of leadership style—transactional, transformational, servant, and collaborative—that occurs in your specific professional environment. List the positive and negative outcomes that exist as a result of the leadership approach used.
3. Debate the position that transformational and charismatic leadership can (or cannot) be learned. Be specific in your support for the position you take.
4. Discuss Benton's six-step plan for executive charisma. Would the plan work for you in your current health care setting?
5. Deliberate the need for transformational or collaborative leadership in the next 5 years as the health care environment transforms as a result of industry reform.

Exercise 12-1

It has been stated that to lead people through the complex changes facing the health care industry, transformational leadership is required (i.e., leaders creating an environment in which staff can best apply their knowledge, skills, and efforts, engaging commitment and developing potential). Suppose you are engaged as the consultant for Beltway Healthcare System to develop a management development program that will be the vehicle that managers can use to develop the necessary skills and knowledge to drive organizational change and improve the system's performance.

What would you propose as the goals of the management development program?

What learning methods would be best suited to achieve these goals?

Exercise 12-2 Are You a Charismatic Leader?

If you were the director of a major department in a health care company, how important would each of the following activities be to you? Answer yes or no to indicate whether you would strive to perform each activity.

1. Help subordinates to clarify goals and how to reach them.
2. Give people a sense of mission and overall purpose.
3. Help to get jobs completed on time.
4. Look for the new product or service opportunities.
5. Use policies and procedures as guides for problem solving.
6. Promote unconventional beliefs and values.
7. Give monetary rewards to subordinates in exchange for high performance.
8. Command respect from everyone in the department.
9. Work alone to accomplish important tasks.
10. Suggest new and unique ways of doing things.
11. Give credit to people who do their jobs well.
12. Inspire loyalty to yourself and to the organization.
13. Establish procedures to help the department operate smoothly.
14. Use ideas to motivate others.
15. Set reasonable limits on new approaches.
16. Demonstrate social nonconformity.

The even-numbered items represent behaviors and activities of charismatic leaders. Charismatic leaders are personally involved in shaping ideas, goals, and direction of change. They use an intuitive approach to develop fresh ideas for old problems, and they seek new directions for the department or organization. The odd-numbered items are considered more traditional management activities, or what would be called transactional leadership.

Managers respond to organizational problems in an impersonal way, make rational decisions, and coordinate and facilitate the work of other people. If you answered yes to more even-numbered than odd-numbered items, you may be a potential charismatic leader.

Data from "Have You Got It?" a quiz that appeared in Patricia Sellers, "What Exactly Is Charisma?" *Fortune* (January 15, 1996): pp. 68–75; Bass, B. M. (1985). *Leadership and performance beyond expectations.* New York, NY: Free Press; and Burns, L. R., & Becker, S. W. (1986). Leadership and managership. In S. Shortell & A. Kaluzny (Eds.), *Health care management.* New York, NY: Wiley.

Exercise 12-3 What Is Your EQ?

A number of testing instruments have been developed to measure emotional intelligence, although the content and approach of each test varies. See the About.com Psychology Website at psychology.about.com/library/quiz/bl_eq_quiz.htm for a quiz that presents a mix of self-report and situational questions related to various aspects of emotional intelligence. Take the quiz to learn more regarding about your quotient.

Do you think you are at a higher or lower level than most people when it comes to emotional intelligence?

What might you be able to do to raise your level of emotional intelligence? How effective do you think this might be, considering that some researchers suggest that emotional intelligence can be learned and strengthened, while others claim that it is an inborn characteristic?

Exercise 12-4

Access a leadership competency assessment tool of your choice. Review your scores to identify strengths as well as areas to further develop. Given your current strengths, how would you conceptualize your leadership style?

Appendix 12-A Traits and Skills of Collaborative Leaders

Traits	Skills
Self-confidence	Communication
Decisiveness	Social
Resilience	Influence
Energy	Analytic
Need for achievement	Technical
Willingness to assume responsibility	Continual learning
Flexibility	Self-management
Service mentality	Strategic thinking
Personal integrity	Facilitation
Emotional maturity	
Collaborative mindset	
Passion towards outcomes	
Systems thinking	
Openness	
Risk-taking	
Sense of mutuality and connectedness	
Humility	

Morse, R. S. (2007). *Developing public leaders in an age of collaborative governance.* University of Delaware, Institute for Public Administration. Available at: http://www.ipa.udel.edu/3tad/papers/workshop4/Morse.pdf

Appendix 12-B Six Key Practices and Necessary Steps for Leaders to Guide Successful Collaborations

	Practices	Action
1	Assess the environment	A collaborative leader needs to be able to recognize common interests and understand others' perspectives. Collaboration seeks goal attainment around shared visions, purposes, and value. When different points of views to an issue or problem are addressed, a collaborative leader facilities connections and encourages group thinking that identifies clear, positive change for all participants. The first priority is to set goals. The second priority is to identify the barriers and obstacles to achieving the goals.

2	Create clarity	Having and communicating the clarity of purpose (i.e., shared vision) is a quality that characterizes collaborative leaders. Clarity allows the group members to focus so their energy can be directed toward problem solving. Visioning in relation to clarity, involves the commitment to a process or a way of doing things. Mobilizing refers to helping people develop the confidence to take action and sustain their energies through difficult times.
3	Build trust	The collaborative leader must have the ability to promote and sustain trust between and among the participants for sharing of innovative approaches. If a collaborative leader fails to engender trust and openness among participants, best Ideas and innovative approaches for problem solving will not be developed or shared by the group.
4	Share power and influence	The collaborative leader must allow the participants to be empowered to fully contribute in the decision-making process. Rather than being concerned about losing power through collaboration, the leader needs to recognize that sharing power actually generates strength.
5	Develop people	The collaborative leader needs to bring out the best in others, maximize the use of other people's talents and resources, build power through sharing power, and cede authoritarian ownership or control. By doing so, the leader increases others' leadership capacities by encouraging experimentation, goal setting, and performance feedback.
6	Self-reflection:	Successful collaborative leaders demonstrate high levels of emotional intelligence or maturity. Through self-reflection, leaders can examine and understand their values and assess whether their behaviors are congruent with their values. In addition, successful leaders critically consider the impact their actions and words have on the group's progress toward achieving its goals and adjust their behaviors if necessary.

Turning Point Leadership Development National Excellence Collaborative, sponsored by The Robert Wood Johnson Foundation.

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PART IV

Intrapersonal and Interpersonal Issues

In Part IV, we explore various intrapersonal and interpersonal issues. The focus in Chapters 13 and 15 is on stress and conflict, respectively, and how the negative effects of both can be avoided or at least minimized. Having an optimal level of stress and conflict in our lives is good. It can lead us to work efficiently and effectively with creativity. However, when we experience too much of either stress or conflict, productivity levels may decrease, and we may experience problems with our physical and mental health. In Chapter 14, we discuss the various ways in which individuals approach decision making. Managers face different types of problems (that cause stress and conflict) and therefore use different types of decision-making models—some more effective than others.

CHAPTER 13

Stress in the Workplace and Stress Management

LEARNING OUTCOMES

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

- The definition of stress.
- The process model of stress and coping.
- How stress can negatively affect individuals and organizations.
- The various forms of stress.
- The three stages of the General Adaptation Syndrome.
- How personalities, race, and gender affect an individual's level of stress.
- The definition and phases of burnout.
- The four categories of stress in the workplace.
- The various coping strategies that are available to organizations and individuals.
- The definition of stress management and the various stress management programs that organizations use.

Overview

Stress is a complex and highly personalized process. Stress levels can vary widely, even in identical situations, because of individuals' varying abilities to cope with different forms and levels of stress. The ways in which people are affected depend on a number of factors, such as their level of self-efficacy, their adaptability, and the resources available to them.

Cognitive-transactional theory defines stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being" (Schwarzer, 2004, p. 343). Lazarus and his associates (Lazarus, 1991; Lazarus & Folkman, 1984; Lazarus, DeLongis, Folkman, & Gruen, 1985) argue that different individuals may perceive the same stressful situation differently on the basis of their cognitive appraisal. Some individuals see a specific situation as a threat; other individuals see the same situation as a challenge or opportunity.

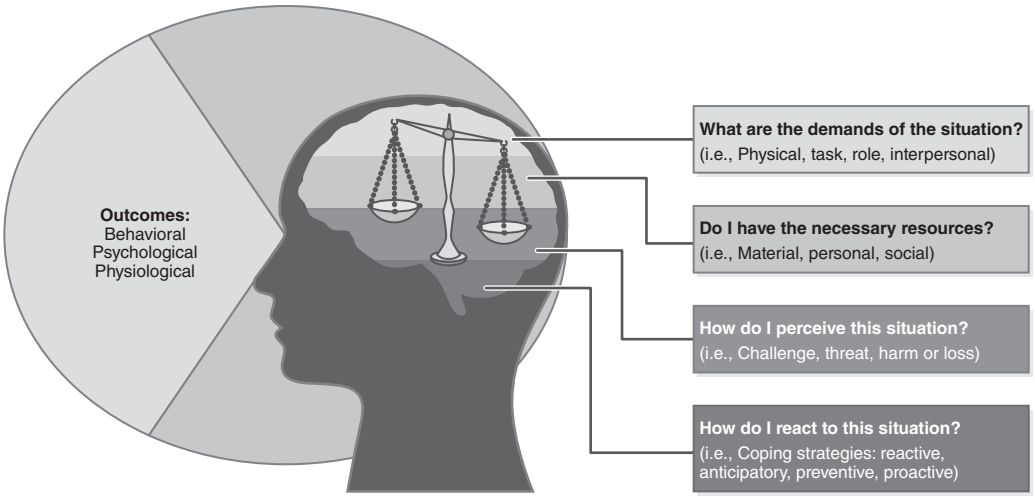

Figure 13-1 The Process Model of Stress and Coping

As **Figure 13-1** illustrates, an individual's assessment of the situation includes demand appraisals or resource appraisals. Demand appraisals relate to the person's perception of (1) physical demands, (2) task demands, (3) role demands, and (4) interpersonal demands (see **Table 13-1**). Resource appraisals may be material, personal, or social. Material appraisals ask the question "Do I have the necessary resources to complete this task?" Personal resource appraisals refer to an individual's internal coping options. Individuals who are affluent, healthy, capable, and self-confident are generally less vulnerable to stressful events. Social resource appraisals relate to external coping options available to an individual, such as availability of obtaining assistance from others, receiving emotional support (reassurance), and/or advice or additional information necessary to complete the task (Lazarus, 1991; Schwarzer, 2004).

The person's appraisal of the situation results in one of three perceptual outcomes: challenge, threat, or harm/loss. When a situation is viewed positively, the person sees the situation as a challenge and an opportunity to achieve personal growth. When the situation is viewed as a threat, the person perceives danger from either physical injury or a blow to the self-esteem. For example, a task demand that is perceived to be difficult, ambiguous, unexpected, or time-consuming with an unrealistic deadline is more likely to induce a threat outcome than is an easy task that can be thoroughly prepared for and solved at a convenient pace without time constraints. If the appraisal is viewed to be harm or loss, the person has determined that damage has already occurred, such as loss of self-worth, a lowering of the person's social standing, or physical injury (Lazarus, 1991; Schwarzer, 2004).

Building on Lazarus' work, Schwarzer's (2004) process model illustrates that, on the basis of an individual's perception of the situation, they may engage in various coping strategies to manage the experience of stress. The combination of an individual's perception of the situation (appraisals) and the coping strategies employed (reactive, anticipatory, preventive, or proactive) will determine the resulting consequences, which may be behavioral, psychological, physiological, or combinations of the three (see **Table 13-2**).

In this chapter, we first examine the factors that contribute to a person experiencing stress in the workplace. Although many extraorganizational factors contribute to an individual's experience

Table 13-1 Demand Appraisals

Physical Demands
■ Indoor climate and air quality
■ Temperature
■ Illumination and other rays
■ Noise and vibrations
■ Office design
Task Demands
■ Occupational category
■ Routine jobs
■ Job future ambiguity
■ Interactive organizational demands (e.g., interface with various constituencies, such as with boundary spanning)
■ Work overload
Role Demands
■ Role conflict
■ Interrole
■ Intrarole
■ Person/role (i.e., conflicting values or beliefs)
■ Role ambiguity
■ Work/home demands
Interpersonal Demands
■ Status incongruity
■ Social density (i.e., interpersonal need for space and distance)
■ Abrasive personalities
■ Leadership style
■ Team pressures
■ Diversity

Quick, J. C., Quick, J. D., Nelson, D. L., & Hurrell, J. J. (1997). *Preventive Stress Management in Organizations* (p. 22). Washington, DC: American Psychological Association.

Table 13-2 Individual Distress: Behavioral, Psychological, and Physiological Consequences

Behavioral Consequences
■ Tobacco use
■ Alcohol use
■ Drug abuse
■ Accident proneness
■ Violence
■ Eating disorders
Psychological Consequences
■ Burnout
■ Family problems
■ Anxiety disorders
■ Sleep disturbances
■ Sexual dysfunction
■ Depression
■ Conversion reaction and somatization
Physiological Consequences
■ Hypertension, heart disease, and stroke
■ Cancer
■ Back pain, arthritis, and other musculoskeletal conditions
■ Peptic ulcer disease and other gastrointestinal conditions
■ Headache
■ Diabetes mellitus
■ Liver cirrhosis and other alcohol-related diseases
■ Lung disease
■ Skin disease
■ Other diseases (e.g., HIV, chronic fatigue syndrome)

Quick, J. C., Quick, J. D., Nelson, D. L., & Hurrell, J. J. 1997. *Preventive Stress Management in Organizations* (p. 66). Washington, DC: American Psychological Association 66.

of stress, such as a pending divorce, housing conditions, and the general economy, this chapter focuses primarily on stress in the workplace. Second, we examine the various methods of coping with stress, referred to as stress management, from both an organizational perspective and an individual perspective.

Work-Related Stress

Stress is a common phenomenon in today's workplace. Numerous surveys and studies confirm that occupation-related pressures are the leading source of stress for adults. Stress, which the World Health Organization has called the "health epidemic of the 21st century," is estimated to cost U.S. businesses up to $300 billion a year (Smith, 2012) as a result of accidents; absenteeism; employee turnover; loss of productivity; direct medical, legal, and insurance costs; workers' compensation awards; and tort and Federal Employers' Liability Act judgments (American Institute of Stress, 2004).

The National Institute for Occupational Safety and Health (NIOSH), the federal agency in the U.S. Department of Health and Human Services that is responsible for conducting research and making recommendations for the prevention of work-related injury and illness, determined the following:

- 40% of workers reported that their jobs were very or extremely stressful.
- 25% viewed their jobs as the number-one stressor in their lives.
- 75% of employees believed that workers have more on-the-job stress than a generation ago.
- 29% of workers felt quite a bit or extremely stressed at work.
- 26% of workers said they were "often or very often burned out or stressed by their work."
- Job stress was more strongly associated with health complaints than with financial or family problems. (NIOSH, 1999)

Workplace Violence

In addition to the effects of stress on health and financial or family problems, it may lead to physical violence in one out of 10 work environments. According to a study of "desk rage" by Integra Realty Resources (2001), almost half of those surveyed said that yelling and verbal abuse were common in their workplaces. In a 2013 study, 51% of British workers reported experiencing rage at work (The Telegraph, 2013). Desk rage or work rage can include behaviors or acts of aggression, hostility, rudeness, and physical violence. Workplace violence affects over 2 million Americans and costs an estimated $36 billion annually (Corporate Alliance to End Partner Violence, 2014) due to lost productivity, diminished image, insurance payments, and increased security costs. Workplace violence is not an uncommon problem in the health care industry. It can occur both in interactions between coworkers and with patients and their families.

It is estimated that health care workers are 20% more likely to be the victim of workplace violence relative to other professions. Of all workplace intentional injuries reported in 2017, 71% occurred in health care and social services workplaces (Coutre, 2019; The Joint Commission, 2018). Health care and social services workers are over four times more likely to experience intentional injuries caused by another person than are workers in all other private sector jobs combined. Health care workers often face violent and aggressive or derogatory behaviors from patients and their family members. One nurse reports, "I've been bitten, kicked, punched, pushed, pinched, shoved, scratched, and spat upon. I have been bullied and called very ugly

names. I've had my life, the life of my unborn child, and of my other family members threatened, requiring a security escort to my car" (The Joint Commission, 2018).

In addition to workplace violence from patients and visitors, workplace violence or desk rage is common in interactions among different members of the health care team. For example, almost one-third of physician executives who participated in a national study conducted by the American College of Physician Executives reported that serious problems erupted in their organization on either a monthly or a weekly basis as a result of disruptive behavior by physicians (Weber, 2004). Two-thirds of the nurses responding to a nurse–physician communication survey reported that they had suffered verbal, mental, or physical abuse by a physician. The most common complaints related to physicians yelling, cursing, and abruptly hanging up on the nurse during telephone conversations. Another behavior that was cited was being berated by the physician in front of patients, family members, or other staff members. The highest number of desk rage responses came from nurses working in hospital operating rooms, and the incidents included throwing of surgical instruments (Homsted, 2003). Because of these types of situations, which undermine a culture of patient and workplace safety, The Joint Commission issued a *Sentinel Event Alert* on the topic and developed a standard requiring all accredited hospitals to have a code of conduct as well as a process for managing disruptive and inappropriate behaviors (Wyatt, 2013).

Stressors

Everyone encounters stress in daily life, but the effects on an individual depend on a number of factors. Causes or sources of stress, known as stressors, can take on a number of forms, such as positive or negative, external or internal, or short-term (acute) or long-term (chronic).

Positive and Negative Stressors

A certain degree of stress is necessary for good mental and physical health; it can be viewed as constructive stress, which compels us to act with optimal performance, helping us to achieve our goals. Hans Selye (1956, 1974), a Canadian physiologist referred to as the grandfather of stress research, coined the term "eustress," incorporating the Greek root *eu* for "good," to describe good or positive stress. Selye suggested thinking of eustress as euphoria + stress. It is only when stress is poorly managed or becomes overwhelming that the negative effects appear; this poorly managed stress is referred to as distress (see **Figure 13-2**).

Distress refers to the unhealthy, negative, destructive outcomes of stressful events (Quick et al., 1997). Distress may have behavioral, physiological, and/or psychological effects on the individual. For example, as early as the 1930s, physiologists were studying the physiological changes in individuals when they were confronted with a negative stimulus or environmental change. This is referred to as an individual's fight-or-flight response. In the fight-or-flight response, certain chemicals in the brain cause a reaction to potentially harmful stressors or warnings (e.g., danger, harassment, noise). Selye (1956) studied the physiological effects of the fight-or-flight response, and the result was his description of General Adaptation Syndrome (GAS). GAS describes the three phases an individual undergoes when they encounter a stressful situation: the alarm phase, the resistance phase, and the exhaustion phase.

The first stage of GAS, the alarm phase, occurs when an individual's fight-or-flight response is elicited for mobilization and geared for either a fight or flight. In the second stage, resistance, the individual fights the stressor or escapes it, and the acute fight-or-flight response ceases. The third stage, exhaustion, occurs when the individual can no longer adapt to the stressor (Jacobs, 2001). In the first two stages, alarm and resistance, bodily responses are adaptive and beneficial.

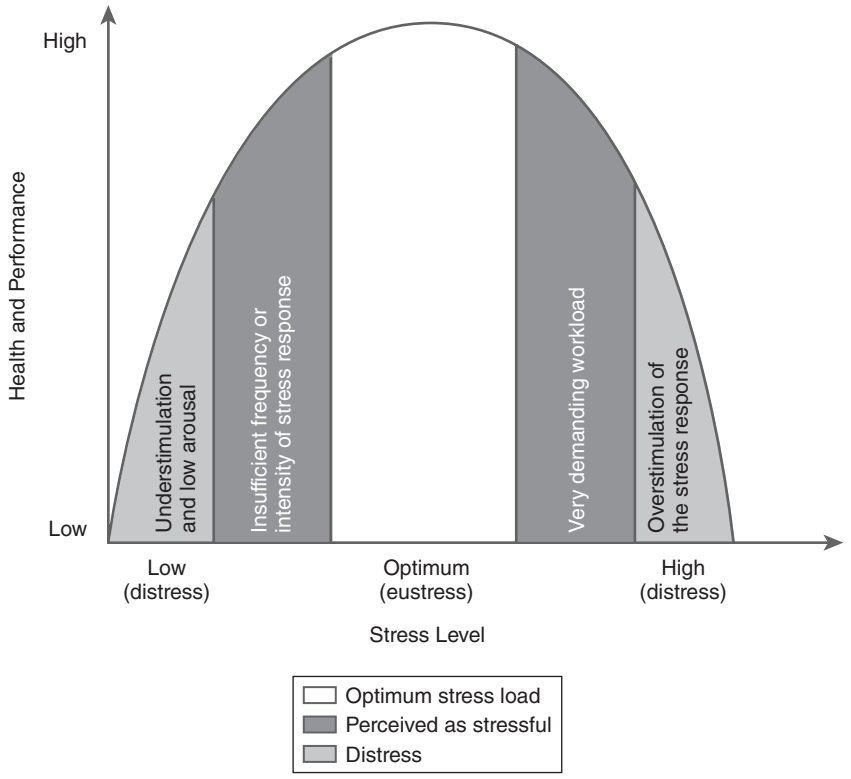

Figure 13-2 Distress–Eustress (an Expanded Yerkes–Dodson Curve)

Quick, J. C., Quick, J. D., Nelson, D. L., & Hurrell, J. J. (1997). *Preventive stress management in organizations.* Washington, DC: American Psychological Association.

It is only in the final stage, exhaustion, that an individual's stress may be reflected in behavioral, physiological, and/or psychological illnesses. Physiological illnesses related to stress may include chronic headaches or fatigue, hypertension, ulcers, and heart disease. Psychological illnesses or the emotional symptoms of stress in the exhaustion stage are rooted in frustration and/or depression. According to von Onciul (1996), these emotional symptoms are the behavioral consequences of the exhaustion stage, which may include emotional outbursts, violent or antisocial behavior, eating disorders, and general indifference and reduced attention to personal issues such as exercise and appearance. The individual may exhibit other mental dysfunctions in the exhaustion stage, such as the inability to concentrate and poor memory retention. This causes impaired performance, poor judgment, and indecisiveness as well as a negative attitude toward life and work, possibly leading to the misuse of alcohol and drugs (von Onciul, 1996).

Internal or External Stressors/Acute or Chronic

Individuals can experience two categories of stressors: external or internal. External stressors can be physical conditions, such as excessive temperatures, or psychological environments, such as abusive relationships. Internal stressors can be physical illnesses or psychological tendencies, such as an individual's personality type. These stressors can be described as either short-term (acute) or long-term (chronic). Short-term acute stress is the reaction to a real or perceived immediate threat

Table 13-3 External and Internal Stressors (Acute and/or Chronic)

External	Internal
Environment—Noise, poor lighting or bright lights, extreme temperatures of hot or cold, confined spaces, violence and other threats to personal safety, general economy, globalization, technology, war, and terrorism *Other People*—Rudeness, domineering attitudes, aggression, peer pressure, and discrimination *Work*—Excessive rules and policies, poor interpersonal relationships, lack of communication, mergers, downsizing, long and/or irregular hours, unrealistic deadlines, retraining, discrimination, and promotion or demotion *Major Life Events*—Death of loved one, poor health and/or disability, loss of job, new job, marriage, divorce, bankruptcy or other financial worries, relocation, new baby, caring for aging parents, and pending retirement *Everyday Hassles*—Commuting, misplacing keys or other important items, poor customer service, standing in lines, dealing with teenagers at home	*Lifestyle*—Unhealthy lifestyles, such as excessive caffeine, smoking, drinking, drugs, lack of sleep, trying to do too much (e.g., supermom) *Mental State*—Pessimistic, self-critical, self-helplessness, unrealistic expectations, and lack of flexibility *Personality*—Perfectionist, workaholic, perceived expectation of others and oneself, and other Type A personality characteristics

(the fight-or-flight response). Long-term chronic stressors are those that are continuous, such as work pressures, ongoing relationship problems, and financial concerns (see **Table 13-3**).

Individuals and Stress

Stress comes in all forms and affects all people. Although there are no external standards that can be applied to predict stress levels in individuals, research has provided us with some insight as to which people are more prone to experience higher levels of stress, such as certain personality types, members of minority groups, and individuals with certain gender orientations.

Personalities

Rosenman and Friedman, along with their colleagues (Rosenman et al., 1966), discovered the first relationship between stress and personality by linking coronary heart disease (CHD) and personality profiles. Starting in the 1950s, the Mount Zion Harold Brunn Institute studied the role of personality in CHD and found that participants with Type A behavior patterns (TABP), such as aggressiveness, anger/hostility, competitiveness, time urgency, impatience, tenseness, and intense commitment to goals, were at higher risk for developing CHD than were people with Type B personality traits (e.g., patient, low-key, noncompetitive) (Young, 1974). Although Type B individuals are as intelligent as Type A individuals and may be just as ambitious, they approach life in a different way (Quick et al., 1997). Friedman and Rosenman (1974) define TABP as an "action-emotion complex that can be observed in any person who is aggressively involved in a chronic, incessant struggle to achieve more and more in less and less time, and if required to do so, against the opposing efforts of other things or other persons" (p. 84).

Other studies suggest that rather than the entire set of Type A characteristics, only particular dimensions, such as tenseness, may be related to CHD (Kim et al., 1998). For example, Barefort, Dahlstrom, and Williams (1983) studied 255 physicians over a 25-year period and found that

anger and hostility were the lethal dimensions of TABP. At this time, researchers are still unsure what component or components of TABP constitute the most important factor leading to CHD for Type A individuals.

Another dimension of personality that is related to stress is the perception of control (Rotter, 1966). Employees with a high need for autonomy and control over their environments, such as the personality traits displayed by Type A individuals, will experience a higher degree of stress when they perceive a lack of control. For example, Kushnir and Kasan (1991) found that high-demand jobs combined with high workload and low perceived control were stressful for Type A but not Type B individuals.

Perceived control is defined as the amount of control that an individual believes they have over the environment, whether direct or indirect, to make the environment less threatening or more rewarding (Ganster & Fusilier, 1989). In the work setting, this concept is reflected in the extent to which an individual is free to decide how to accomplish a task or the goals of the job. Very low levels of personal control have been found to be psychologically harmful, whereas greater control has been associated with better mental health (Evans & Carrere, 1991; Ganster & Fusilier, 1989). High levels of perceived control have been found to increase an employee's job satisfaction, commitment, and performance (Spector, 1986).

Much of the research on perceived control stems from Robert Karasek's (1979) job demands–decision latitude model. This model proposes that the effects of job demands (psychological stressors in the work environment) on employee well-being are influenced by job decision latitude (i.e., the degree to which the employee has the potential to control their work). Karasek found that individuals in occupations with high demands and low decision latitude suffered the most severe psychosomatic complaints and the highest levels of both depression and job and life dissatisfaction. Other studies have confirmed that employees who perceive that they are subject to high demands (job responsibility) but have little control over their environment (authority and/or choices) are at increased risk for stress-related illnesses such as cardiovascular disease (Karasek, Baker, Marxer, Ahlbom, & Theorell, 1981). For example, Fox, Dwyer, and Ganster (1993) found that nurses employed in a medium-sized private hospital in the Midwest who experienced high workloads or demands with perceived low controllability showed increased physiological problems and lower attitudinal outcomes (job satisfaction), with the physiological responses continuing after the nurses left work. The researchers suggested that it was not the higher levels of workload or demands but the nurses' perception of low controllability over the situation that caused the nurses to display symptoms of job stress (i.e., low job satisfaction, high blood pressure, and high cortisol levels). Simmons and Nelson (2001), however, found that nurses with a high level of hope (the belief that one has both the will and the way to accomplish one's goals) had a significant, positive relationship with the perception of their health and ability to deal with the demands and stressfulness of their jobs.

An employee's sense of loss of control is an important form of emotional stress. Therefore, employers need to pay particular attention to this matter in the workplace. Middle managers are among those with the most stressful positions; they need to respond to others' demands and project deadlines while having little perceived control over their environments. Savery and Hall (1986) relate that "managers are beleaguered by demands not only from their superiors but also from government agencies, from subordinates and union representatives pushing for a greater say in the running of the enterprise, and from community and other interest groups with their many and rising expectations. Many of these demands are also mutually exclusive" (p. 160). Savery and Hall also found that a significant relationship existed between managers' perceived lack of autonomy (i.e., control) in decision making and stress-related illnesses. The researchers further found

that middle managers under 30 years of age felt more stress than senior managers because the middle managers experienced less autonomy, closer supervision, and more confusion over lines of authority in the organization.

However, a perceived lack of control might not be stressful to some employees. Some employees may want minimum control in their jobs. These employees may not want the increased responsibility that is often connected with greater job autonomy. In such situations, a greater degree of job control would actually have negative effects on the employee's well-being.

Underrepresented Populations

The nation's workforce is becoming more culturally and ethnically diverse. Surprisingly, the literature is limited about the specific impact of workplace diversity on organizations or about the stress that such diversity imposes on members of different cultural and ethnic groups (Keita & Hurrell, 1994; Quick et al., 1997). However, managers need to be attentive to the fact that employees from underrepresented ethnic groups may be more prone to stress than employees from majority groups because of issues associated with prejudice and discrimination, whether perceived or real, as well as potential language difficulties and differences in cultural values and attitudes.

Quick et al. (1997) point out that "blatant prejudice is the most obvious source of stress for those in minority ethnic groups" (p. 57). For example, in an early study, Kasschau (1977) found that the "overwhelming majority" of 800 minority survey respondents identified prejudice and discrimination at work. More recently, a survey of health care executives found that over 50% of Black respondents and 25% of Asian and Hispanic respondents felt that that their careers had been negatively affected by racial or ethnic discrimination, compared to 10% of White respondents (ACHE, 2015). African Americans, Hispanic Americans, and White respondants who reported that they had been discriminated against were found to have poorer mental health outcomes than their same-race counterparts who did not acknowledge being discriminated against (Roberts, Swanson, & Murphy, 2004).

James, Lovato, and Khoo (1994) argue that differences in cultural values and attitudes between workers from underrepresented populations and majority workers are a major source of stress for minority workers. For example, Cox, Lobel, and McLeod (1991) found that Asian American, African American, and Hispanic American individuals have a more collectivist orientation than European Americans as described by Hofstede's four dimensions of national culture. Therefore, as a minority-culture member takes on a work role in which they attempt to fit in with a majority-culture orientation, increased stress levels may occur because this attempt to fit in, or assimilate, causes a departure from the societal role the person is expected to fill in their collectivist community.

Assimilation is the process by which an individual develops a new cultural identity. The individual who assimilates into the dominant culture to become successful may eventually lose identification with their culture of origin. Members of minority cultures that have a collectivist orientation may experience stress as they attempt to assimilate into the majority culture that dominates many workplaces. For example, Bell, as cited by Richard and Grimes (1996), found that African American women who were career-oriented experienced more stress than their counterparts who were community-oriented or family-oriented. Because minority cultures may differ in race, attitudes, and beliefs from the majority culture in an organization, minority members are likely to find working in the organization stressful. Richard and Grimes (1996) point out that this is due to the minority members' need to work harder to socialize, or assimilate, into the dominant organizational culture for a significant portion of their day.

Gender

Over the years, research has been conducted on the stress levels of women, and considering that 92% of the 4.3 million nurses and nursing aides in the United States are female, health care employers need to be sensitive to the work-related stress issues experienced by women. Statistics from Roper Starch Worldwide's (2000) Global 2000 Consumer Study of 30,000 people between the ages of 13 and 65 years in 30 countries showed that increased stress is felt worldwide, with women consistently reporting being more stressed than men. The most stressed women are mothers with children under the age of 13, full-time working mothers, and full-time working mothers with children under age 13. In addition, one-fourth of women executives and professionals say that they feel "superstressed."

A second study, Creating Healthy Corporate Cultures for Both Genders, revealed that stress affects women differently from men (Peterson, 2004). The study indicated that women reported nearly 40% more health problems than their male counterparts and noticeably higher stress. Furthermore, Swanson (2000, pp. 77–78) found the following:

- Women face gender-specific work stress, such as sex discrimination and the need to balance work and family demands, in addition to general job stressors such as work overload, lack of control over their job, or underutilization of their skills.
- Barriers to financial and career advancement based on sex discrimination have been linked to more frequent psychological and physical symptoms, such as depression and high blood pressure.
- Half of all working women will experience on-the-job sexual harassment at some point in their lives, and women who experience sexual harassment report a range of psychological symptoms, including depression, anxiety, fearfulness, and feelings of guilt and shame as well as physical symptoms such as headaches and sleep disorders. Sexual harassment is a particularly noxious stressor for women and has a significant impact in terms of psychological distress and absenteeism beyond that attributable to regular job stressors.

Beliefs About Stress

Research on stress suggests that one's beliefs about stress are associated with whether or not stress leads to heart damage or increased mortality. A 2012 study asked participants whether they had experienced high or low levels of stress over the past year and then linked responses to public death records. They found that people who indicated experiencing high levels of stress were 43% more likely to die. However, the study also asked whether people believed that stress was harmful to their health. Surprisingly, the people who experienced high stress but did not believe that stress was harmful were no more likely to die than were those who experienced low stress (Keller et al., 2012). These results suggest that an individual's beliefs about stress are significant in shaping whether or not stress will have harmful effects on that person's health. Another study that examined people in a stressful environment studied an intervention that helped people see their body's stress response as positive. For example, breathing faster brings more oxygen to the brain. Subjects who were taught to believe that stress could be helpful instead of harmful to their health actually had a different physiological response that minimized potential heart damage when compared to those who believed that stress was harmful to health (Jamieson, Nock, & Mendes, 2012). These findings suggest that both stress and one's beliefs about stress may be important factors in how stress affects one's health.

Burnout

Stress occurs when job requirements do not match the employee's capabilities, resources, or needs . Studies show that stressful working conditions are associated with increased absenteeism, tardiness, and turnover, which affects an organization's productivity and profitability. An extreme case of job-related stress is known as burnout.

First discovered in the 1970s, burnout has been recognized as an occupational hazard in people-oriented professions such as health care, human services, and education (Maslach & Goldberg, 1998). Burnout symptoms include overwhelming exhaustion; feelings of frustration, anger, and cynicism; and a sense of ineffectiveness and failure. Burnout is a major issue among health care workers. Health care professionals have reported substantially higher degrees of burnout than have managers who are not employed in the health care industry (Golembiewski & Boudreau, 1991). Harvard School of Public Health announced burnout as a public health crisis (Jha et al., 2019). In 2018, a survey found that 78% of physicians reported experiencing symptoms of burnout (Hawkins, 2018). An earlier study reported that 33% of new nurses seek another job within a year (Lucian Leap Institute, 2013). Suicide rates have been found to be 1.4 times and 2.27 times higher among physicians than in the general population for males and females, respectively (Schernhammer & Colditz, 2014). This has resulted in estimates of more than 300 suicides per year (Frank, Biola, & Burnett, 2000), which equates to roughly two full medical school classes (AMA, 2017).

Burnout can have serious implications for a health care organization's ability to provide good care to its patients and for its bottom line. A more engaged workforce is associated with higher patient satisfaction and a lower incidence of medical error (Shanafelt et al., 2010). One study found that the cost of replacing one full-time physician, including lost revenue, recruitment and startup costs, is approximately $1.2 million (Scutte, 2012). If multiple physicians leave or reduce clinical hours because of burnout, the result could be potentially generating millions of dollars in additional costs. Furthermore, as a society, it takes at least 12 years to create one physician (considering undergraduate and medical school and residency training). Therefore, when a physician leaves the field of medicine altogether, it takes a long time to produce a replacement. There is a physician shortage in the United States, which is expected to worsen in future years. Total shortfalls are expected to reach between roughly 60,000 to 90,000 physicians by 2025, and current shortfalls are estimated to be in the tens of thousands (Shanafelt, Dyrbye, West, & Sinsky, 2016).

Maslach and Jackson (1981) identified three dimensions associated with burnout: emotional exhaustion, depersonalization, and diminished personal accomplishment.

- Emotional exhaustion results in apathy and loss of concern, a feeling that one has reached the end of one's rope. As their emotional resources are depleted, health care professionals feel that they cannot give of themselves emotionally or psychologically.
- Depersonalization is characterized by the development of negative and cynical attitudes toward the workplace and toward people with whom one interacts (patients and coworkers in the case of health care professionals). Depersonalized individuals distance themselves and see other people as things or objects.
- Diminished personal accomplishment is characterized by the tendency to evaluate oneself negatively, including viewing oneself as performing poorly in the job—a job that is viewed as having no worth or meaning (low professional efficacy).

Golembiewski and his associates (Golembiewski, 1986, 1990; Golembiewski & Boss, 1991; Golembiewski & Boudreau, 1991) studied over 13,000 managers and health care professionals regarding burnout. The researchers found that varying degrees of burnout existed and that health

Table 13-4 Golembiewski's Phases of Burnout

	Phase	Phase	Phase	Phase	Phase	Phase	Phase	Phase
Dimensions of Burnout	I	II	III	IV	V	VI	VII	VIII
Depersonalization	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi
Personal	Lo	Lo	Hi	Hi	Lo	Lo	Hi	Hi
Accomplishment (reversed)								
Emotional Exhaustion	Lo	Lo	Lo	Lo	Hi	Hi	Hi	Hi

Golembiewski, R. T. (1986). The epidemiology of progressive burnout: A primer. *Journal of Health and Human Resources Administration, 9*(1), 18. Reprinted with permission.

care workers experienced the most advanced phases (Golembiewski & Boudreau, 1991). As illustrated in **Table 13-4**, Golembiewski's phase model suggests that employees who are suffering from burnout first experience depersonalization, which induces feelings of inadequacy, followed by diminishing personal accomplishment and ending with emotional exhaustion. Golembiewski and Boudreau relate that employees show growing deficits or deficiencies as they move from phase to phase:

- Broad ranges of perceptions or attitudes about the worksite deteriorate; for example, satisfaction and job involvement fall, and tension at work increases.
- Performance appraisals tend to decrease.
- Physical symptoms increase.
- Turnover increases.
- Self-esteem decreases.
- Various clinical indicators of mental health show deterioration.The quality of social and emotional life at work declines; for example, group cohesiveness is down and social support falls.

In support of Golembiewski's phase model, Kalliath, O'Driscoll, Gillespie, and Bluedorn (2000) found that nurses, laboratory technicians, and managers employed by a general community hospital in a Midwestern city who reported higher levels of burnout experienced decreased job satisfaction, decreased satisfaction with interpersonal relationships, and lower levels of organizational commitment reflected by either job turnover or increased intentions to leave their jobs.

Presenteeism

As was noted earlier, symptoms of burnout may include lower job performance and satisfaction, higher job tension and turnover, and increased absenteeism. However, a low rate of absenteeism does not always indicate that employees are not suffering from burnout. A relatively new buzzword is "presenteeism," which occurs when employees show up for work but are less productive because of illness. A study of 29,000 U.S. employees estimated that absenteeism and presenteeism cost U.S. industry more than $60 billion a year and that more than three-fourths of lost productivity is explained by presenteeism, not by absenteeism (Stewart et al., 2003). Dow Chemical Company estimates that presenteeism has the largest health-related economic impact

on the company, ahead of absenteeism, health insurance, and workers' compensation (Berry, Mirabito, & Berwick, 2004). A pilot study assessing the impact of 28 medical conditions on workers' productivity was conducted by Tufts–New England Medical Center researchers at Lockheed Martin Corporation. The researchers found that employees who came to work sick during the study year—with ailments such as allergies, headaches, lower-back pain, arthritis, colds, and the flu—cost Lockheed Martin approximately $34 million (Hemp, 2004). A study of British workers found that the number of sick days workers take was halved between 1993 and 2017, likely owing to a changing workplace culture that is not supportive of taking sick time off. A survey found that only 42% of senior managers thought that having the flu was a serious enough reason to miss work (Rubinstein, 2019). In health care, workers who continue to work while contagious with serious illnesses such as the flu can have serious and sometimes deadly affects on immunocompromised patients. (See **Case Study 13-1**.)

CASE STUDY 13-1 Presenteeism: A Public Health Hazard

On January 19, 2005 (day 1), three nursing home residents and one staff member at a 100-bed, two-floor urban facility developed symptoms of nausea, vomiting, and diarrhea. General infection control measures were reinforced, including hand hygiene education for nursing home residents and staff, contact isolation for symptomatic residents, and new surface disinfection procedures. On days 2 and 3 of the outbreak, seven more residents developed similar symptoms, as well as four additional staff. Two of these staff members reported diarrhea after arriving at work and were asked to go home after discussions with the infection control team. At this point, the public health department was notified and more restrictive measures were instituted, including closure of the dining room; suspension of group activities and outings; limitation of visitors, volunteers, and trainees; rescheduling of elective surgery and non-urgent clinic appointments; and discontinuation of new admissions. Staffing strategies were also temporarily changed so that nursing staff did not float in or out of the unit. As per policy, supervisors were instructed to refer employees with signs or symptoms of an infectious illness to Employee Health for diagnosis and determination of suitability to continue work. However, no daily systematic screening process took place to identify ill staff members at the start of their shift.

Over the course of the next 10 days, 23 residents and 18 staff developed symptoms of nausea, vomiting, and diarrhea. Laboratory studies of affected staff and residents confirmed norovirus genotype 2. By day 8 of the outbreak, it became increasingly clear that ill staff members continued to work despite strong recommendations to the contrary by management. Often, symptoms were not reported until employees had arrived for and sometimes completed their shifts. Several employees also reported ill family members with similar symptoms. Infection Control responded by contacting each ill staff member to verify symptoms, provide education, and ask that they remain home. Several nursing staff members who were symptomatic at work were asked to leave as soon as they reported symptoms and to not return until they received clearance from Employee Health. Staffing was managed through the use of registry or per diem nursing coverage when appropriate.

No new cases occurred from days 13 through 17 of the outbreak. However, on day 18, a staff member arrived at work ill with gastrointestinal symptoms. On day 21, an additional two residents developed gastroenteritis. As voluntary measures to prevent presenteeism failed, the local department of public health mandated enforcement of "back to work" rules. These rules required employees with gastrointestinal symptoms to obtain clearance from Employee Health before being allowed to return to work. This clearance was given only after 48 symptom-free hours had elapsed. The final case was identified 24 days into the outbreak, and gastroenteritis-specific infection control measures were discontinued on day 34.

Reproduced from Widera, E., Chang, A., & Chen, H. L. (2010). Presenteeism: A public health hazard. *Journal of General Internal Medicine, 25*(11), 1244–1247.

Causes of Workplace Stress

Workplace stress can be related to (1) individual task demands, (2) individual role demands, (3) group demands, and (4) organizational demands (Kinicki & Williams, 2003) (see **Table 13-5**).

- Individual task demands include unrealistic deadlines, fear of failure, new technology, lack of necessary resources (e.g., poor physical work environment, such as noise, heat, and crowding), work overload, lack of control, and repetitive, unchallenging work (work underload).
- Individual role demands include job ambiguity, role conflict, and difficulty balancing work and family life.
- Group demands include poor interpersonal relationships with coworkers and/or supervisors, inadequate support, and lack of participation in decisions.
- Organizational demands encompass politics, communication problems, excessive rules and regulations, organizational structure and culture, lack of career development activities, and change without clear strategic direction.

How these various demands can affect employees' stress levels is illustrated in **Case Study 13-2**.

Table 13-5 Job Stressors

Categories of Job Stressors	Examples
Individual Task Demands (factors unique to the job)	■ Workload (overload and underload) ■ Pace/variety/meaningfulness of work ■ Autonomy (e.g., the ability to make your own decisions about your own job or about specific tasks) ■ Shift work/hours of work ■ Physical environment (noise, air quality, etc.) ■ Isolation at the workplace (emotional or working alone)
Individual Role Demands (role in the organization)	■ Role conflict (conflicting job demands, multiple supervisors or managers)Role ambiguity (lack of clarity about responsibilities, expectations, etc.) ■ Level of responsibility ■ Difficulties balancing work and personal lives
Group Demands	■ Relationships at work with supervisors, coworkers, and subordinates ■ Threat of violence, harassment, etc. (threats to personal safety) ■ Lack of participation in decision making ■ Inappropriate leadership/management styles (autocratic versus participatory)
Organizational Demands (including organizational structure and climate)	■ Management/leadership styles ■ Communication patterns ■ Career development opportunities (under-/overpromotion)Job security ■ Unplanned change ■ Overall job satisfaction

Murphy, L. R. (1995). Occupational stress management: Current status and future directions. In C. L. Cooper & D. M. Rousseau (Eds.), *Trends in organizational behavior* (Vol. 2, pp. 1–14). West Sussex, UK: John Wiley & Sons.

CASE STUDY 13-2 Stress in Today's Workplace

The longer he waited, the more David worried. For weeks, he had been plagued by aching muscles, loss of appetite, restless sleep, and a sense of complete exhaustion. At first, he tried to ignore these problems, but he eventually became so short-tempered and irritable that his wife insisted that he get a checkup. Now, sitting in his primary care physician's office and wondering what the verdict would be, David didn't even notice when Theresa took the seat beside him. They had been good friends when she worked in the billing office at the drug-manufacturing facility where David worked, but he hadn't seen her since she left 3 years ago to take a job as a member service representative at a local health maintenance organization. Her gentle poke in the ribs brought him around, and within minutes, they were talking and gossiping as if she had never left.

"You got out just in time," he told her. "Since the reorganization, nobody feels safe. It used to be that as long as you did your work, you had a job. That's not for sure anymore. They expect the same production rates even though two people are now doing the work of three. We're so backed up I'm working 12-hour shifts six days a week. I swear I hear those machines humming in my sleep. Employees are calling in sick just to get a break. Morale is so bad they're talking about bringing in some consultants to figure out a better way to get the job done."

"Well, I really miss everyone," she said. "I'm afraid I jumped from the frying pan into the fire. In my new job, the computer routes the calls, and they never stop. I even have to schedule my bathroom breaks. All I hear the whole day are complaints from unhappy members. I try to be helpful and sympathetic, but I can't promise anything without getting my supervisor's approval. Most of the time, I'm caught between what the member wants and company policy. I'm not sure who I'm supposed to keep happy. The other reps are so uptight and tense they don't even talk to one another. We all go to our own little cubicles and stay there until quitting time. To make matters worse, my mother's health is deteriorating. If only I could use some of my sick time to look after her. No wonder I'm in here with migraine headaches and high blood pressure. A lot of the reps are seeing the employee assistance counselor and taking stress management classes, which seems to help. But sooner or later, someone will have to make some changes in the way the place is run."

Job Conditions That May Lead to Stress

- *The Design of Tasks*: Heavy workload, infrequent rest breaks, long work hours, and shift work; hectic and routine tasks that have little inherent meaning, do not utilize workers' skills, and provide little sense of control.
  Example: David works to the point of exhaustion. Tied to the computer, Theresa is allowed little room for flexibility, self-initiative, or rest.
- *Management Style*: Lack of participation by workers in decision making, poor communication in the organization, lack of family-friendly policies.
  Example: Theresa needs to get her supervisor's approval for everything, and her employer is insensitive to Theresa's family needs.
- *Interpersonal Relationship*: Poor social environment and lack of support or help from coworkers and supervisors.
  Example: Theresa's physical isolation and the tension within the office reduce her opportunities to interact with her coworkers or receive help from them.
- *Work Roles*: Conflicting or uncertain job expectations, too much responsibility, too many "hats" to wear.
  Example: Theresa is often caught in a difficult situation trying to satisfy both the members' needs and her employer's expectations.
- *Career Concerns*: Job insecurity and lack of opportunity for growth, advancement, or promotion; rapid changes for which workers are unprepared.
  Example: Since the reorganization at the drug-manufacturing facility, everyone, including David, is worried about their future with the company and what will happen next.
- *Environmental Conditions*: Unpleasant or dangerous physical conditions such as crowding, noise, air pollution, or ergonomic problems.
  Example: David is exposed to constant noise at work.

Modified from National Institute for Occupational Safety and Health. (1999). *Stress at work. DHHS (NIOSH)* (Publication No. 99–101). Cincinnati, OH: Author. Available at: https://www.cdc.gov/niosh/docs/99-101/. Last accessed December 18, 2019

Coping with Stress

Coping with stress at work can be defined as "an effort by a person or an organization to manage and overcome demands and critical events that pose a challenge, threat, harm or loss to that person and that person's functioning or to the organization as a whole" (Schwarzer, 2004, p. 342). Coping is considered one of the top skills of effective managers. With population samples from business, education, health care, and state governments, Whetton and Cameron (1993) identified 402 effective managers on the basis of responses from peers and superiors. Responses from the participants revealed that coping with stress was second on a list of 10 skills attributed to effective managers.

Stress is inevitable, but the degree of stress that is experienced can be modified in two ways: by changing the environment and/or by changing the individual. This is referred to as stress management. Stress management can refer to a narrow set of individual-level interventions (e.g., relaxation training, biofeedback, meditation) or a broader meaning that includes any type of stress intervention (Murphy, 1995). However, to be successful, stress management interventions need to target characteristics of the individual worker, the job, and the organization.

Schwarzer (2004) provides managers with a model using four perspectives for assisting themselves and others to cope with job-related stress (refer to **Figure 13-3**). The differences between the perspectives are based on time-related stress appraisals and on the perceived certainty of critical events or demands. The four perspectives are (1) reactive coping, (2) anticipatory coping, (3) preventive coping, and (4) proactive coping.

- Reactive coping refers to efforts to deal with a stressful encounter that either is ongoing or has already happened, such as a job loss or demotion.
- Anticipatory coping pertains to efforts to deal with an inevitable event that is certain to occur in the near future, such as public speaking, a job interview, or downsizing.
- Preventive coping refers to an effort to build up resistance resources, whereby the level of stress felt by an individual is reduced (the severity of impact is minimized) if a critical event is expected to occur in the future. For example, an individual might return to school to earn a master's degree in health administration or completes the requirements to become a board-certified health care executive in anticipation of a possible job loss due to a merger or buyout.

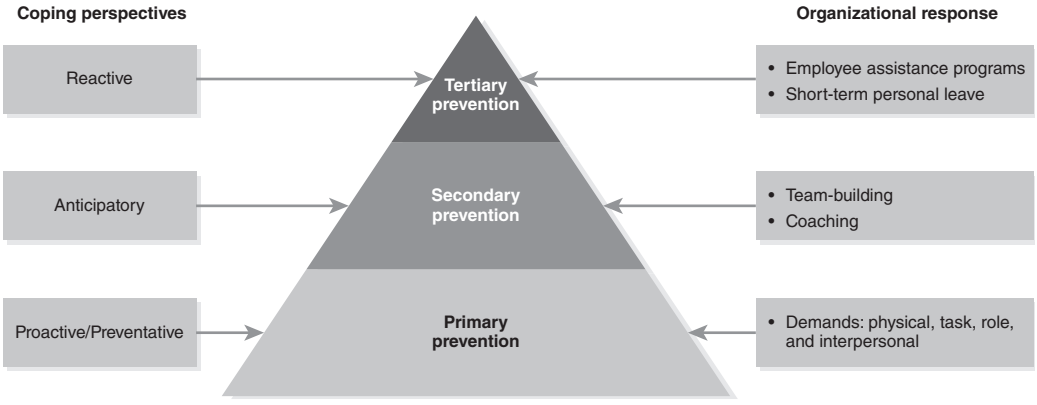

Figure 13-3 Four Coping Perspectives

- Proactive coping is defined as an effort to build up general resources that facilitate movement toward challenging goals and personal growth, such as hardiness training and learned optimism (Schwarzer, 2004).

As Schwarzer (2004) points out, "The distinction between these four perspectives of coping is highly useful because it moves the individual's focus away from mere responses to negative events towards a broader range of risk and goal management that includes the active creation of opportunities and the positive experience of stress" (p. 349).

Organizational Coping Strategies

At the organizational level, when reactive coping or anticipatory coping occurs, managers' efforts are focused on reducing the harm or loss to the organization. Managers using reactive coping or anticipatory coping are concerned with putting out fires rather than with using their efforts to develop and implement preventive and proactive coping strategies, which are more beneficial for both the organization and the employee. For example, preventive coping is called for when no specific event is envisioned but a more general threat in the distance comes into view, such as an economic decline, a potential merger or downsizing, an aging workforce, or new technology (Schwarzer, 2004).

The health care industry is using preventive coping strategies to deal with the envisioned future shortage of health care leaders as the workforce ages. For example, HCA, Inc. anticipated that many of the baby boom–generation chief executive officers (CEOs) at its hospitals would retire within a 10-year period. Furthermore, given the likelihood that those vacancies would be filled by incumbent chief operating officers (COOs), HCA anticipated a hospital leadership gap at the COO level. To address this challenge proactively, HCA created an intensive COO development program. This program was a development-in-place approach whereby the program is not supplemental to the duties of a regular hospital job, but instead individuals are hired by HCA for the sole purpose of participating in the program with the goal of developing critical, advanced executive-level skills. Participants were given the title of "associate administrator" and were assigned to an HCA hospital. The current CEO of the hospital served as the associate administrator's mentor and superior over a 2- to 4-year period. After successfully completing the development program, the associate administrator would be promoted to COO for one of HCA's hospitals (HCA, 2004).

Preventive coping and proactive coping are also referred to as primary prevention or organizational prevention (Quick et al., 1997). Organizational prevention is designed to enhance an employee's health and performance at work by eliminating the stressors that lead to distress. Methods to accomplish this include modifying work demands and improving relationships in the workplace (Schwarzer, 2004). Anticipatory coping is related to secondary prevention; the goal is changing individual stress responses to necessary demands. Reactive coping may be referred to as tertiary prevention, which attempts to minimize the amount of individual and organizational distress that results when organizational stressors and resulting stress responses have not been adequately controlled (Quick et al., 1997) (see Figure 13-3).

To illustrate these coping concepts, consider the following scenario: A physician displays inappropriate behavior* toward a nurse (a stressor), which leads to the nurse experiencing

* Inappropriate physician behavior may be defined as "any inappropriate behavior, confrontation or conflict, including verbal abuse to physical and sexual harassment" (Rosenstein, 2002, p. 26).

anxiety (a stress response), and in turn, the nurse resigns (an organizational consequence of distress). Primary prevention would attempt to eliminate the stressor by having the hospital establish a zero-tolerance policy regarding inappropriate physician behavior (preventive and/or proactive coping). Secondary prevention would address the problem by providing programs to improve interpersonal relations between physicians and nurses (anticipatory coping). These programs may include improving team building and communication skills, whereby the physician recognizes that nurses are an integral part of the patient's health care team and interactions should therefore be based on mutual respect and trust. Tertiary prevention might include establishing an employee assistance program designed to help nurses to cope with inappropriate behavior by physicians.

The preceding example is based on a study that linked inappropriate physician behavior with nurses leaving the nursing profession. Rosenstein (2002) surveyed 1200 nurses, physicians, and executive administrators at several hospitals affiliated with VHA, a national network of community-owned hospitals and health care systems, to assess how these disparate groups viewed nurse–physician relationships, disruptive physician behavior, the institutional response to such behavior, and how such behavior affected nurse satisfaction, morale, and retention. Rosenstein found that daily interactions between nurses and physicians strongly influence nurses' morale. All respondents indicated that they were concerned with the significance of nurse–physician relationships, and over 90% of all respondents reported witnessing disruptive physician behavior and that they saw a direct link between this disruptive behavior and nurse satisfaction and retention. In addition, 30% of the nurse respondents reported knowing at least one colleague who had resigned because of disruptive physician behavior.

Subsequent research by Rosenstein and O'Daniel (2005, 2006, 2008) found an almost equal amount of disruptive behavior in nurses and other hospital employees, but more disconcerting was the downstream negative impact of disruptive behavior on stress levels, loss of focus, concentration, communication, collaboration, and information transfer resulting in medical errors, adverse events, and significant compromises in patient safety, quality, and even mortality. As was noted earlier, The Joint Commission issued a 2008 standard requiring hospitals to develop a disruptive behavior policy and provide necessary education about this topic.

Joy in Work

The Institute for Health care Improvement has suggested the "Joy in Work" framework to help senior leaders, managers and individuals identify their roles in reducing stress and burnout in the worklife by seeking to increase joy in work, resulting in happy, healthy and productive employees, see **Figure 13-4**. The basic premise is that employees can better withstand the stressors that are inevitable in health care if they can find joy in the work they are doing.

The IHI suggests nine components that are critical for improving joy in work (see **Table 13-6**).

As noted above, an employee's work setting may create physical stress because of noise, lack of privacy, poor lighting or ventilation, and so forth. Therefore, organizations should redesign employees' physical settings to minimize distressful effects (i.e., primary preventive and proactive coping). For example, Williams (2003) found that the odds of feeling stress because of fear of accident or injury were 7.2 times higher for employees working in health care occupations than those in the fields of management, business, finance, or science. This high source of workplace stress by health care workers may be caused by their constant exposure to risk of infection, long hours, and irregular shifts. Other studies have shown that the creation of pleasant and suitable

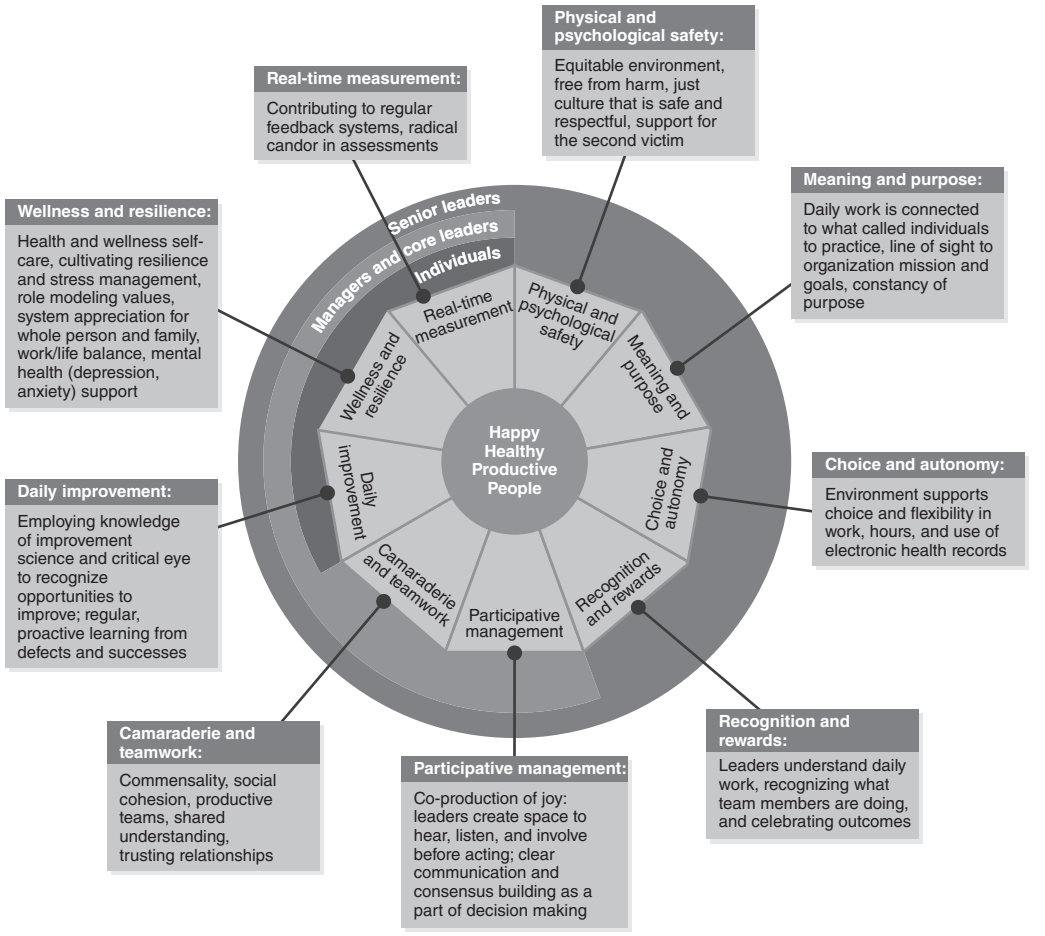

Figure 13-4 Components for Improving Joy in Work

Perlo, J., Balik, B., Swensen, S., Kabcenell, A., Landsman, J., & Feeley, D. (2017). IHI framework for improving joy in work. *IHI White Paper.* Cambridge, MA: Institute for Healthcare Improvement. Available from ihi.org

work areas can elevate an employee's job satisfaction, job safety, and mental health, which may indirectly improve job performance.

Job Design

Another important component of reducing work-related stress is job design. Proper job design accommodates an employee's mental and physical abilities. According to the MFL Occupational Health Centre (2000), a Canadian community health center whose mission is to improve workplace health and safety conditions and eliminate hazards, employers can better design jobs by doing the following:

- Clearly defining jobs and responsibilities that reduce role conflict and/or role ambiguity;
- Giving workers a say in how they do their jobs;
- Giving workers opportunities to learn new skills;

Table 13-6 Description of Components for Improving Joy in Work

Physical and Psychological safety	*Physical*—People feel safe from physical harm at work *Psychological*—People feel free to change, to share feedback and ideas, and to admit mistakes.
Meaning and Purpose	People feel that they are making a difference and can connect their daily work to the mission and purpose of the organization.
Choice and Autonomy	People have choice in how they structure and accomplish their daily work and a voice in changes that affect them.
Recognition and Rewards	People are recognized for their contributions and rewarded accordingly.
Participative Management	Managers encourage and engage others in their decision making processes, and regularly gather and incorporate feedback.
Camaraderie and Teamwork	People feel that they are a part of a team and have mutual support and companionship at work.
Daily Improvement	A proactive approach to improvement is a part of daily practice across the organization .
Wellness and Resilience	The organization values and invests in the wellness and well-being of its employees. Taking care of one's own well-being is seen as a part of the larger organizational effort, not a stand-alone solution.
Real-time Measurement	Systems allow for regular feedback and performance monitoring to support ongoing improvement.

Modified from Perlo, J., Balik, B., Swensen, S., Kabcenell, A., Landsman, J., & Feeley, D. (2017). IHI framework for improving joy in work. *IHI White Paper*. Cambridge, MA: Institute for Healthcare Improvement. Reprinted from www.IHI.org with permission of the Institute for Healthcare Improvement (IHI), ©2019.

- Allowing time for social interactions among workers;
- Making work schedules flexible for responsibilities outside of work;
- Clearly communicating about job security;
- Training managers to apply participative-management styles as part of a culture that emphasizes open communication, support, and mutual respect;
- Implementing effective performance-management systems with clear expectations and procedures that are understood by managers and staff;
- Ensuring that effective change management accompanies organizational change.

Individual Coping Strategies

At the individual level, one of the best techniques for reducing stress is through the relaxation response (see **Exhibit 13-1**). However, relaxation is a reactive coping strategy as a result of an individual's appraisal of a threat or harm/loss situation such as failing to meet a work goal, conflict with a colleague or supervisor, or job loss. Reactive coping strategies do little if anything to solve the underlying problems. Therefore, employees need to learn to use preventive and proactive coping strategies so that their fight-or-flight response is not automatically engaged at the first sign of stress (Schwarzer, 2004).

Exhibit 13-1 How to De-stress

One of the most well-documented techniques for reducing stress is through the relaxation response, a term coined by Dr. Herbert Benson of Harvard Medical School to describe a state of deep, mindful rest that offsets the physical effects of stress by lowering heart rate, blood pressure, and breathing rate. The relaxation response can be elicited at any time and in any place by sitting comfortably with your eyes closed, breathing slowly, letting your muscles relax, and repeating a certain word, sound, phrase, or prayer for 10 minutes while disregarding all other thoughts. The slow, repetitive movements and meditative thoughts involved in activities such as yoga and T'ai Chi have also been found to evoke a similar physiological response, which in turn can help you to think more rationally about your own predicament and how you can work to improve it.

Reproduced from Optimistic People Live Longer. (2003, January). *Tufts University Health and Nutrition Letter, 20*(11), 4–5.

Friedman (1999) suggests training employees to cope with stressful situations by improving their problem-solving and conflict resolution abilities and developing their leadership skills. For example, when an employee is going to be facing stress due to increasing workload, they can be trained beforehand how to delegate tasks, use good time management skills, and increase their social support system. In addition, employees need to learn how to maintain a healthy balance between work, family, and leisure activities, although this may be a difficult process for workaholics and individuals displaying other Type A personality characteristics. It is known that healthy lifestyles (e.g., nutrition and exercise) provide a protective shield against the experience of stress (Schwarzer, 2004). In addition, the use of learned optimism and resilience training has been shown to be successful in assisting employees to reinterpret perceived threats (i.e., stressful events) into challenges, thereby transforming distress into eustress.

Learned Optimism

From extensive research throughout his career as a psychologist, Martin Seligman (1991) developed the concept of learned optimism and applied it directly to workplace productivity. According to Seligman, when pessimistic people run into obstacles in the workplace, they give up. By contrast, when optimistic people encounter obstacles, they try harder. Seligman's learned optimism theory suggests that people can undo pessimistic thinking and learn optimism by recognizing and then disputing their own negative thoughts and beliefs.

Optimism is not the same as the popular concept of positive thinking. Optimists and pessimists attribute the reasons for success and failure differently. Drawing on attribution theory, Seligman (1991) refers to how a person interprets events as their explanatory style. Seligman identified three primary elements of an individual's explanatory style: stability, globality, and locus of control.

- Stability refers to whether the event's outcomes are temporary or permanent. For example, if the outcome is negative, the optimist tends to think that the event was an isolated incident. If the outcome is positive, the optimist tends to think that it will reoccur in the future. By contrast, the pessimist views positive outcomes as one-time events and negative outcomes as more likely to occur in the future.
- Globality refers to whether the event's outcomes are specific to this one situation or whether the outcomes apply to everything in a person's life. For example, when a positive event occurs, the optimist is more likely to extend the outcomes to their whole life. When a

negative event occurs, the optimist will tend to isolate the incident as being specific to that situation. The opposite holds true for the pessimist: Positive events are viewed as strokes of good luck, and negative events are viewed as representative of the person's whole life.

- Locus of control refers to whether the individual believes that the outcome is attributable to their actions or to factors in the environment. For example, when a positive event occurs, the optimist attributes the success to their own efforts. When a negative event occurs, the optimist looks to causes outside of their control, such as bad luck, to explain the outcome. The pessimist will view positive events as attributable to good luck, other people's hard work, or something else outside of their control and negative events as being caused by their own personal deficiencies.

Pessimists tend to attribute failure and negative events to permanent, personal, and pervasive factors. Optimists tend to attribute negative events to nonpersonal, nonpermanent, and nonpervasive factors. Optimists attribute their failures to causes that are temporary rather than stable, specific to the attainment of a particular goal rather than all their goals, and see the problem as a result of the environment or setting they are in rather than being inherent in themselves. Optimists have high self-efficacy and view setbacks, obstacles, and a noncontingent environment as challenges that provide excitement in their lives (Seligman & Csikszentmihalyi, 2000). The opposite is true for pessimists. Pessimists see no relationship between their actions and goal attainment. Their low outcome expectancy causes deficits in future learning as well as motivational disturbances such as procrastination and depression (Seligman, 1991). Thus, even when the situation changes so that they can exert control over their environment and make progress toward their goal, pessimists do not try to do so because they have learned that giving up is a rational response. Their attribution has led to what is referred to as learned helplessness (see **Exhibit 13-2**) (Seligman, 1991). An individual's habitual blaming of themselves undermines self-efficacy (Bandura, 1997).

Optimism may serve as a buffer against the physiological effects of stress. Research suggests that the immune function in optimists is better than that in pessimists. It is not that optimists

Exhibit 13-2 Learned Helplessness

Learned helplessness is an acquired condition that has a negative impact on an individual's physical, emotional, mental, and spiritual well-being. It is a phenomenon in which people who experience failure at a task, often numerous times, determine that the task cannot be accomplished—at least not by them—and so they stop trying. They internalize their failures (self-blame) and develop a helpless attitude.

A study on learned helplessness looked at stress levels in two groups that were subjected to the same loud and unpleasant noise. One group was given a button that could turn the noise off, while the second group was not given any way to turn it off. The subjects who were denied control over the noise experienced significant stress and called the noise "unbearable." The group that had the option of turning off the noise considered the noise only "unpleasant" but chose not to turn off the sound. Just knowing that they had the option of turning the noise off was enough.

Following the sound session, the researchers observed that the group that had been subjected to helplessness in the noise experiment tended to act helpless in subsequent situations, whereas the group that had been given control to turn off the noise in the experiment looked for and chose to exercise control over subsequent situations. Both helplessness and empowerment are learned conditions. Once learned, they are extended into other areas of life.

experience fewer stressful situations than pessimists; optimists are just more adept at coping with such situations, so they can work through the problems and develop solutions rather than feeling helpless or like victims.

Stress Management Programs

Organizations are developing comprehensive health promotion strategies for their employees, which include various types of individual-level stress management programs (Schwarzer, 2004). Stress management programs often consist of breathing and stretching exercises, yoga, meditation, and/or massage. The programs' goals are to lessen the adrenaline response to minor stress. For example, St. Paul Fire and Marine Insurance Company conducted several studies on the effects of stress-prevention programs in hospital settings. Program activities included (1) employee and management education on job stress, (2) changes in hospital policies and procedures to reduce organizational sources of stress, and (3) establishment of employee-assistance programs. In one study, the frequency of medication errors declined by 50% after prevention activities were implemented in a 700-bed hospital. In a second study, there was a 70% reduction in malpractice claims in 22 hospitals that implemented stress-prevention activities. In contrast, there was no reduction in claims in a matched group of 22 hospitals that did not implement stress-prevention activities (Jones et al., 1988).

In another example, Baptist Health South Florida (BHSF), the largest nonprofit health care organization in South Florida, provides a holistic approach to the well-being of its staff. The organization sponsors a healthy lifestyle program for its employees, called the Wellness Advantage. On-site fitness coaches are available to employees at each of the system's six hospital fitness centers to provide screening and personal training. Discounts are offered to employees who choose the meals that are designated "healthy" in the system's cafeterias. For employees who face life-threatening illnesses, the system offers flexible, reduced scheduling so that the employees can maintain some level of employment during stressful times. Senior management believes that the organization's success, as measured by patient satisfaction, physician satisfaction, employee satisfaction, clinical outcomes, and operating profits, is directly owed to the "healthy" infrastructure of its employees. Baptist Health's commitment to its employees is recognized nationally. The National Business Group on Health has recognized Baptist Health's longtime commitment to its employees by naming the health system one of the Best Employers for Healthy Lifestyles for the past 10 years (BHSF, 2015; May, 2004).

Crampton, Hodge, Mishra, and Price (1995) contend that stress management programs need to contribute to the goals and needs of both the organization and the individual. Organizations need to believe that the benefits of stress management programs outweigh their costs. Employees need to perceive that they will benefit from stress management programs or they will not voluntarily participate. To meet both organizational and individual goals, Crampton and colleagues provide the following recommendations:

Preventive and/or Proactive Coping (Primary Prevention)

1. Identify the major stressors in the workplace and assess which ones are controllable. Organizations should do more than simply provide stress management techniques. If the causes of stress can be reduced or eliminated, they should be. Organizational-level strategies might include redesigning employees' jobs; improving the selection, placement, and orientation of new employees; providing employees with more participation and autonomy in

decision making; disseminating information; providing needed education and training; reducing workloads or the pace of work; modifying work schedules to be compatible with demands and responsibilities outside of work; conducting time management programs; clearly defining work roles; providing opportunities for career development; and providing emotional and task support.
2. Communicate with employees about the benefits of stress management. Explain what stress is, along with the health implications of excess stress or distress. Employees should be encouraged to lead healthier lives by lowering their stress on the job as well as at home.

Anticipatory Coping (Secondary Prevention)

1. Help employees to identify their stressors and stress-tolerance levels. Before learning how to deal with stress, employees first have to identify the stressors to which they react, because not everyone responds the same way to the same stressors. To aid in this process, organizations can conduct health-risk appraisals that test for their employees' levels of stress.
2. Develop individualized stress management programs that meet the needs of the organization's employees. Programs should be topic-specific and should be implemented in stages. If all aspects of a program are implemented at one time and parts of the program fail, employees will lose faith in the program and in management. This will be another cause of anxiety and stress for the employee. Stress management programs may include learning relaxation and meditation techniques, developing a good support system, undertaking outside hobbies, learning to set realistic goals, developing time management skills, and learning when to say no rather than taking on more than one can handle.
3. Communicate with employees. Providing more information about their jobs and other factors that affect them will allow employees to feel more in control of their circumstances and can help to build cohesion. Organizations must also communicate and describe the stress management strategies that are available to employees and must help employees to develop personalized action plans.

Reactive Coping (Tertiary Prevention)

1. Make sure employees learn to recognize symptoms of distress. These may include gastrointestinal problems, rapid pulse, frequent illness, insomnia, persistent fatigue, irritability, lack of concentration, and increased use of alcohol and/or drugs. Common methods used to help identify stressors and symptoms include self-report measures (e.g., interviews and surveys), behavioral measures (e.g., observation and performance measures), and physiological stress measures (e.g., heart rate and blood pressure).
2. Exercise and maintaining a nutritious diet are two of the most agreed-upon stress management techniques. Organizations can help employees by providing information and access to physical recreation facilities or equipment by either establishing on-site facilities or providing memberships to local health clubs. One type of organizational stress management program provides employees with access to an employee assistance program, a corporate psychologist, a toll-free hotline, or some other form of counseling assistance. These programs can help employees to deal with a variety of problems that range from learning to cope to dealing with substance abuse.
3. Help employees to keep a positive perspective on life and feel a sense of purpose. It is important for employees to feel that they are making a valuable contribution to the organization.

Summary

Stress has become a widely used but misunderstood term, and a number of misconceptions about stress exist. The first misconception is that all stress is negative. A certain degree of stress is necessary for good mental and physical health; it can be viewed as positive or constructive stress, which compels us to act with optimum performance, whereby we achieve our goals. The second misconception is that nothing can be done to eliminate or diminish workplace distress. Organizations and individuals can use preventive or proactive coping strategies (primary prevention) to change negative events into positive experiences and growth opportunities.

In the past, the phrase "healthy organization" almost always denoted a firm's financial health. But studies of "healthy organizations" suggest that policies benefiting workers' health also benefit the organization's bottom line. Today, the healthy organization focuses not only on financial soundness but also on the physical and mental well-being of its employees. Healthy employees create stronger businesses and healthier profits (Berry et al., 2004).

Discussion Questions

1. Define the term "stress" and explain the difference between eustress and distress.
2. Discuss the various components of the process model of stress and coping.
3. Discuss the negative effects of distress from both an organizational perspective and an individual perspective.
4. Describe the various forms of stress.
5. Describe the three stages of the General Adaptation Syndrome and positive and negative effects that occur in each stage.
6. Discuss why personalities, ethnicity, and gender may affect an individual's level of stress.
7. Discuss the symptoms of burnout using Golembiewski's phase model.
8. Discuss the four categories of causes of stress in the workplace.
9. Discuss and provide examples of the various coping strategies available to organizations and individuals.
10. Discuss the concept of learned optimism and how it relates to coping with stress by individuals.
11. Discuss the concept of hardiness training and how it relates to coping with stress by individuals.
12. Discuss what is meant by the term "stress management" and available interventions for organizations and individuals.

CASE STUDY 13-3 Why Are All the Employees Leaving?

The administrator of a large physician group practice is becoming alarmed about the growing level of turnover the organization has recently been experiencing. It has already passed the industry average, and they are concerned about the practice's capacity to staff the medical clinics for the upcoming flu season. In conducting exit interviews, they have learned that the employees who are leaving generally liked their work and felt that their salaries were fair. However, they were unhappy with the way their managers treated them, which was creating stress in their lives. They are leaving to take less stressful positions in other health care organizations.

Discussion Questions

1. How should the managers behave differently so that the employees experience less stress on the job?
2. What strategies can the organization use so that the employees experience less stress on the job?
3. What could the individual employees do to help manage their own stress levels more effectively?

CASE STUDY 13-4 Scott's Dilemma

Scott is a licensed physical therapist who works for a national rehabilitation company. The rehabilitation facility in which Scott works is located in an urban Southwest city. He has worked at this facility for four years, and up until recently was satisfied with his working environment and the interactions he shared with his coworkers. In addition, Scott received personal fulfillment from helping his patients recover from their disabilities and seeing them return to productive lives.

Last year the health system went through reorganization, with some new people being brought in and others reassigned. Scott's new boss, George, was transferred from one of the system's Midwest facilities. Almost immediately upon taking his new position, George began finding fault with Scott's care plans, patient interactions, and so on. Scott began feeling as if he couldn't do anything right. He was experiencing feelings of anxiety, stress, and self-blame. Although his previous performance evaluations had been above average, Scott was shocked by his first performance review under George's authority—George gave him an extremely low rating.

Scott began trying to work harder, thinking that by working harder he could exceed George's expectations. Despite Scott's working long hours and addressing George's critiques, George continued to find fault with Scott's work. Staff meetings began to be a great source of discomfort and stress because George would belittle Scott and single him out in front of his colleagues.

Scott began to feel alienated from his family, friends, and colleagues at work. His eating and sleeping habits were adversely affected as well. Scott's activities held no joy for him anymore, and the career that he once loved and been respected in became a source of pain and stress. He began to call in sick more often and started visualizing himself confronting and even hurting George, which created even more guilt and anxiety for Scott.

As time went on, George encouraged Scott's coworkers to leave Scott alone to do his work. The perception of the coworkers became more sympathetic to George's point of view. Scott's coworkers mused that perhaps Scott really was a poor worker and that George knew better because of his position as the supervisor of the rehabilitation department. Eventually, Scott's coworkers began to distance themselves from him, in order to protect their own interests. They began to see Scott as an outsider, with whom it was unsafe to associate.

In an effort to resolve the situation, Scott spoke to George directly, stating his feelings and expressing an interest in how they might improve the situation. Rather than making the situation better, what George perceived as Scott's insubordination served to enrage George, and the personal attacks against Scott intensified. Feeling frustrated and helpless, Scott then decided to take his problem to the Human Resources Department (HRD). A human resources manager listened to Scott's complaints and suggested that Scott return with documentation evidence of what Scott perceived to be George's mistreatment. In an effort to help ease the situation, the HRD manager discussed the issue with George, which only stirred the flames of George's anger and his negative behavior toward Scott.

As a last resort, Scott decided to go to George's boss, Rebecca. Rebecca met with George to get his side of the story. George portrayed Scott as an unproductive employee with no respect for authority. The result was a strong letter of reprimand in Scott's file for insubordination.

Discuss the symptoms of stress that Scott is experiencing. What recommendations can you make to Scott for coping with his stress?

Reproduced from: "Case Discussion: Workplace Bully," by J. Pinto, M. Vecchione, and L. Howard, October 2004. Presented at the 12th Annual International Conference of the Association on Employment Practices and Principles, Ft. Lauderdale, FL.

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CHAPTER 14

Decision Making

LEARNING OUTCOMES

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

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

Overview

Managers face different types of problems, both well-structured and poorly structured ones, and use different types of decision-making models to solve them. When confronting a well-structured problem, defined as one that is straightforward, repetitive, familiar, and easily defined, managers use a routine approach that relies on an organization's policies and procedures. For example, if two employees request the same vacation period, the manager, who must ensure adequate coverage in the workplace, follows company policy by granting the vacation request to the employee with the most seniority. However, middle and senior managers usually deal with poorly structured problems, those that are new and complex, for which information is limited and incomplete. This is especially true as new legislation and payment models evolve rapidly and health care systems consolidate, becoming larger and more multifaceted.

In the context of behavioral decision making, there are various means that an individual can use to choose the optimal or most desired outcome. Individuals typically use the rational approach to decision making when there is enough time for an orderly, thoughtful process. However, because of constraints on time, resources, and information and the complexity of today's health care organizations, managers are limited, or "bounded," as to their rational decision making. The bounded rationality perspective takes into consideration that because of the complexity of problems, limited time, personal biases, and other factors, managers will not be able to weigh all possible alternatives to a problem and therefore must sometimes rely on intuitive decision making or the heuristics and biases approach.

Rational Approach

The rational approach to decision making, also referred to as the economic rationality model, involves a systematic analysis of the problem followed by the choice and implementation of a solution in a logical, step-by-step sequence (Daft, 2004). The rational model is considered the ideal method of decision making, as illustrated in **Figure 14-1**.

1. *Monitor the External and Internal Environments*: Managers need to first monitor the external (outside the organization) environment then the internal (within the organization) environment for needed changes to the status quo. These needed changes can arise from reviewing financial statements, performance evaluations, industry indices, competitors' activities, new regulations, and the like.
2. *Identify the Problem Requiring Action*: The manager responds to a needed change by identifying important issues, such as where, when, who are the stakeholders affected and involved, and how current activities will be influenced.
3. *Determine Desired Outcomes of the Decision*: The manager determines what performance outcomes need to be achieved by the decision.
4. *Analyze the Problem*: The manager needs to fact find the causes of and/or issues surrounding the problem. Additional data will be generated in this process so the appropriate alternatives can be generated.
5. *Determine Possible Courses of Action*: Before moving ahead with a decisive action plan, the manager must have a clear understanding of the various options available to achieve the desired outcomes. The manager should seek input from stakeholders and evidenced-based research for varying ideas and suggestions.
6. *Evaluate Alternatives*:. The manager assesses the merits of each alternative and the probability that each alternative will reach the desired outcomes.
7. *Choose the Best Course of Action*: This step is critical to the decision process. The manager uses their analysis of the problem, outcomes, and alternatives to select the single best course of action for success.
8. *Implement the Selected Decision*: Finally, the manager allocates the necessary resources and gives directions to ensure that the selected decision is carried out.
9. *Evaluate the Decision*: Finally, the manager needs to assess if the decision met the desired outcomes and communicate the results to others. Thereafter, the monitoring activity (step 1) begins again.

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

Bounded Rationality Model

The bounded rationality model of decision making, proposed by Simon (1957), recognizes that individuals have cognitive limitations that prohibit the processing of all the necessary or optimal information for decision making; therefore, an individual will limit their search for information

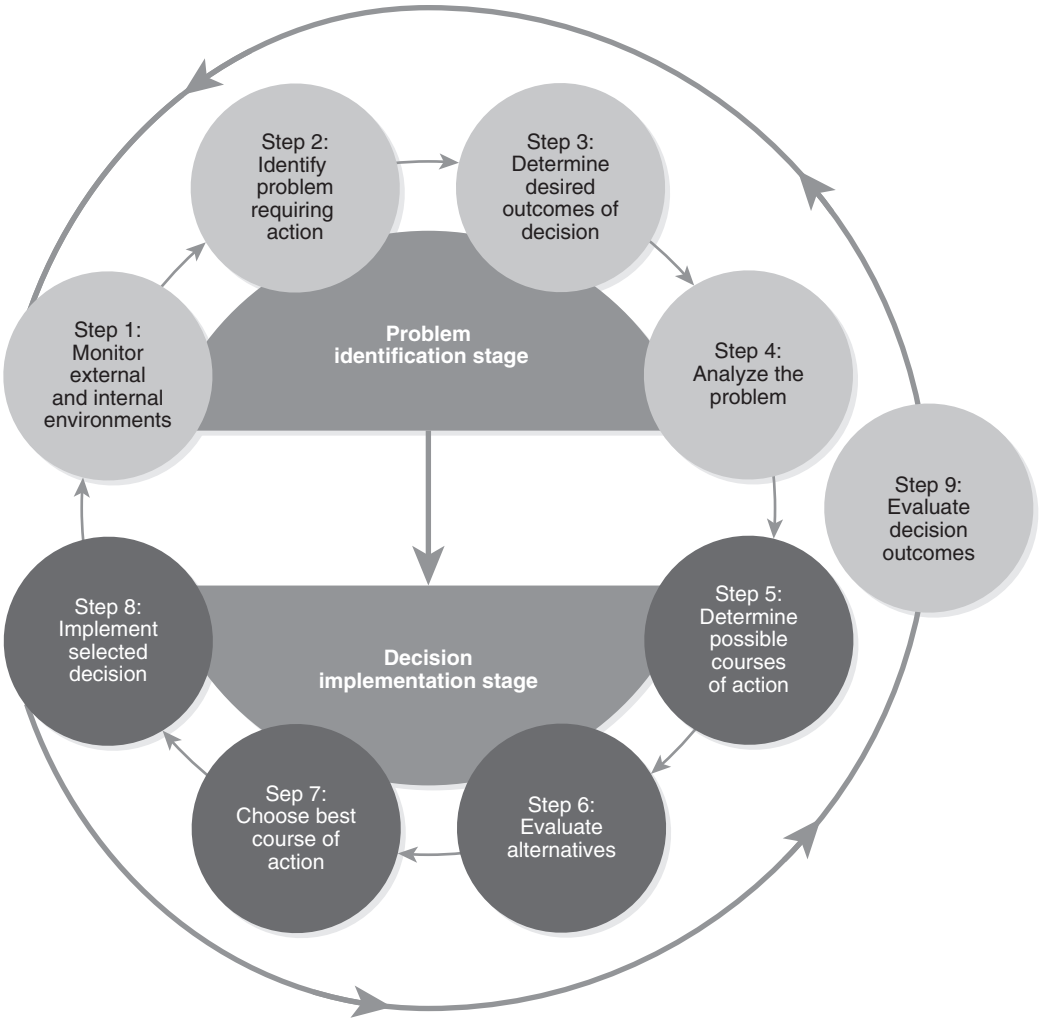

Figure 14-1 Steps in the Rational Approach to Decision Making

before making a decision. Dequech (2001, p. 913) explains the concept of bounded rationality in the following manner:

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

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

Intuition

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

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

Heuristics or Biases Approach

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

Availability bias is an intuitive technique in which the perceived probability of an event is influenced by the ease of recollection. More easily recalled events are given a higher probability of reoccurring. More frequent events are often the most easily recalled, but the most easily recalled are not necessarily the most frequent (Hall, 2002). Ease of recall is also affected by salience (i.e., the degree to which some information is perceived as being more relevant to

the decision being made) related to the emotional strength of a memory; memories associated with strong emotions are recalled more easily. For example, performance appraisals of staff are affected by the use of availability heuristics by managers while evaluating them. It is common to find the most recent and vividly etched event—positive or negative—influencing the appraisal. (See **Case Study 14-1**.)

Representativeness bias is an intuitive technique whereby probabilities are evaluated according to the degree to which the given sample matches, or is representative of, a class of samples or populations. In the workplace, representativeness heuristics can be traced as the reason behind many cases of employee discrimination. (See Case Study 14-1.)

Anchoring and adjustment bias is an intuitive technique that is used when a series of estimates is used to obtain a proposed answer to a current problem. People create a preliminary solution on the basis of initial information (anchoring) and then modify the answer when more information becomes available (adjustment). For example, when the salary of a new employee is being set, the anchoring and adjustment heuristic is used. The employee's starting salary is invariably set close to the last paid salary without regard to what the new job description may entail. In other words, the initial value significantly influences the process of the adjustment toward the new value, irrespective of the rationality in the choice of the initial value. (See **Case Study 14-2**).

CASE STUDY 14-1 Just Like the Others

Dr. Smith walked into the patient's room after quickly reviewing the chart. The patient was a 42-year-old woman with a long history of diabetes. The patient was complaining of need to urinate frequently throughout the day, which is a sign of uncontrolled diabetes. When Dr. Smith entered the room, he noticed the patient was very obese and was wearing clothes that were quite worn with a few holes here and there. "Oh great. Another low-income patient who doesn't manage their diabetes. Ten bucks says this person is still eating sugary foods and can't get their insulin right. No wonder they have to urinate all the time." Dr. Smith typically counsels 4–5 patients a week about managing their diabetes, and finds that his lower-income patients do not always seem to have the health literacy to really understand his instructions. Without asking many questions, Dr. Smith started lecturing the patient on eating better foods and doing a better job of managing her insulin. When she protested that she was doing all of those things, he just reinforced the importance again.

Six months later, Dr. Smith got a call from hospital's lawyer. The patient had a tumor in her pelvic region that was putting pressure on her bladder, increasing her urinary frequency. The cancer had progressed quickly, and had metastasized to her lungs. The lawyer informed him that he was named in a lawsuit from the patient, claiming that he negligently refused to listen to her concerns and misdiagnosed her, thus resulting in her metastatic cancer.

Discussion

Dr. Smith used the availability heuristic when giving his diagnosis. Symptoms of mismanaged diabetes were very salient and accessible to Dr. Smith, because he saw several cases per week, often among low-income patients. Dr. Smith also used the representativeness heuristic by comparing the patient to former patients based on her appearance. Had Dr. Smith listened to the patient and created a robust differential diagnosis in addition to relying on his previous experience, he would have realized that the patient's symptoms could have been due to other causes such as a tumor.

CASE STUDY 14-2 How Much Am I Worth?

Kim was really excited to start her new job. She had just graduated and was finally going to work at a big hospital in town. When the hiring manager, John, was negotiating Kim's salary, he asked what her salary expectations were. Because she had only ever worked student jobs, she wasn't really sure what the salary should be for this type of position. She tried to look it up online, but it was hard to find accurate information for this particular title. She knew her college friends who were teachers were making about $35,000 a year, so she said, "around $35,000." John said that he would start her at $37,000. "Wow!" Thought Kim. "That's pretty good for my first real job, and I got even more than I asked for, plus awesome benefits! I am so excited!" John thought to himself, "Wow! That was cheap. The last person I hired for that role started at $55,000." After a few months, Kim became friends with the other employee who had the same role, Sarah. In passing, Sarah casually mentioned that she was a little disappointed with her starting salary of $55,000 because she was making $65,000 at her last job in a different industry. When Kim heard about Sarah's higher salary for doing the same job, she wasn't so happy with the $37,000 anymore. She made an appointment with John to discuss a raise. He replied, "I'm sorry, Kim, but HR will only let me go up a little bit from the starting salary without a different title."

How was the anchoring and adjustment heuristic used by Kim, Jim, and Sarah?.

As Case Studies 14-1 and 14-2 illustrate, there are many similarities between clinical decision making and managerial decision making. Extensive literature exists regarding the use of intuition and heuristics in medical decision making because of the high degree of uncertainty within the practice of medicine. As Sox et al. (1988, p. 17) point out, "[M]edicine is the art of making decisions without adequate information." As such, decisions made by clinicians through the use of intuition or heuristics can have a tremendous impact on health care managers. Clinicians make the decisions as to the commitment of scarce resources to patients and the associated care and treatment plans (Hall, 2002; Thompson, 2003). However, it is the responsibility of health care managers to provide the resources for clinicians to perform their work, and their health systems are judged on the clinical outcomes of the patient populations they serve. Therefore, health care managers need to appreciate not only how intuition and heuristics play a part in their own decision making but also how they affect the decision making of clinicians because both affect the achievement of organizational goals. (See **Case Study 14-3**.)

Escalation of Commitment and Framing Heuristics

In addition to Tversky and Kahneman's (1974) three commonly used heuristics, there is another bias that may cause low-quality decision making: escalation of commitment. Staw (1981) defines the problem of escalation of commitment as what occurs when a manager continues to allocate more resources to a losing proposition. One reason escalation of commitment may occur is because a manager does not want to admit that they have made a mistake (Staw & Ross, 1987). Research finds that a manager who feels personally responsible for an initial decision that is failing they are more likely to allocate additional resources than is another person who was not responsible for the initial decision (Staw, 1981). The expression "throwing good money after bad" describes escalation of commitment in a decision. For example, one of the main reasons for the bankruptcy of the Allegheny Health System in Pennsylvania was the unwillingness of the top leaders of the organization to make midcourse corrections in their grand plans on the basis of what was and was not working in hospitals and office practices in Philadelphia and Pittsburgh (Bottles, 2001). Examples from the public sector (Staw & Ross, 1987) include the

CASE STUDY 14-3 Cognitive Errors in Clinical Decision Making

Heuristic processing strategies enable individuals to cut through overwhelming data by applying simplifying assumptions to information. Consider the following clinical examples illustrating commonly used heuristics:

- *Availability error* occurs when clinicians misestimate the prior probability of disease because of recent experience. Experience often leads to overestimation of probability when there is memory of a case that was dramatic or that involved a patient who fared poorly or a lawsuit. For example, a clinician who recently missed the diagnosis of pulmonary embolism in a healthy young woman who had vague chest discomfort but no other findings or apparent risk factors might then overestimate the risk in similar patients and become more likely to do chest CT angiography for similar patients despite the very small probability of disease. Experience can also lead to underestimation. For example, a junior resident who has seen only a few patients with chest pain, all of whom turned out to have benign causes, may begin to do cursory evaluations of that complaint even among populations in which disease prevalence is high.
- *Representation error* occurs when clinicians judge the probability of disease based on how closely the patient's findings fit classic manifestations of a disease without taking into account disease prevalence. For example, although several hours of vague chest discomfort in a thin, athletic, healthy-appearing 60-year-old man who has no known medical problems and who now looks and feels well does not match the typical profile of a myocardial infarction (MI), it would be unwise to dismiss that possibility because MI is common among men of that age and has highly variable manifestations. Conversely, a healthy 20-year-old man with sudden onset of severe, sharp chest pain and back pain may be suspected of having a dissecting thoracic aortic aneurysm because those clinical features are common in aortic dissection. The cognitive error is not taking into account the fact that aortic dissections are exceptionally rare in a 20-year-old, otherwise healthy patient; that disorder can be dismissed out of hand and other, more likely causes (e.g., pneumothorax, pleuritis) should be considered. Representation error is also involved when clinicians fail to recognize that positive test results in a population where the tested disease is rare are more likely to be false positive than true positive.
- *Anchoring errors* occur when clinicians steadfastly cling to an initial impression even as conflicting and contradictory data accumulate. For example, a working diagnosis of acute pancreatitis is quite reasonable in a 60-year-old man who has epigastric pain and nausea, who is sitting forward clutching his abdomen, and who has a history of several bouts of alcoholic pancreatitis that he states have felt similar to what he is currently feeling. However, if the patient states that he has had no alcohol in many years and has normal blood levels of pancreatic enzymes, clinicians who simply dismiss or excuse (e.g., the patient is lying, his pancreas is burned out, the laboratory made a mistake) these conflicting data are committing an anchoring error. Clinicians should regard conflicting data as evidence of the need to continue to seek the true diagnosis (acute MI) rather than as anomalies to be disregarded. There may be no supporting evidence (i.e., for the misdiagnosis) in some cases in which anchoring errors are committed.

city of Vancouver's commitment to Expo '86, Chicago's Deep Tunnel project, and the Washington Public Supply System.

In the case of the World Exposition on Transportation and Communication, or Expo '86, the fair was supposed to operate close to financial breakeven. But as the plans moved forward, the projected losses burgeoned. The planners continued because politically it was

too late to stop, owing to the interests of various stakeholders. British Columbia had to create a lottery to cope with the $300 million deficit. The good news was that the fair did open as scheduled.

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

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

Decision-Style Model

Managers have different styles when it comes to making decisions and solving problems. Rowe and Boulgarides (1983, 1998) developed a decision-style model that proposes that managers differ along two dimensions in the way they approach decision making: value orientation and tolerance for ambiguity. Value orientation reflects the extent to which an individual focuses on either task and technical concerns or people and social concerns when making decisions. Tolerance for ambiguity reflects the extent to which a person has a high need for structure or control in their life.

As illustrated in **Figure 14-2**, the decision-style model encompasses four basic styles: directive, analytic, conceptual, and behavioral. Boulgarides and Cohen (2001, pp. 59–60) describe the four basic styles as follows:

1. *Directive*: The decision maker who uses this style has a low tolerance for ambiguity and low cognitive complexity. The focus is on technical decisions, and this style is generally autocratic.

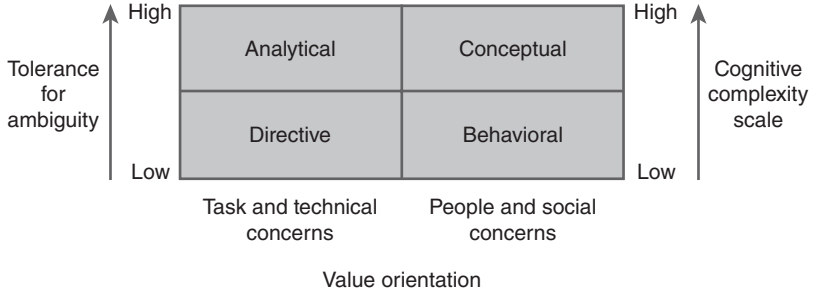

Figure 14-2 Decision-Making Styles

Reproduced from Rowe, A. J., & Boulgarides, J. D. (1983). Decision styles: A perspective. *Leadership & Organization Development Journal*, *4*(4), 3–9.

The decision maker may adopt this style because of a high need for power. Because of the use of little information and few alternatives, speed and satisfactory solutions are typical. The decision makers tend to be focused and are frequently aggressive. Generally, they prefer structure and specific information, which is given verbally. Their orientation is internal to the organization and short range. They tend to operate with tight controls. Although they are efficient, these decision makers have a high need for security and status. They have the drive that is required to achieve results, but they also want to dominate others.

2. *Analytic*: This decision maker has a much greater tolerance for ambiguity than the directive-style manager and also has a more cognitively complex personality that leads to the desire for more information and the consideration of many alternatives. Because of the focus on technical decisions and the need for control, the analytic style contains an autocratic bent. The analytic style is typified by the ability to cope with new situations (but in a structured manner) and problem solving. Position and ego are important to individuals who use an analytic decision-making style. These individuals often reach top positions in an organization or start their own companies. They are not particularly quick in their decision making, and they enjoy variety and prefer written reports. They also enjoy challenges and examine every detail in a situation.
3. *Conceptual*: Including both high cognitive complexity and people orientation, managers with this decision-making style tend to use data from multiple sources and to consider many alternatives. Like individuals using the behavioral decision-making style, conceptual-style decision makers share goals with subordinates in trusting and open relationships. These individuals tend to be idealists who may emphasize ethics and values in their behavior. They generally are creative and can readily understand complex relationships. Their focus is long range with high organizational commitment. They are achievement-oriented and value praise, recognition, and independence. They prefer loose control over power and will frequently encourage the participation of those they lead. They may be characterized as thinkers rather than doers.
4. *Behavioral*: Although low on the cognitive complexity scale, this leader has a deep concern for the organization and the development of people. Behavioral-style managers tend to be supportive and are concerned with subordinates' well-being. They provide counseling, are receptive to suggestions, communicate easily, show warmth, are empathetic, are persuasive, and are willing to compromise and accept a looser style of control. With low data input, this style tends toward a short-range focus and uses meetings primarily for communicating. These managers avoid conflict, seek acceptance, and tend to be more people-oriented but sometimes are insecure.

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

Vroom-Yetton Decision-Making Model

A decision-making method that is good under one set of circumstances might not be considered so under other conditions. A classic contingency model for decision making was first described by Vroom and Yetton (1973). Fifteen years later, Vroom and Jago (1988) replaced the decision tree system of the original model with an expert system based on mathematics.

	FIVE TYPES OF DECISION PROCESSES																		
	AUTOCRATIC AI			AUTOCRATIC AII					CONSULTATIVE CI	CONSULTATIVE CII						COLLABORATIVE GII			
1. Is the quality of the decision important?	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
2. Is the team commitment to the decision important?	N	N	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
3. Do you have the information to make the decision on your own?	Y			Y	N	N	N	N	N	Y	N	N	N	N	N	Y	N	N	
4. Is the problem well-structured?					Y	Y	Y	Y	Y		N	Y	N	Y	N		Y	N	
5. If you made the decision yourself, would the group support it?			Y	Y	Y			Y	Y	N	Y	N	N	N	N	N	N	N	N
6. Does the group share organizational goals?					N	N	Y	Y	Y	N		Y	N	N		Y	Y	Y	
7. Is conflict over the decision likely?							N	N	Y			N					Y		

Figure 14-3 Vroom-Yetton Decision-Making Model

You might see the model referred to as Vroom-Yetton, Vroom-Jago, or Vroom-Yetton-Jago (see **Figure 14-3**). The contingency model for decision making suggests that individuals should consider choosing from five types of decision processes based on a number of factors. Two of the five processes are autocratic (AI and AII), two are consultative (CI and CII), and one is group-based (GII). This decision-making model can be used to choose between individual and group decision-making strategies.

The five decision processes as described by Vroom and Yetton (1973) are as follows:

1. *Autocratic I (AI)*: Completely autocratic. You solve the problem or make the decision yourself, using the information available to you at the present time.
2. *Autocratic II (AII)*: Request specific information. You obtain any necessary information from team members or subordinates and then decide on the solution to the problem yourself. You may or may not tell subordinates the purpose of your questions or give information about the problem or decision you are working on. The input provided by subordinates is clearly in response to your request for special information. They do not play a role in the definition of the problem or in generating or evaluating alternative solutions.
3. *Consultative I (CI)*: One-on-one discussion. You share the problem with the relevant team members or subordinates individually, getting their ideas and suggestions without bringing them together as a group. Then you make the decision. This decision may or may not reflect your subordinates' influence.
4. *Consultative II (CII)*: Group discussion. You share the problem with your team members or subordinates in a group meeting. In this meeting you obtain their ideas and suggestions. Then you make a decision that may or may not reflect your subordinates' influence.
5. *Group (GII)*: Consensual group decision making. You share the problem with your team members or subordinates as a group. Together, you generate and evaluate alternatives and attempt to reach agreement (i.e., consensus) on a solution. Your role is much like that of facilitator, coordinating the discussion, keeping it focused on the problem, and making sure that the critical issues are discussed. You can provide the group with information or ideas that

you have, yet you do not try to pressure them to adopt your solution, and you are willing to accept and implement any solution that has the support of the entire group.

Many people find this decision making model helpful when the following seven yes/no questions are answered, as shown in Figure 14-3. Note, however, that, in some scenarios, you do not need to answer all of the questions as evident by the blank cell in the table. The seven questions are answered in order from 1 to 7 and followed across the table from left to right:

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

For example, in the case in which the quality requirement (question 1) is low (e.g., the nature of the solution is not critical) and team commitment (question 2) is also not critical, the method suggests that you should make the decision on your own (i.e., choose method AI). Alternatively, if team commitment is critical, you would consider question 5 about the certainty of acceptance if you made the decision on your own. If people are likely to accept your decision, the method suggests once again making the decision on your own (i.e., AI). However, if acceptance of your decision is not reasonably certain, the method suggests a consensual group method (i.e., GII) to help overcome this.

Situational factors that may influence the model include the following:

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

The Vroom-Yetton model works best when there are clear and accessible opinions about the decision quality importance and decision acceptance factors. However, these are not always known with any significant confidence.

Conclusion

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

Discussion Questions

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

Exercise 14-1

There are times when you have made good decisions. You knew it was a good decision at the time, and when you looked back on it later, you recognized that, yes, that was a good decision. Even now, you still think it was a good decision. There are also times when you have made poor decisions. You might have felt uneasy about it at the time, and when you look back on it, you recognize that it was a poor decision. Analyze the factors that you think contributed to both your good decisions and your poor decisions.

Exercise 14-2

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

Describe each step in your decision-making process.

Exercise 14-3

Project Implicit at Harvard has created a series of tests to help people better understand their own implicit biases so that they can become aware of how these biases could influence decisions and behavior. Choose one of the tests at their website (https://implicit.harvard.edu/implicit/takeatest.html), and discuss what you learned about yourself from the results.

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CHAPTER 15

Conflict Management and Negotiation Skills

LEARNING OUTCOMES

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

- The definition of conflict.
- The four basic types of conflict.
- The five levels of conflict.
- The five conflict-handling modes.
- The three major negotiation models.

Overview

Conflict is a natural part of human relationships. As such, it is inevitable and unavoidable. It is a part of our everyday professional and personal lives; therefore, it is inherent in any type of work setting (Thomas, 1976). Although there are numerous definitions of conflict, Thomas (1992a, b) suggests that most definitions have three common components: (1) perceived incompatibility of interests, (2) some interdependence of the parties, and (3) some form of interaction. For example, Rahim (1985) defined conflict as an "interactive state" manifested in disagreement or differences, or incompatibility, within or between individuals and groups. For our discussions, we will define conflict as occurring when an individual or group feels negatively affected by another individual or group.

No organization is exempt from conflict, and the health care setting is a particularly conflictual environment because of factors such as high stress, strong emotions, scarce resources, competition, downsizing, mergers, excessive regulations, diversity and cultural issues, and multiple stakeholders' demands. These factors increase conflict in organizations (Gardner, 1992; Johnson, 1994). Research has shown that both health care and non-health care managers spend an average of 30% of their time dealing with conflict, and this is often cited as one of the least enjoyable aspects of

their leadership roles (McElhaney, 1996; Robbins, 1990; Shelton & Darling, 2004; Thomas & Schmidt, 1976).

It is important to note that conflict does not necessarily lead to ineffectiveness. Conflict, like stress, can be either positive or negative. Positive conflict can act as a stimulus for positive change. Positive or constructive conflict can lead to creative problem solving and alternatives, increased motivation and commitment, high-quality work, and personal satisfaction (i.e., functional outcomes) (Cosier & Dalton, 1990). However, negative or unconstructive conflict can be counterproductive for an organization by diverting efforts from goal attainment (i.e., dysfunctional outcomes). Negative conflict may also affect the psychological well-being of employees. Severe, unconstructive conflicts may result in employee resentment, tension, and anxiety, which may lead to low-quality work, personal stress, and possible sabotage. For example, it is estimated that over 65% of performance problems result from strained relationships and that conflict accounts for up to 50% of involuntary employee departures (Dana, 2000; Watson & Hoffman, 1996). Negative conflict may create an organizational culture of competition versus cooperation, thereby eliminating the sustainability of supportive and trusting relationships, which are necessary for successful organizations (Baron & Richardson, 1990). For example, Forte (1997) points out that in clinical environments, conflict among health care professionals can be counterproductive with respect to patients, resulting in increased mortality and morbidity due to medical errors.

Lewicki, Weiss, and Lewin (1992) identify six major areas in conflict research: the micro-level (psychological) approach, the macro-level (sociological) approach, the economic-analysis approach, the labor-relations approach, the bargaining and negotiation approach, and the third-party dispute approach. The micro-level approach includes research on factors that affect intrapersonal and interpersonal conflict (i.e., within and among individuals), whereas the macro-level approach focuses on factors that affect conflict among and within groups, departments, and organizations (i.e., intragroup, intergroup, and interorganization). Economic analysis refers to economic rationality and how it applies to individual decision making. The research areas of labor relations, bargaining and negotiation, and third-party resolution relate to studies that deal with the effects of workplace and conflict resolutions and/or conflict management.

Using this framework, we first discuss the various types and levels of conflict. Second, we examine the various methods to deal with conflict effectively, referred to as conflict resolution or conflict management. This discussion includes individual decision making and the negotiation skills that are necessary for effective conflict management.

Types of Conflict

There are four basic types of conflict: goal, cognitive, affective, and procedural (Kolb & Bartunek, 1992). Goal conflict occurs when two or more desired or expected outcomes are incompatible. It may involve inconsistencies between individual or group values and norms (e.g., standards of behavior). Cognitive conflict occurs when the ideas and thoughts within an individual or between individuals are incompatible. Affective conflict emerges when the feelings and emotions within an individual or between individuals are incompatible. Procedural conflict occurs when people differ over the process to use for resolving a particular matter. As illustrated in **Case Study 15-1**, the different types of conflict are not mutually exclusive.

CASE STUDY 15-1 Who's the Boss?

"Dr. Jordan on line three for you, Mary." When Mary Jones pressed the blinking button, she knew Dr. Jordan was not calling to set up their next tee time. As chief of surgery, Dr. Jordan had full access to the board of directors, and Mary, the chairperson of the board, noticed he took full advantage of it. Lately, Dr. Jordan's calls were mostly about Harriet Briggs, the hospital's administrator. Today was no different.

"Mary, as chief of surgery, I have authority over all issues that affect the quality of patient care. When something or someone is compromising that quality, it is my prerogative, not the prerogative of some layman [Dr. Jordan's word for anyone not holding an MD] to do what I deem necessary to correct the situation. Don't you agree?"

Mary mentally ran through job descriptions and the hospital's charter and she could remember no clause that explicitly gave the chief of surgery this authority. Implicitly though, his stance was probably correct. "I'll reserve comment on that, Alex, until you tell me the specific situation that has you this upset."

The problem that concerned Dr. Jordan involved the nursing supervisor, Judith Brady, RN. Ms. Brady scheduled the hospital's surgical nurses according to her interpretation of established hospital policy. Surgeons were frustrated with her attitude that maximum utilization must be made of the hospital's operating time for training purposes. She therefore scheduled in such a way that nurses were often assigned to procedures they had not seen before. Surgeons complained that this scheduling method often added to the time it took to perform an operation. This caused problems because the operating room was run at full capacity. Surgeons already felt they must hurry to complete a procedure because another procedure was scheduled directly following theirs. Having to wait because a nurse did not automatically know what instrument is needed next only exacerbated this problem and did not permit them sufficient time to complete a surgical procedure in the proper manner. The surgical staff were concerned that this scheduling system was impacting quality of care. Furthermore, some of the surgeons had complained that Ms. Brady clearly favored some physicians over others and tended to assign more experienced nurses to their procedures.

The situation came to crisis earlier in the morning when Dr. Jordan, following a confrontation with Ms. Brady, told her she was fired. Ms. Brady then made an appeal to Harriet Briggs, the hospital administrator. Harriet overturned Ms. Brady's dismissal and then instructed Dr. Jordan that discharge of nurses was the purview of the hospital administrator and only she had the authority to do so. Dr. Jordan vehemently disagreed. The conversation ended with Dr. Jordan yelling, "This is clearly a medical problem, and I am sure the board of directors will agree with me." Dr. Jordan then called Mary.

After listening to Dr. Jordan, Mary decided to call Harriet Briggs to get her side of the story. Harriet told Mary, "I cannot be responsible for improving patient care if the board will not support me. I must be able to make decisions and develop policies and procedures without worrying whether or not the board will always side with the physicians. As you already know, Mary, I am legally responsible for the care that patients receive here at the hospital. And another thing, the next time Dr. Jordan tells me that I should restrict my activities to fund raising, maintenance, and housekeeping, I will not be responsible for my actions!"

The severity of the problem was obvious, but the answers were not. All Mary knew was she needed to fix the situation quickly.

Discuss the goal, cognitive, affective, and procedural conflicts illustrated in this case.

Friedman, R. (2002). Musical operating rooms: Mini-cases of health care disputes. *International Journal of Conflict Management, 13*(4), 419–420. Reprinted with permission.

Levels of Conflict

There are five levels of conflict: intrapersonal conflict (within a person), interpersonal conflict (between or among individuals), intragroup conflict (within a group), intergroup conflict (between or among groups), and interorganizational conflict (between or among organizations).

Intrapersonal Conflict

Intrapersonal conflict occurs within the individual and may involve some form of goal or cognitive or affective conflict. Intrapersonal goal conflict happens when several alternative courses of action are available and when the outcome, whether positive or negative, is important to the individual (Locke, Smith, Erez, Chah, & Schaffer, 1994). Brehm and Cohen (1962) identified three types of intrapersonal conflict that may develop, involving alternative courses of action:

- *Approach/Approach*: The approach/approach type occurs when an individual must choose between two or more alternatives, each of which is expected to have a positive outcome. For example, Judy Lewis, a recent graduate of a local university's master of health services administration (MHSA) program, has been offered job positions in two different health care organizations. The first is a managed care coordinator position with a national, publicly held laboratory company. The second is a network analyst position with a fast-growing third-party administrator. The salary levels of the two positions are comparable.
- *Avoidance/Avoidance*: The avoidance/avoidance type occurs when an individual must choose between two or more alternatives, each of which is expected to result in a negative outcome. For example, after Judy Lewis accepted the position as the managed care coordinator with the laboratory company, management announced that because of a recent merger, the company is in the process of rightsizing. Two options were presented to Judy: retain her position by relocating to the organization's headquarters, which is 1000 miles away from her hometown, or be laid off.
- *Approach/Avoidance*: The approach/avoidance type occurs when an individual must choose an alternative that is expected to have both positive and negative outcomes. Judy Lewis chooses the relocation option. Although she realizes that she will gain valuable experience working in the organization's corporate headquarters, where she will have opportunities for advancement, she is unhappy about having to leave her family, friends, and familiar surroundings.

Intrapersonal conflict may also be a consequence of cognitive dissonance, which occurs when individuals recognize inconsistencies in their own thoughts and behavior. Individuals seek consistency among their beliefs and/or opinions (i.e., cognitions), and when an inconsistency arises between one's beliefs or attitudes and one's behavior (i.e., dissonance), something must change to eliminate or lessen the conflict. When there is a discrepancy between an individual's attitude and behavior, the individual's attitude is likely to change to accommodate their behavior, thereby reducing or eliminating the intrapersonal conflict (Brehm & Cohen, 1962).

In the workplace, dissonance occurs most often in the context of role conflict. The three types of role conflict are (1) the person and the role, (2) intrarole, and (3) interrole. Person–role conflict occurs when the expectations associated with a work role are incompatible with the individual's needs, values, or ethics. For example, a pharmaceutical representative believes that making untested claims about a new drug is unethical, but whose work role requires them to do so. Intrarole conflict occurs when an individual experiences different expectations from their role. For example, a hospital's purchasing manager who reports administratively to the vice president of operations and functionally to the medical director may face conflicting expectations, as the former may, because of decreasing reimbursements, stress cost efficiency by restricting choices of prosthesis devices in the surgery department, whereas the latter may emphasize having available whatever prostheses the surgeons prefer to use without regard to cost. Interrole conflict occurs

when there is a clash between work and nonwork role demands. For example, if an individual must travel extensively or work excessive hours, it may conflict with their family's needs or their desire to spend time together.

Interpersonal Conflict

Interpersonal conflict is a natural outcome of human interaction. Interpersonal conflict involves two or more individuals who believe that their attitudes, behaviors, or preferred goals are in opposition. Kottler (1996) relates that there are three major sources of interpersonal conflict: (1) personal characteristics and issues, (2) interactional difficulties, and (3) differences around perspectives and perceptions of the issues. Porter-O'Grady and Epstein (2003, p. 36) summarize these components as follows:

- *Personal Characteristics and Issues:* As a result of the diversity of today's workplace, an extensive range of differences exists between persons and cultures. These differences are embedded with a kind of emotional content related to variations in beliefs, behaviors, roles, and relationships. Individuals function in the context of these diverse characteristics, further validating differences others see in us.
- *Interactional Difficulties:* As we mature and socialize, we learn effective communication and relational skills. A lack of communication skills, combined with our personal and cultural differences, creates powerful deficits in our ability to relate to one another. Because of this broad-based inadequacy, relational conflicts regularly emerge.
- *Perspective and Perceptive Differences:* When combined with personal differences and communication inadequacies, dissimilarity in the way people view issues and interactions is a common source of interpersonal conflict. This source of interpersonal conflict may include erroneous perceptions based on incomplete information, disparate interpretations of meaning, or personal bias.

Many interpersonal conflicts involve goal conflict or role ambiguity. Role ambiguity involves a lack of clarity or understanding in terms of expectations about an individual's work performance. Often, the misunderstanding is the result of perceptual differences regarding an issue or process. Unclear performance expectations can easily intensify interpersonal conflicts and undermine sustainability of healthy relationships. Role ambiguity may cause stress reactions, such as aggression, hostility, and withdrawal behavior (Jackson & Schuler, 1985).

Intragroup Conflict

Intragroup conflict involves clashes among some or all of a group's members, which often affect the group's processes and effectiveness. Jehn and Mannix (2001) suggest that there are three types of intragroup conflict: (1) relationship, (2) task, and (3) process.

- Relationship conflict is an awareness of interpersonal incompatibilities. It includes affective components such as feeling tension and friction. Relationship conflict involves personal issues such as dislike among group members and feelings such as annoyance, frustration, and irritation.
- Task conflict is an awareness of differences in viewpoints and opinions pertaining to a group task. Like cognitive conflict, it pertains to conflict about ideas and differences of opinion about the task. Task conflicts may coincide with animated discussions and personal

excitement but, by definition, are devoid of the intense interpersonal negative emotions that are commonly associated with relationship conflict.

- Process conflict is an awareness of controversies about aspects of how task accomplishment will proceed. More specifically, process conflict pertains to issues of duty and resource delegation, such as who should do what and how much responsibility should be assigned to different people. For example, when group members disagree about whose responsibility it is to complete a specific duty, they are experiencing process conflict.

Intergroup Conflict

Intergroup conflict involves opposition and clashes between groups. Under extreme conditions of competition and conflict, the groups develop attitudes toward one another that are characterized by a failure to communicate, distrust, and a self-interest focus (see **Case Study 15-2**). Nulty (1993) relates that there are four categories of intergroup conflict: (1) vertical conflict, (2) horizontal conflict, (3) line–staff conflict, and (4) diversity-based conflict.

- Vertical conflict occurs between employees at different levels in an organization. For example, when supervisors attempt to control subordinates, subordinates may resist because they believe that the control infringes too much on their autonomy to perform their jobs. Vertical conflict may also arise because of poor communication, goal or value incompatibility, or role ambiguity (Pondy, 1967).
- Horizontal conflict occurs between groups of employees at the same hierarchical level in an organization. It occurs when each department or team strives only to achieve its own goals, disregarding the goals of other departments and teams, especially if those goals are incompatible (see **Case Study 15-3**; see also Pondy, 1967).

CASE STUDY 15-2 Turf Battles

Andrea Bevans, chief operating officer of Holy Name Hospital, knew it was a matter of when, not if. The memo she had just read was the first salvo in what promised to be another turf battle within the medical staff organization. In the memo, the hospital's vascular surgeons demanded that radiologists not be allowed to perform balloon angioplasty. Bevans knew that this treatment used a balloon at the end of a catheter and that after the catheter had been threaded into an artery in the peripheral vascular system, the balloon was inflated to break up deposits that narrowed the arteries.

The memo stated that vascular surgeons had the background, training, expertise, and proven outcomes using surgical skills and that they could best learn and apply the new techniques, if those techniques were appropriate at all. To allow radiologists to work inside the peripheral vascular system would violate previously tried and tested relationships and would cause other, unspecified, disruptions. The memo ended with a chilling, thinly veiled threat: "Should the hospital allow radiologists to perform balloon angioplasty, it may not be possible for members of the surgical staff to be available to treat untoward events, should they occur as the result of a procedure done by radiologists."

Bevans reread the memo and mused about the path of modern medicine. It was reaching the point where many conditions were treated without a scalpel. She thought fleetingly about "Bones," the *Star Trek* physician, who had only to pass a device over a patient's body to make a diagnosis. "Is this where we're headed?" she thought. "But, enough of science fiction," she said to herself. "How do I solve yet another turf battle without too many casualties, not the least of whom could be me?"

Discuss the intergroup conflicts reflected in this case.

Reproduced from Darr, K. (1996). The developing crisis in medical staff organization. *Hospital Topics, 74*(4), 4–6. Reprinted with permission.

CASE STUDY 15-3 The Managed Care Factor

Cedars-Sinai is a 400-bed community hospital located in a major East Coast metropolitan area. The hospital has a reputation as a high-quality, low-cost provider. The medical staff at Cedars-Sinai comprises board-certified physicians who are predominantly solo practitioners or are part of two- or three-physician practices. No single- or multispecialty group practices are affiliated with Cedars-Sinai. Medical staff matters are handled cautiously and conservatively by the hospital administration.

Nine years ago a large West Coast health maintenance organization (HMO) established a presence on the East Coast and grew rapidly. Because of its fine reputation, Cedars-Sinai has become a major provider of services for the HMO, and many of the HMO's physician–employees have admitting privileges. Almost 20% of Cedars-Sinai's inpatient days come from the HMO.

Following a review of the HMO's utilization patterns, a West Coast consultant noted the large difference in hospital inpatient days per 1000 enrollees between East and West Coast branches of the HMO. The HMO's clinical director was asked to assess how many days of care and, consequently, how many premium dollars could be saved with various levels of progress toward the West Coast utilization patterns.

Word of this study came to the attention of Cedars-Sinai's chief executive officer (CEO), who was immediately alarmed by the implications. He knew that if the HMO's physicians reduced the lengths of stay for their patients by moving utilization patterns toward the West Coast experience, shockwaves would run through the majority of the members of his medical staff—the voluntary, fee-for-service physicians. The consequences of such a disparity in patient-day utilization patterns could be a decision by the medical staff leadership not to reappoint the HMO's physician–employees to the medical staff because the voluntary medical staff would judge that the lengths of stay were inappropriately short and risked patient morbidity and mortality.

Discuss the horizontal conflict reflected in this case.

Reproduced from Darr, K. (1996). The developing crisis in medical staff organization. *Hospital Topics, 74*(4), 4–6. Reprinted with permission.

- Line–staff conflict occurs over authority relationships. Most managers are responsible for the processes that create the organization's services or products. Staff managers often serve an advisory or control function that requires specialized technical knowledge. Line managers may feel that staff managers are intruding on their own areas of legitimate authority. Staff personnel may specify the methods and partially control the resources used by line managers. Line managers often believe that their authority over employees is reduced by staff managers, although their responsibility for the outcomes remains unchanged (March & Simon, 1993).
- Diversity-based conflict relates to issues of race, gender, gender identity or expression, ethnicity, and religion. These conflicts may encompass all five levels of conflict: intrapersonal, interpersonal, intragroup, intergroup, and interorganizational.

Interorganizational Conflict

Interorganizational conflict occurs between organizations as a result of interdependence on membership and divisional or system-wide success. For example, as Longest and Brooks (1998) point out, health care organizations participate in a variety of forms of organizational integration. The most extensively integrated organizations are integrated delivery systems (IDSs). As health care reform leads to increasing integration levels, senior managers become ever more involved in interorganizational conflict. Integration that involves extensive linking of providers at different points in the patient care continuum—especially when IDSs are linked with insurers or health

plans and perhaps with suppliers in very highly integrated situations—brings into close interactive proximity what are often quite disparate organizations. Conflicts are unavoidable, and the knowledge and skills to manage them effectively are imperative. Interpersonal and collaborative competence is, of course, required of senior managers in all settings, but in an IDS, such competence becomes more complex overall, especially given the new dimension of managing interorganizational conflict (Longest & Brooks, 1998).

Conflict Management

As Winder (2003, p. 20) points out:

> Disagreements between people are an inherent and normal part of life. These disagreements can stem from differences in perceptions, lifestyles, values, facts, motivations or procedures. Differing goals, expectations or methods can turn disagreements into conflict, which can be damaging to both parties. Conflict may also be positive and beneficial in that it can force clarification of policy or procedures, relieve tensions, open communications and resolve problems. In its negative form, conflict can direct energy from real tasks, decrease productivity, reduce morale, prevent cooperation, produce irresponsible behavior, break down communication, and increase tension and stress, all resulting in loss of valuable human resources.

Understanding how conflict arises in the workplace is helpful for anticipating situations that may become conflictual. However, individuals also need to understand how they themselves cope with or handle these conflictual situations. Thomas and Kilmann (1974), building on Blake and Mouton's (1964) work in the area of leadership, identified five conflict-handling modes. Thomas and Kilmann describe the five conflict-handling modes in two dimensions: (1) assertiveness (i.e., attempt to satisfy one's own concern) and (2) cooperativeness (i.e., attempt to satisfy others' concerns). The five conflict-handling modes are (1) competition, (2) avoidance, (3) compromise, (4) accommodation, and (5) collaboration (see **Figure 15-1**).

Competition involves assertive and uncooperative behaviors and reflects a win/lose approach to conflict. A dominating or competing person goes all out to win their objective and, as a result, often ignores the needs, concerns, and expectations of the other party (Rahim, Garrett, & Buntzman, 1992). When dealing with conflict between subordinates or departments, competition-style managers use coercive powers such as demotion, dismissal, negative performance evaluations, or other punishments to gain compliance (Winder, 2003). When conflict occurs between peers, a competition-style manager will try to get their own way by appealing to their supervisor in an attempt to use the supervisor to force the decision on their peer (Blake & Mouton, 1984b).

Competition-style management is appropriate in some situations, such as when the issues involved in a conflict are trivial or when emergencies require quick action. It is also appropriate when unpopular courses of action must be implemented for long-term organizational effectiveness and survival (e.g., cost cutting, dismissal of employees for poor performance). This style is also appropriate for implementing strategies and policies that have been formulated by higher-level management (Dewine, Nicotera, & Perry, 1991; Rahim et al., 1992).

Collaboration involves highly assertive and cooperative behaviors and reflects a win/win approach to conflict. A collaboration-style manager attempts to find a solution that maximizes the outcomes of all parties involved. Managers who use the collaborating style see conflict as a

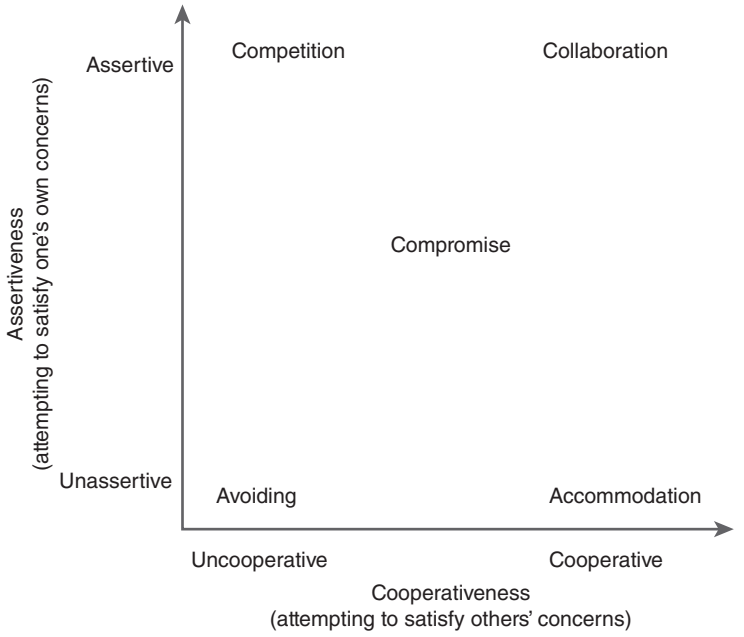

Figure 15-1 Thomas and Kilmann's Two-Dimensional Taxonomy of Conflict-Handling Modes

means to a more creative solution that would be fully acceptable to everyone involved (Winder, 2003). This style involves openness, exchange of information, and examination of differences to reach an effective solution acceptable to all parties. Rahim et al. (1992) suggest that when issues are complex, the collaboration conflict-handling mode emphasizes the use of skills and information possessed by different employees to arrive at creative alternatives and solutions. This style may be appropriate for dealing with the strategic issues relating to objectives and policies, long-range planning, and the like. However, as Winder (2003) points out, this style requires sufficient interdependence and parity in power among individuals that they feel free to interact candidly, regardless of their formal status as superior or subordinate. In addition, this style requires expending extra time and energy; therefore, sufficient organizational support must be available to resolve disputes through collaboration (Winder, 2003).

Compromising is the middle ground, in which managers display both assertive and cooperative behaviors. It involves give-and-take, whereby each party gives up something to reach a mutually acceptable agreement. According to Rahim et al. (1992), it may mean splitting the difference, exchanging concessions, or seeking a middle-ground position. Compromising may be appropriate when the goals of the conflicting parties are mutually exclusive or when two parties that are equally powerful (e.g., labor and management) have reached a deadlock in their negotiation.

According to Winder (2003), heavy reliance on the compromising style may be dysfunctional because it can create several problems if used too early in trying to resolve conflict. First, the parties involved may be encouraged to compromise on the stated issues rather than on the real issues. The first issues that are raised in a conflict often are not the real ones, so premature compromise may prevent full diagnosis or exploration of the real issues. Second, accepting an initial position as presented is easier than searching for alternatives that are more acceptable to everyone involved.

Third, compromise may be inappropriate for all or part of the situation because it may not be the best decision available.

Compared with the collaborating style, the compromising style does not maximize optimal outcomes for all involved parties. Compromise achieves only partial satisfaction for each person. Kabanoff (1991) points out that this style is likely to be appropriate when agreement enables each party to be better off or at least not worse off than if no agreement were reached, achieving a total win/win agreement is not possible, and conflicting goals or opposing interests block agreement on one party's proposal.

Accommodating involves cooperative and unassertive behaviors and is the opposite of competing. Accommodations may represent an unselfish act, a long-term strategy to encourage cooperation by others, or a submission to the wishes of others (Winder, 2003). This style is associated with attempting to play down differences and emphasizing commonalities to satisfy the concern of the other party. An obliging person neglects their own concern to satisfy the concern of the other party; thus, accommodating-style managers may be perceived as weak and submissive because they try to reduce tensions and stress by reassurance and support (Rahim et al., 1992; Winder, 2003).

According to Lee (1990), accommodating is generally ineffective if used as a dominant style, but it may be effective on a short-term basis when individuals are in a potentially explosive emotional conflict situation and smoothing is used to defuse it, when keeping harmony and avoiding disruption are especially important in the short run, and when the conflicts are based primarily on the personalities of the individuals and cannot be easily resolved. In addition, this style is useful when an individual believes that they might be wrong or the other party is right and the issue is much more important to the other. It can be used as a strategy when a party is willing to give up something with the hope of getting something in exchange from the other party when needed (Rahim et al., 1992).

Avoiding involves unassertive and uncooperative behaviors and is the opposite of collaborating. It is associated with withdrawal, buck-passing, or sidestepping situations (Rahim et al., 1992). This approach often reflects a decision to let the conflict work itself out, or it may reflect an aversion to tension and frustration. Because ignoring important issues often frustrates others, consistent use of the avoidance mode of handling conflict usually results in increasing frustration for others. When unresolved conflicts affect goal accomplishment, the avoiding style will lead to negative results for the organization (Winder, 2003).

Conflict Negotiation Models

Rubin and Brown (1975) define negotiation as the process by which two or more parties decide what each will give and take in an exchange. Since the 1960s, there has been extensive research in the field of conflict resolution or conflict management. From this research, three major negotiation models have been developed: (1) distributive, (2) integrative, and (3) interactive. Each of these models is associated with different goals and indicators of success, and each may be appropriately applied in different contexts (Winder, 2003).

Distributive Model

The distributive model originated in the field of labor negotiations (Lewicki et al., 1992; Stevens, 1963; Walton & McKersie, 1965) and can be described as a set of behaviors for dividing scarce resources. Distributive negotiation is often referred to as hard bargaining or a win/lose, zero-sum approach. The negotiators are viewed as adversaries that reach agreement through a series

of concessions with the goal of obtaining the greater "piece of the pie." Tactics that are used in the distributive negotiation model are withholding information, guarded communications, power positioning, limited expressions of trust, use of threats, and distorted statements and demands (Walton & McKersie, 1965). Brett and Shapiro (1998) referred to distributive negotiations as a tug-of-war with each party trying to tug the other to its own side. The winner wins when the opponent's strength gives out and the opponent is pulled across the midline. The result is an agreement that favors one side more than the other.

Winder (2003) outlines the four win/lose strategies practiced by negotiators in using the distributive approach. The first negotiating strategy is the "I want it all" tactic. This tactic involves making extreme offers and then granting concessions grudgingly if at all. The party using this tactic hopes to wear down the resolve of the other party by pressuring the other to make significant concessions and forcing the other into a position of nonreciprocation. The second negotiating strategy is "time warp." The time-warp tactic communicates an arbitrary deadline for acceptance of the offer. For example, the party using this tactic will relate to the other party that an offer is good only until a certain date and time. If not accepted by the arbitrarily set deadline, the offer will be withdrawn. The third negotiating strategy is the "good cop, bad cop" scenario. In this scenario, one party attempts to sway the other by alternating sympathetic behavior and threatening behavior. The fourth negotiating strategy is the ultimatum tactic, which is designed to try to force one party to submit to the will of the other. In this negotiation approach, "take it or leave it" offers are presented, and one party overtly tries to force acceptance of demands; one party is unwilling to make any concessions, and the other party is expected to make all of the concessions (Fisher, Ury, & Patton, 1991).

Integrative Model

The integrative negotiation model, like the distributive model, evolved primarily in the field of labor negotiations (Follett, 1940, 1942; Lewicki et al., 1992; Walton & McKersie, 1965). It is currently one of the most frequently used models of conflict resolution because of its collaborative versus confrontational approach.

Integrative negotiation is a cooperative, interest-based, agreement-oriented approach to dealing with conflict that is viewed as a win/win or mutual-gain dispute. Integrative negotiation is a process by which parties attempt to explore options to achieve mutual gains rather than unilateral gains. Parties recognize and define a problem, search for possible solutions to it, evaluate the solutions, and select one that maximizes joint gains (Lewicki et al., 1992).

Filley (1975), building on the work of Walton and McKersie (1965), developed an integrative decision-making model. Filley's six-step approach is as follows:

1. Create an environment that promotes equality, cooperation, communication, and information sharing.
2. Review and adjust perceptions.
3. Review and adjust attitudes (i.e., create processes that maximize information sharing and clear the air of past hostilities and negative attitudes).
4. Define the problem.
5. Search for alternatives.
6. Achieve consensus.

The concept of integrative negotiation is based on a value system that stresses interpersonal trust, cooperation, a willingness to share information combined with open communication, and a search for mutually acceptable outcomes (Lewicki et al., 1992). This model looks beyond the

existing resources and aims to expand the alternatives and increase the available payoffs to both parties through joint problem solving (Winder, 2003).

Fisher and Ury (1981) and Fisher et al. (1991) define integrative negotiation as "principled negotiation." They suggest that negotiations should be grounded in substantive concerns when the participants do the following:

- Separate the people from the problem. In other words, separate the issues that are in conflict from the personal relationships. Negotiators should be hard on the issues but do so in a cooperative relationship with the other party.
- Focus on interest or need rather than position. In other words, do not allow individual egos to negate the negotiation process. This requires trust, respect, and open communication by both parties.
- Identify the best alternative to a negotiated agreement (BATNA) for both parties. By identifying BATNAs, the parties' goal will be to achieve better outcomes than their BATNA through negotiations.
- Invent options or alternatives that provide mutual gain. Brainstorming, before and during meetings, can assist in developing creative alternatives.
- Insist on using only objective criteria to judge solutions. When negotiations are based on objective rather than subjective criteria, discussions focus on equitable solutions, not false assumptions.

The integrative-conflict model encourages equitable solutions to problems. Negotiators are viewed as partners who cooperate in searching for a fair agreement that meets the interests of both sides and seeks to maximize the gain for all the parties involved (Winder, 2003). (see **Case Study 15-4**).

CASE STUDY 15-4 Creating a Win/Win Situation

A hospital anesthesiology department is deeply financially troubled. Department leaders approach senior hospital administrators seeking additional funds. Department leaders say that without funding they will lose staff and be forced to close operating rooms. The administrators take the position that if they provide funding to the anesthesiology department, every department will demand it. Furthermore, the anesthesiology department has enjoyed the privilege of having an exclusive contract. If rooms are closed, the hospital may entertain looking at other anesthesiology practices. The senior vice president for medical affairs (i.e., VPMA) is called in to mediate. A meeting is set up to negotiate a solution.

Applying Fisher's Principled Negotiations, How Should the VPMA Proceed?

The first component of principled negotiation is to attack the problem over which the parties are negotiating. The further apart the positions, the more likely emotions will obscure the objective merits of the problem. Most negotiations are as much about emotion as they are money. The negotiation process will deteriorate rapidly if both sides firmly settle into their respective positions. If the anesthesiology group and hospital administration settle into their respective positions of closing rooms and denying the anesthesia group their exclusive contract, the negotiation soon will become a series of personal attacks.

The first step is for the VPMA to acknowledge that negotiation is an emotional undertaking. As mediator, they should encourage both parties to consider what they would be thinking if they were on the other side of the table. The point is to get both parties to address the problem and not to react immediately to emotional outbursts.

Relationship building and the "spirit of the deal" are important factors to keep in mind. The way to accomplish this relationship building is simple. Lay down the ground rules so that each party agrees to show the same degree of honesty, respect, and fairness that it would demand from others.

The ultimate objective of any negotiation is to satisfy the underlying interests of each side in the best way possible. As mediator, the VPMA must get each party to recognize the importance of each other's interests.

What are the interests of each group in this example? For the anesthesiologists, it may be increasing salaries to retain current staff and recruit new staff, while not having to work unreasonable or unsafe amounts of time to achieve this goal. For the hospital, it may be maintaining or even increasing operating room time to retain and attract high-volume surgeons.

The point is that each side has multiple interests. Positions such as "We will close down an operating room" obscure the underlying interests. Both parties must be cautioned to recognize and avoid any preconceived perceptions they may have about the other party.

For example, not all anesthesiology groups seeking stipends are greedy. Not all hospital administrators are clueless to clinical issues. No attempt should be made to discard any solutions until there has been a discussion of the problem and interests at hand.

With the interests articulated and understood, the VPMA should begin to look at options, looking first for shared or common interests. In this example, it is a common interest for both the anesthesiology group and hospital to keep the operating rooms open and running, since both derive revenue from the cases (i.e., common ground).

Unfortunately, it may be difficult or impossible to find common ground in many situations. As a result, capitalizing on differences may hold the key to developing options for achieving agreement. For example, the hospital may state that in order to provide a stipend, the anesthesiology group must be willing to expand operating room coverage in the evenings. The anesthesiology group may claim it does not have the staff to expand coverage and there is no need for expansion.

Could there be a solution in the disagreement? If both sides agree to look at both decreasing room turnover time and more accurate posting of procedure times by surgeons on the basis of historical data, the interest of the hospital in providing time for high-volume surgeons, and the anesthesiologists' interest in not expanding evening coverage, might be achieved. Remember that agreement often can be based on disagreement.

Once the parties begin looking at options, the problem can be discussed on the basis of objective criteria. The VPMA must have both parties prepare objective data to present prior to negotiating a solution. The anesthesiology group should be prepared to have benchmarks as to current salaries, workload, and operating room staffing models. The hospital should know how other institutions handle stipends, the legal implications, and objective criteria used to judge performance.

Tarantino, D. P. (2004). The role of the physician executive in negotiation. *Physician Executive, 30*(5), 71–73. Reprinted with permission.

Interactive Model

When negotiations become locked into a win/lose situation, a third party may be invited to assist in resolving the issues (Schwarz, 1994). Interactive problem solving is a form of third-party consultation or informal mediation. Third-party facilitators can be mediators, arbitrators, or consultants. Depending on the situation, a third-party facilitator may have high or low control of either the conflict-resolution process and/or the outcomes. For example, the third party in intraorganizational conflicts is most often the person in the hierarchy to whom the contesting parties report (Lewicki et al., 1992). In this situation, the mediator/supervisor would have high control of both the conflict-resolution process and the outcomes. Mediators usually have high control of the conflict-resolution process and low control of the outcomes (as demonstrated by the VPMA in Case Study 15-4), whereas arbitrators have low control of the conflict-resolution process and high control of the outcomes.

In general, interactive negotiation is designed to facilitate a deeper analysis of the problems and issues that are forcing the conflict. According to Winder (2003), interactive negotiation usually begins with an analysis of the needs of each of the parties and a discussion of the constraints faced by each side that make it difficult to reach a mutually beneficial solution to the conflict. After the analytical dialogue, the parties engage in joint problem solving rather than a fight to be won. Interactive negotiation is less focused on directly helping parties reach binding agreements (excluding arbitration) and more devoted to improving the process of communication, increasing perspectives and understanding, enabling the parties to reframe their substantive goals and priorities, and engaging in more creative problem solving. Other goals include improving the openness and accuracy of communication, improving intergroup expectancies and attitudes, reducing misperceptions and destructive patterns of interaction, inducing mutual positive motivations for creative problem solving, and ultimately building a sustainable working relationship between the parties (Winder, 2003).

Benefits of Skilled Conflict Resolution and Negotiation

Managers need to understand and appreciate that negotiation is not a zero-sum game. Managers who demonstrate effective conflict-resolution skills are often seen as competent, effective leaders (Gross & Guerrero, 2000; Stamato, 2004). A study by Eckerd College's Management Development Institute (2003) found a significant link between a person's ability to resolve conflict effectively and their perceived effectiveness as a leader and suitability for promotion. The sample for the study consisted of 172 employees (90 male and 82 female) from five different types of organizations. Approximately one-half of the participants were middle-level managers or higher in their organization; all of them participated in a program focusing on workplace conflict. The study revealed a strong correlation between certain conflict-resolution behaviors and perceived effectiveness as a leader and promotion potential. Employees who were perceived as being good at creating solutions, expressing emotions, and reaching out were considered more effective. By contrast, destructive behaviors, such as winning at all costs, displaying anger, demeaning others, and retaliating, were found to be the worst behaviors in terms of career advancement and leadership. Avoidance behaviors were found to be particularly problematic for would-be negotiators because individuals who are uncomfortable with negotiating or who perceive themselves to be unskilled or ineffective in negotiating often avoid conflict and thus fail to manage differences effectively. Of particular significance is the study's finding that negotiation skills are an important aspect of leadership.

Conclusion

In this chapter, we discussed the positive and negative outcomes of conflict and pointed out that conflicts originate from a variety of sources. We can predict with 100% certainty that managers will deal with conflict and negotiation in the course of their work. Conflict-handling behavior can be learned, and managers should adapt their behavior to the situation to be resolved. Collaborative behavior is strongly desired as a way to manage conflict and reflects positively on the individuals who use this approach.

Discussion Questions

1. Explain the definition of conflict.
2. Describe the four basic types of conflict.
3. Discuss the five levels of conflict.
4. Describe the five conflict-handling modes.
5. Describe the three major negotiation models.

CASE STUDIES

Case Study 15-5 Health Care System Versus Insurance

UAB to No Longer Accept UnitedHealth Care After Negotiations Fail

At the end of the month, UnitedHealth care insurance will not be accepted at most UAB Health System entities after the two companies failed to reach a contract agreement.

The end of UAB entities accepting United is July 31, and approximately 25,000 policyholders will be affected.

"UnitedHealth care forced us in this position," said UAB Health System CEO Will Ferniany. "We haven't had these kinds of problems with any other provider but United."

Entities like UAB Hospital, The Kirklin Clinic, all other UAB Medicine primary care, specialty care and urgent care clinics, UA Health Services Foundation, UAB Callahan Eye Hospital, Medical West and Baptist Health in Montgomery are some of the UAB providers who won't be accepting the insurance plans after July 31. The change also includes all services provided by UAB doctors, regardless of where the service is provided.

The emergency departments at UAB hospitals will remain open to United customers, officials said, and some United policyholders who have an open benefit plan may also be exempt from additional charges when the change goes into effect.

Last month, the UAB Health System sent out 40,000 letters to patients who went to a UAB entity in the past two years with United insurance to notify them they may soon have to pay out-of-pocket costs if no agreement is reached.

UAB currently accepts Medicare, Medicaid, Blue Cross Blue Shield of Alabama and VIVA Health (an affiliate of the UAB Health System). The change won't affect supplemental plans, arrangements with Medicare or PEEHIP policies.

"We recognize and appreciate that some of the services UAB Health System provides are unique and more costly. We reimburse them accordingly for these types of services," a spokesperson from United said. "However, UAB Hospital charges significantly more than other hospitals even for common services and tests."

The university said it is opposed to the tier two designation which would make some of United's policyholders pay more to come to UAB, while United would pay less. In some cases, the extra out-of-pocket costs would be applied even if the patient had no choice but to come to UAB Hospital because of the severity of their illness or the services needed.

"UAB is demanding that they be designated a Tier 1 provider despite the fact that they don't meet the criteria because of their egregiously high costs," a spokesperson from United said. "If we agreed to this demand, it would undercut employers' ability to design competitive benefit plans that reward their employees for choosing quality, cost-effective care providers." United said it would continue to pay the contracted rate no matter what UAB's tier designation is.

In their negotiations, Ferniany said United believed UAB's costs should mirror smaller, less comprehensive hospitals. These demands ignore the complexity of the services UAB offers, he said.

UAB is the only Trauma I center in Alabama recognized by the American College of Surgeons, which causes the system to treat some of the state's most critical patients. The hospital also serves as a public

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Case Study 15-5 Health Care System Versus Insurance *(continued)*

safety net to other hospitals in the state that cannot provide the same level of care as UAB, Ferniany said. Its charity costs are more than $70 million a year.

"We are also opposed to a program that only looks at price and not quality of care," Ferniany said. He added the tier system isn't fair to UAB, because many patients must go to a UAB entity for various reasons related to their condition or illness. He asked if UAB is the only place someone can go, why should they have to pay more?

He also said United shouldn't punish UAB for being a teaching hospital, but recognize that Alabama would have far fewer doctors without the residents who train there. Other insurance companies realize that, Ferniany said.

United is one of the most profitable insurance companies, according to data, and generates more cash profit than all other national publicly traded health plans in the country combined. The company had $9 billion in earnings in 2018—profits that come at the expense of its policyholders and health care providers, Ferniany said.

This is not the first time UAB could not reach an agreement with United. The two could not reach a deal in 2005, and United was not accepted at the university from 2006 to 2011.

Raheel Farough, vice president of UAB Health System Managed Care, and Ferniany called the lack of partnership a sad and unfortunate situation, but maintain that UAB will not accept something that puts profits ahead of patient care.

"The things they're asking for... are just not things we can accept," Ferniany said. "This is very, very worrisome to these people. This is not a good thing."

Farough added that United's policies can harm patients, as the company will only pay for what they deem is medically necessary, regardless of what's best for the individual.

United has not been able to renew contracts with hospitals across Alabama and the country, according to information from UAB. South Alabama Medical Center and University of Colorado Hospital/CU Medicine were two of those hospitals, citing reasons including "frequent difficulty in obtaining authorization for services needed by patients" that were often not paid for. The hospitals also mentioned United's refusing to pay health care providers after initially approving care.

The two are still committed to discussions of an agreement. "I'm planning to be reasonable," Ferniany said. "They've not provided us anything close to reasonable."

United responded Friday: "Despite repeated efforts to reach a compromise, UAB has decided to put Alabama residents square in the middle of this dispute. This is unfortunate and completely avoidable. We hope UAB will reconsider so we can continue working toward a new agreement that will ensure our members have continued access to UAB at a more affordable cost."

1. What level of conflict is represented in this case?
2. What type of negotiation style did UAB use in this case?
3. What type of negotiation style did UnitedHealthcare use in this case?
4. Who are the winners and losers in this conflict?

Reproduced from Auglair, H. (2019). UAB to no longer accept UnitedHealth care after negotiations fail. Al.com. Available from https://www.al.com/news/birmingham/2019/07/uab-to-no-longer-accept-united-health care-after-negotiations-fail.html

Case Study 15-6 Musical Operating Rooms

Dr. John Wilkins sat staring at the phone message in front of him. Dr. Peter Mikelson, chief of orthopedics, had called again wanting to discuss the current system used to schedule operating room times. As chief of medicine, technically, Dr. Wilkins had the power to dictate who would use the operating resources and when. Up to now he had been reluctant to use that power, relying instead on scheduling administrators to handle the schedule for operating room use. Perhaps the time had come to review that system and implement changes if necessary.

Mercy Hospital, a not-for-profit hospital located in the Northeast, employed 1000 doctors in 30 different departments. The facility had an outstanding reputation as a teaching hospital. About 40% of its doctors were full-time faculty, while the remaining 60% were volunteer staff (those doctors who, while not employees of the hospital, worked with residents and had access to hospital resources). The hospital currently had 25 operating rooms located throughout the hospital. Operating rooms were not assigned to any particular department, but doctors tried to use the rooms closest in proximity to their department wing. In some more extreme cases, it was simply understood that the operating rooms in certain wings were to be used only by certain departments.

Dr. Wilkins decided to have some informal discussions with different department chairs to gauge how dire the situation really was. His first stop was with Dr. Steve Daly, chief of urology. "You know, John," Dr. Daly explained, "I understand urology is not a high-profile glamour specialty, but I am having a very difficult time attracting both volunteer staff and the best residents because of the trouble I have scheduling procedures. We have 20 doctors in three different departments sharing four operating rooms. I know to you this may sound like an inability on my part to plan, but let me put this in terms that may mean something to you. The operating room is where we make our money. If my doctors and I can't easily schedule time in the OR, we can't continue to build the department. I have already seen a decline in the number of referrals from primary care physicians. If this keeps up, this hospital will have a hard time maintaining this specialty at a competitive level."

Next on Dr. Wilkins's list was Dr. Jack Palmer, chief of neurosurgery. Jack Palmer was a bit of a legend in the region. This was due to a combination of the high-profile nature of his specialty, his long tenure at the hospital, and his impressive client list, which included many of the people who sat on Mercy Hospital's board of directors as well as their families and friends. As John walked through the department, he noticed that all three of the ORs in the Neurosurgery wing were not in use. When he mentioned this to the department secretary, she replied that this was always the case on Friday mornings. For as long as she could remember, Neurosurgery held a weekly teaching conference from 7:00 to 12:00 every Friday. The secretary then informed John that Jack could not free up any time to speak with him, but she did relay the message that all was fine in Neurosurgery as far as OR time.

Dr. Wilkins next spent some time with Dr. Sheehan, chief of ophthalmology. After reviewing the OR schedule for the next month, Dr. Wilkins was astounded at the number of procedures Dr. Sheehan and members of her department were scheduled to perform. Dr. Sheehan explained, "Well, John, I've actually put a little cushion in there to make sure I have the time I need. At the beginning of the month I sign up those surgeries I am sure we will perform as well as some 'phantom' patients. That way, if surgery runs over because I'm teaching the procedure to a resident, or if a patient shows up in a condition under which I cannot operate, I can easily reschedule them. Patients get quickly rescheduled, doctors' office hours aren't disrupted, and everyone is happy. The name of the game is customer service. Peter [Dr. Mikelson] is new and will learn the system like everyone else did. I'm feeling particularly charitable today. Send Peter my way and we'll see if we can't negotiate for some of my scheduled time."

Dr. Wilkins spoke with Dr. Mikelson last. Dr. Mikelson said, "John, I know I'm the new kid on the block, but this system is simply unacceptable. Six months ago when I took this position, you and the board made it very clear to me the importance of building the practice. I've done as much as I can, but my capacity analysis shows that if my growth continues, I'll need four operating rooms instead of the one I am currently allocated. The bottom line is the bottom line, and you and I both know the money Orthopedics brings into the hospital. If I have to beg and plead with Susan Sheehan every time an unexpected change in my schedule pops up or rely on the grapevine to figure out when the OR is available, I can't keep my patients happy. The game has changed, John. Unhappy patients simply go elsewhere for surgery."

Dr. Wilkins knew Dr. Mikelson was right. How would he fix the situation in a way that made everyone happy, including patients, doctors, administrators, and the board of directors? What was the proper criteria to use: longevity, political clout, fiscal impact? How was he going to allow for emergency surgeries? How much control did he really want to take away from the physicians in scheduling their procedures?

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Case Study 15-6 Musical Operating Rooms *(continued)*

Discussion Questions

1. What is this conflict about?
2. Why is there a conflict over these issues?
3. How are each of the doctors doing now at managing the conflict? What should they have done? Would you do what they did? Why or why not?
4. Imagine that you are Dr. Wilkins, who has been asked to resolve this dispute. What source of leverage do you have? What options are possible? What impact would each option have? What are your overall goals?

Case Study 15-7 What Went Wrong?

Tim Hardwood, CEO of Community Health System, hung up the phone with a heavy sigh. He had just received the news from Mary Martin, vice president of human resources, that negotiations had stalled between the health system and the service employees' union. Mary had told him, "As of now, the 2,000 service employees at our three hospitals are without a contract and threatening to strike. But don't worry, Tim. I told the union negotiators that the health system is prepared to handle a strike."

"A strike!" Tim thought. "The media will have a field day with this! What went wrong?"

Jim Brentward, one of the union negotiators, sat across the table from Mary Martin. Jim told Mary that his members understood that Community Health System was having financial difficulties because of the current state of the industry with decreasing reimbursements and increasing regulations, but the union members were not pleased with the organization's proposed offer for salary increases and benefits package over the next 4 years. Jim said, "Unless the health system signs a contract by 5:00 P.M. Friday with acceptable salary and benefit increases, members of the union are threatening to strike." He continued, "The union plans to hold an informational picket on Thursday, and although the union doesn't want to strike, it's a strong possibility. After the informational picket, we will hold a strike vote and see what our members have to say about the situation."

Mary was shocked by Jim's comments. She simply could not believe that Community Health's service employees would threaten to strike! Because of her position as vice president of human resources, Mary knew that the service employees represented by Jim's union were at the bottom end of the health care system's pay scale. These employees included patient transporters, housekeeping, and cafeteria workers. Mary also knew that the union benefits paid to members during a strike equaled only 50% of the employee's weekly salary. Mary felt confident that because they had too much to lose financially, the employees would never vote to strike. In addition, she knew that Community Health System was considering outsourcing its dietary departments to Thomson Health care Food Services. If the employees did strike, although Mary considered that very unlikely, dietary services would continue without interruption. Knowing this inside information, Mary decided that she wasn't going to let Jim and the other union negotiators bully her. Mary told Jim that the health care system would not give in to the union's demands and was prepared for a strike.

Explain to Tim Hardwood what went wrong. If you were hired as the mediator, how would you go about resolving the situation to achieve a win/win agreement?

Case Study 15-8 Healthy Conflict Resolution

"Cindy, please reschedule my afternoon clinic; I am going to be out for the rest of the day," says Dr. Jones, a senior physician in a hospital-owned multispecialty group.

"But, Dr. Jones," Cindy says, while whipping off her telephone headset and turning away from the open patient registration window, "you are double booked for most of the afternoon because you canceled

your clinic twice this month already. Many of these patients have been waiting more than three months to see you!"

Jones glances furtively at the waiting room, and already half turned and heading toward the clinic exit, says, "I'm sure you will be able to smooth things over. Just tell them that I got called to an emergency."

Cindy has a suspicion that, because the weather is nice, Jones is taking off with a couple of colleagues to go sailing or play a round of golf. After all, he always sports a darn tan, comes to clinic late, and often leaves early. Cindy does not relish having to call and reschedule these patients, some of whom have already been rescheduled at least once in the past couple of months.

Cindy decides enough is enough. She calls her manager and requests a meeting as soon as possible. Her manager can sense that Cindy is upset and offers to have someone cover for Cindy so that they can talk privately.

Cindy tells the manager about the situation with Jones that happens "all the time," and how she is "sick of it," and will not "work another day under these conditions." After calming Cindy down, the manager promises to bring the matter up with the chief of the department.

To make a long story shorter, suffice it to say that this conflict continues to mushroom to involve several more individuals (the chief medical officer, the executive director of the clinic, the director of human resources, and the union representative) before Jones is ever made aware that Cindy has filed a formal complaint about him. When he is finally confronted, in a meeting with the chief medical officer and the director of human resources, he is caught completely off guard.

After all, the incident happened several weeks ago, and Cindy did not mention anything to him about it. They have continued to work together, in his opinion, as if nothing were wrong. He is also surprised to find out that Cindy has been keeping a tally of the number of times that he has canceled his clinic, left early, or started clinic late.

Jones goes from astonishment to red-faced anger in a few minutes. It is clear to all that the relationship between Cindy and the doctor is irreparable. Jones is labeled as a disruptive physician. Cindy is not welcome in any department because the other physicians are fearful of being targeted. Cindy eventually resigns, and Jones feels betrayed and unappreciated by his staff and his employer.

If you were the manager in this case, how would you have handled the situation?

Reproduced from Pierce, K. P. (2009, January/February). Healthy conflict resolution. *Physician Executive, 35*(1), 60–61.

Case Study 15-9 Conflict-Handling Styles

For each of the five scenarios that follow determine the most appropriate conflict-handling style(s).

Scenario One

A radiologist on the staff of a large community hospital was stopped after a staff meeting by a colleague in internal medicine. On Monday of the previous week, the internist referred an elderly man with chronic, productive cough for chest X-ray, with a clinical diagnosis of bronchitis. On Thursday morning, the internist received the radiologist's written X-ray report with a diagnosis of "probable bronchogenic carcinoma." The internist expressed his dismay that the radiologist had not called him much earlier with a verbal report. Visibly upset, the internist raised his voice, but did not use abusive language.

How should the radiologist handle this conflict with the internist?

Scenario Two

The Family and Community Medicine Division of a large-staff model HMO serves a population that is ethnically diverse. The senior management team of the HMO, spurred by repeated complaints from representatives of one racial group, has encouraged the division, all of whose physicians are White, to diversify. Several Black and Hispanic physicians with strong credentials apply for the open positions, but none are hired. Weeks later, a young female family physician learns from several colleagues that the division director has identified her as racist and the obstructionist to recruiting. The comments attributed

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Case Study 15-9 Conflict-Handling Styles *(continued)*

to her are not only false but are also typical of discriminatory statements that she has heard the division chief utter. The rumors about her "behavior" have circulated widely in the division.

How should the young female family physician handle this conflict with the division chief?

Scenario Three

A manager who reports to the vice president for clinical affairs (VPCA) of a tertiary-care hospital hired a young woman to supervise development of a large community outreach program. During the first four months of her employment, several behavioral problems came to the VPCA's attention: (1) complaints from community physicians that the coordinator criticizes other physicians in public; (2) concerns from two community leaders that the coordinator is not truthful; and (3) complaints about written reports about the project that label and blame others, sometimes in language that is disrespectful. The VPCA spoke several times to the manager about these problems. The manager reported other dissatisfactions with the coordinator's performance, but he showed no sign of dealing with the behavior. Two more complaints come in, one from an influential community leader.

How should the VPCA handle this conflict with the manager?

Scenario Four

The medical school in an academic health center recently implemented a problem-based curriculum, dramatically reducing the number of lectures given and substituting small-group learning that focuses on actual patient cases. Both clinical and basic science faculty are feeling stretched in their new roles. In the past, dental students took the basic course in microanatomy with medical students. The core lectures are still given, but at different times that do not match with the dental-curriculum schedule. The anatomists insist that they don't have time to teach another course specifically for dental students. The dean has informed the chair of the Department of Anatomy and Cell Biology that some educational revenues will be redirected to the dental school if the faculty do not meet this need.

How should the dean handle this conflict with the chair of the Department of Anatomy and Cell Biology?

Scenario Five

The partners in a medical group practice are informed by the clinic manager that one physician member of the group has been repeatedly upcoding procedures for a specific diagnosis. This issue first came to light 6 months ago. At that time the partners met with him, clarified the Medicare guidelines, and outlined the threat to the practice for noncompliance. He argued with their view, but ultimately agreed to code appropriately. There were no infractions for several months, but now he has submitted several erroneous codes. One member of the office staff has asked whether Medicare would consider this behavior "fraudulent."

How should the partners handle the situation with the other physician partner?

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PART V

Groups and Teams

People are social beings and have a need for affiliation or achieving a sense of belonging. Groups help to satisfy this need. In Chapter 16, we examine group dynamics. "Group dynamics" is a term created by Kurt Lewin and used to describe the subfield of organizational behavior that attempts to understand the nature of groups, how they develop, and how they interact with the members of the groups, with other groups, and with their environments. In Chapter 17, we discuss the various types of groups and their related functions. Chapter 18 examines the use of teams in today's complex health service organizations. Health care delivery "takes a village." Few tasks can be performed from start to finish by one person. To complete a task requires resources from many individuals. Today, we see the widespread use of interdisciplinary teams to deliver effective and efficient health care.

CHAPTER 16

Overview of Group Dynamics

LEARNING OUTCOMES

After completing this chapter, the student should understand:

- The importance of group dynamics.
- The characteristics that define a group.
- The meaning of group interaction and methods to measure it.
- What motivates individuals to join and remain in groups.
- The various roles that members assume in groups and the importance of these roles.
- The meaning of group norms and how they are formed and sustained.
- The factors that contribute to or inhibit group cohesiveness.
- The impact of conformity on group performance.
- The impact of groupthink on group decision making.

Overview

Human beings are social animals. Although we are born into and leave the world in a singular manner, we spend the majority of our time working, worshiping, learning, and playing in groups. Because we spend so much of our time in groups, there is great interest in understanding the inner workings of groups and their members. This research is referred to as the study of group dynamics, which is the attempt to understand the behavior in which people interact with, influence, and are influenced by others within groups.

Why is understanding group dynamics important to managers? It is important to the success of an organization. More and more organizations are moving toward a stronger emphasis on their employees working in groups and/or teams. A study by Blackburn and Rosen (1993) found that Federal Express had 4000 employee teams, Motorola used 2200 problem-solving teams, and at any given time 75% of Xerox's employees serve on some type of task force or on advisory teams. When individuals transition from a staff role to a management role, their objective moves from being an individual performer to accomplishing work through others. It is increasingly

rare for managers to work independently. For example, it is estimated that, on average, managers spend 50%–80% of their working day in one sort of group or another. In the health care setting, this estimate is not surprising. Health care managers, both clinical and administrative, participate in numerous work groups and teams on a daily basis, such as operating room teams, disease management teams, patient safety committees, biomedical ethics committees, patient care teams, trauma teams, and emergency-preparedness and disaster-management teams. The movement toward accountable care organizations and patient-centered medical homes will increase the importance of teams in health care (Taplin, Foster, & Shortell, 2013). Additionally, as health care systems expand geographically and integrate vertically, more managers may find themselves working on virtual teams with people they may have never met face to face. Therefore, to be able to manage groups effectively, managers need to understand the variables involved relating to groups: formation and development, structure, and interrelationships with individuals, other groups, and organizations (Turner, 2000).

Our discussion of groups is divided into three sections. We define what a group is, discuss why individuals join groups, and then examine the interactions and behavior of members within a group. Although the terms "groups" and "teams" are often used interchangeably, there are differences. The concept of groups is broader than the concept of teams; therefore, not every group is a team. Katzenbach and Smith (1993) point out that teams are a special form of groups that have highly defined tasks and roles and demonstrate high group commitment. Because of these characteristics, we discuss the nature of teams separately.

What Is a Group?

Social scientists usually define a group using four characteristics: (1) two or more people in social interaction, (2) a stable structure, (3) common interests or goals, and (4) the individuals perceiving themselves as a group. For example, two patients waiting to be treated in a hospital's emergency department are not a group. This collection of two individuals is not a group because (1) there is no interaction between the two patients, nor are they attempting to influence each other; (2) patients in an emergency department constantly change, so a stable environment does not exist for future interactions; (3) although patients may have similar goals (e.g., restoring their healthy status, alleviation of pain), they are not working in a coordinated effort to achieve a common goal; and (4) these patients do not perceive themselves as a group, only as individuals occupying space in the same location at the same time. However, a group exists when volunteer members of the local chapter of the American Heart Association meet to plan the next fundraising event or when a multidisciplinary group of clinicians convenes for the purpose of developing evidence-based guidelines for patients admitted to the hospital with congestive heart failure. These groups represent collections of individuals with a common interest or goal in a stable environment (although members may join and leave the group at various times) wherein members interact with one another with the intent of influencing each other. One important factor relating to group dynamics is understanding the interactions that occur between a group's members.

Group Interaction

Tubbs (2001) defines group interaction as the process by which members of a group exchange verbal and nonverbal messages in an attempt to influence one another. Therefore, interaction includes talking, listening, nonverbal gestures, texts, emails, and any other behavior to which people assign meaning. By observing these interactions, we can better understand the dynamics

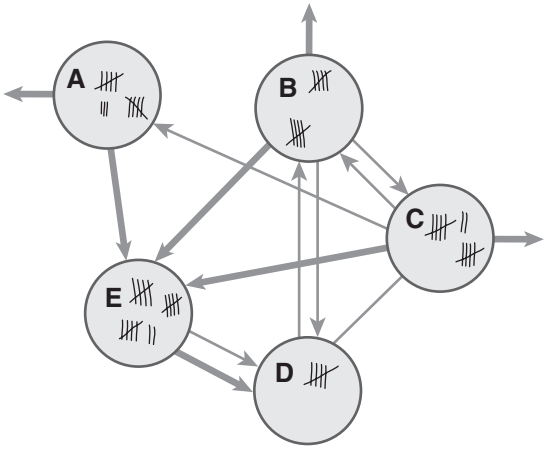


Figure 16-1 A Typical Sociogram

within a group. On a formal level, researchers may use a sociogram to record their observations of the interactions between members of a group (see **Figure 16-1**).

A sociogram is a pictorial method of mapping out and recording the contributions of members to a group interaction. In the example shown in Figure 16-1, the number of inputs is recorded as lines in the circles, each of which represents a participant in the interaction. The arrows show the direction of the contributions made, and their thickness indicates the intensity of the traffic. An arrow pointing outward indicates a contribution made to the group as a whole rather than to an individual member (such as when an individual addresses the group in general).

However, a sociogram is limited to documenting the direction and intensity of communication; it does not include the content of what was communicated by the members in their attempt to influence one another. Other assessment tools, such as Bales's Interaction Process Analysis, can provide insight into the content of the members' communication (see **Figure 16-2**).

As Sprott (1958) noted, Bales's Interaction Process Analysis includes 12 categories of interactions; these interactions are classified as relating to either emotion or task. The emotional responses are either positive (items 1–3) or negative (items 10–12). Task responses are either giving information (items 4–6) or asking for information (items 7–9). The 12 categories are also grouped into pairs, as noted in **Table 16-1**. The interactions of these 12 categories greatly influence the roles assumed by members and group norms.

Why Do People Join Groups?

Individuals join groups for many reasons, and many of these reasons are explained by Maslow's Hierarchy of Needs. Individuals join groups to satisfy their need for belonging (i.e., the need to have close contact with others and to be accepted by them) in addition to social and affection needs. Groups can satisfy an individual's need for safety by reducing the sense of powerlessness and anxiety, which may be experienced in ambiguous or threatening situations. Members may join because group affiliation can be an important part of an individual's self-esteem as well as social identity. People need to have a positive opinion of themselves, which they gain in part from acceptance by others in a group and evidence that other group members share their views and values. Furthermore, a group can help members to achieve stated goals that they could not have achieved alone as individuals.

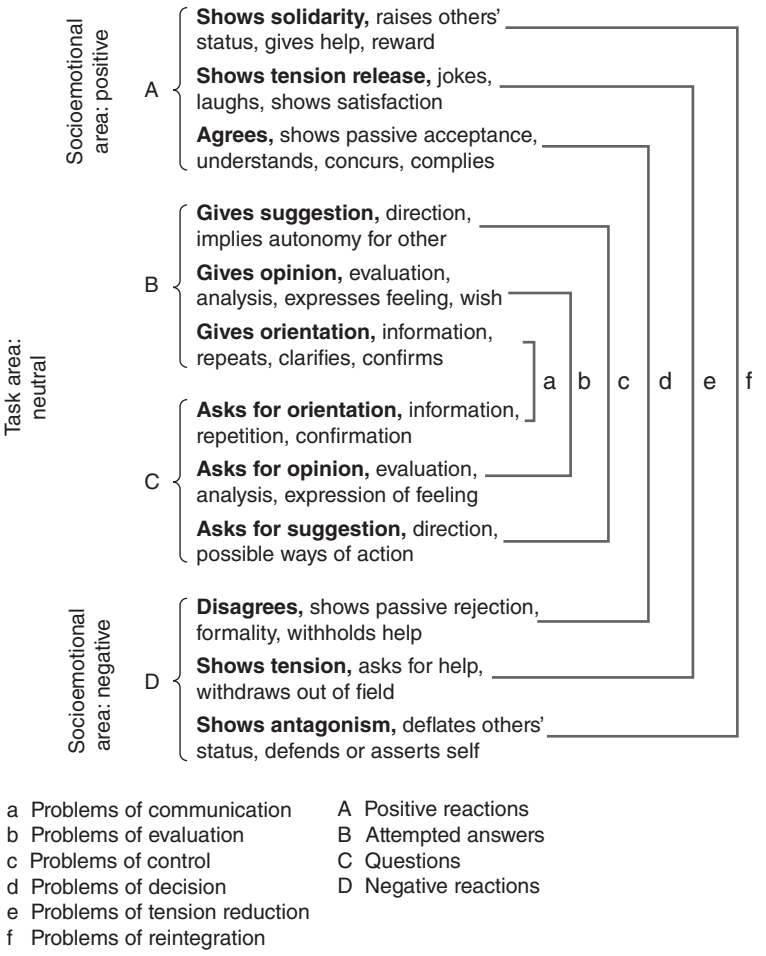


Figure 16-2 Bales's Interaction Process Analysis

Reproduced from Bales, R. F. (1950). *Interaction process analysis: A method for the study of small groups.* Chicago: University of Chicago Press.

Group membership can satisfy a number of needs for an individual, in addition to the member contributing to other members and the group achieving objectives. However, deciding whether to join a group or to continue membership in a group poses an approach–avoidance conflict. To resolve the conflict, an individual will perform a cost–benefit analysis of the relationship. Members will continue with their association as long as the rewards (satisfaction of needs) outweigh or are equal to the costs of being a member, such as required time to participate and financial commitment. This cost–benefit analysis is analogous to Adams Equity Theory of Motivation.

Roles of Group Members

Functional Role Theory, as introduced by Benne and Sheats (1948), identified the functional roles that they saw individual group members assuming in small group interactions. The three roles identified were task, maintenance, and individual (sometimes called "self-centered") roles (see **Exhibit 16-1**). Task-oriented roles focus on goal accomplishment, maintenance roles focus on

Table 16-1 Bales's Interaction Process Analysis: Twelve Categories Paired

Items	Description	Example
1 and 12	Orientation	How well do the group members cohere? Bales gives the example of a man who makes an offensive remark directed at another member (item 12); however, the laughter that follows is classified under item 2.
2 and 11	Emotional response only	Bales gives the example of a member sighing heavily and examining his fingernails.
3 and 10	Acceptance or rejection	This is where decisions are made. If positive, the member may show understanding, passive acceptance, and complies with the decision. If negative, the member may show disagreement, passive rejection, and without assistance.
4 and 9	Control	Asking for suggestions such as "I think we should do this" or "How do you think we ought to tackle this?" By asking for suggestions, a member is getting the others to commit themselves. By committing themselves, members limit their future choices. This is a method of bringing other members under control, which may or may not lead to resentment.
5 and 8	Opinion	"Have we done that?" "We ought to make sure that we do this." Any comments that involve summarizing the issues.
6 and 7	Orientation	Setting out the problem and giving factual information.

Bales, R. F. (1950). *Interaction process analysis: A method for the study of small groups.* Chicago: University of Chicago Press. Reprinted with permission.

relationships, and individual roles focus on individual needs (such as needs for power or recognition), which may in the long run be harmful to the group's overall success. Benne and Sheats's task and maintenance roles are similar to the two communication patterns—task-oriented and socioemotional—that Bales (1950, 1953, 1970, 1999) identified in his research on group members' interactions. Bales's task role relates to a member's activities that help the group accomplish its goals (e.g., concern for production), and the member's socioemotional role is described as the activities that the member performs to promote harmonious relations within the group (e.g., concern for people) (refer to Figure 16-2).

Members may assume different roles depending on the needs of the individual or the group. Bales found that some members engaged in more task and socioemotional activities than others and, as a result, were offered leadership status in the group. However, Bales also found that the person who engaged in the most task activities was not the same person who performed the most socioemotional activities. Therefore, two leaders emerged: the task leader, who was rated as having the best ideas, offering the most guidance, and being most influential in forming the group's opinions, and the socioemotional leader, who was the best liked. The usual explanation for the emergence of the second leader is that a task leader's sense of purpose gives rise to activities (e.g., unpopular orders, sharp criticism) that hurt group members' feelings. The second leader emerged to smooth things over and restore harmony to the group.

Belbin (1981, 1993, 2004) studied the performance of a team and how performance was directly affected by the roles that members play. Belbin developed the Team Role Theory, which proposes that for optimal operation of a management team, nine (originally eight) personality-related team roles needed to be fulfilled. The roles are chairman/coordinator, shaper, plant, teamworker, completer/finisher, company worker/implementator, resource investigator, monitor/evaluator, and

Exhibit 16-1 Benne and Sheats's Functional Roles of Group Members

Task Roles—Groups have members who play roles relating to job completion:

- *Initiator–contributor*: Generates new ideas.
- *Information-seeker*: Asks for information about the task.
- *Opinion-seeker*: Asks for the input from the group about its values.
- *Information-giver*: Offers facts or generalization to the group.
- *Opinion-giver*: States their beliefs about a group issue.
- *Elaborator*: Explains ideas within the group and offers examples to clarify ideas.
- *Coordinator*: Shows the relationships between ideas.
- *Orienter*: Shifts the direction of the group's discussion.
- *Evaluator-critic*: Measures group's actions against some objective standard.
- *Energizer*: Stimulates the group to a higher level of activity.
- *Procedural-technician*: Performs logistical functions for the group.
- *Recorder*: Keeps a record of group actions.

Maintenance Roles—Groups also have members who play certain social roles:

- *Encourager*: Praises the ideas of others.
- *Harmonizer*: Mediates differences between group members.
- *Compromiser*: Moves group to another position that is favored by all group members.
- *Gatekeeper/expediter*: Keeps communication channels open.
- *Standard setter*: Suggests standards or criteria for the group to achieve.
- *Group observer*: Keeps records of group activities and uses this information to offer feedback to the group.
- *Follower*: Goes along with the group and accepts the group's ideas.

Individual Roles—Member roles that can be counterproductive to the accomplishment of the group's task or goals:

- *Aggressor*: Attacks other group members, deflates the status of others, and shows other aggressive behavior.
- *Blocker*: Resists movement by the group.
- *Recognition seeker*: Calls attention to themselves.
- *Self-confessor*: Seeks to disclose non-group-related feelings or opinions.
- *Dominator*: Asserts control over the group by manipulating the other group members.
- *Help seeker*: Tries to gain the sympathy of the group.

Benne, K., & Sheats, P. (1948). Functional roles of group members. *Journal of Social Issues, 4,* 41–49. Reprinted with permission.

specialist. Belbin's nine roles can be categorized as task/task-oriented, maintenance/socioemotional positive, or individual/socioemotional negative according to Benne and Sheats's Functional Role Theory and Bales's Interaction Analysis (see **Table 16-2**). All groups need task leadership as well as attention to detail and a concern for people in order to be effective. Understanding the various members' roles is important for comprehending the interactions that either push a group toward or hinder the group from meeting its goals, including member satisfaction with the interactions. The role(s) that a member assumes and the resulting interactions greatly influence the group's norms.

Group Norms

Every group has a set of norms, which is an implied code of conduct about what is acceptable and unacceptable member behavior. Norms can be written or unwritten; positive, negative, or neutral; and applied to all members of the group or only to certain members. In addition, groups will apply

Table 16-2 Comparison of Members' Roles

Benne and Sheats (1948)	Bales (1950)	Belbin (1981, 1993)	Description (Belbin, 1993)
Task	Task-oriented	Chairman	Also referred to as the coordinator—the mature and confident person who enables others to give their best, keeps the team oriented toward its goals, and is rarely the source of ideas
Task	Task-oriented	Shaper	The top-down leader, energetic, challenging, and pressurizing, who drives their ideas to conclusion
Task	Task-oriented	Plant	The creative and unorthodox problem solver, probably not very good with people
Maintenance	Socioemotional	Teamworker (positive)	Interpersonally perceptive and caring person who enables individuals to work together but who may be indecisive under pressure
Task	Task-oriented	Completer/ finisher	The rules person who dots the i's and crosses the t's and will not give up until the job is satisfactorily completed and who may be a worrier
Task	Task-oriented	Company worker	The person who implements, gets things done to meet goals, and may be somewhat inflexible
Task	Task-oriented	Resource investigator	The person who is out and about, seeking new ideas and exploring opportunities, and who may become bored with routine
Individual (negative)	Socioemotional	Monitor/ evaluator	The person who is judgmental, looking for faults, and seeking to prevent errors but who may not inspire others
Task	Task-oriented	Specialist	The person who is single-minded and dedicated, who has unique knowledge but whose contributions are limited to that knowledge

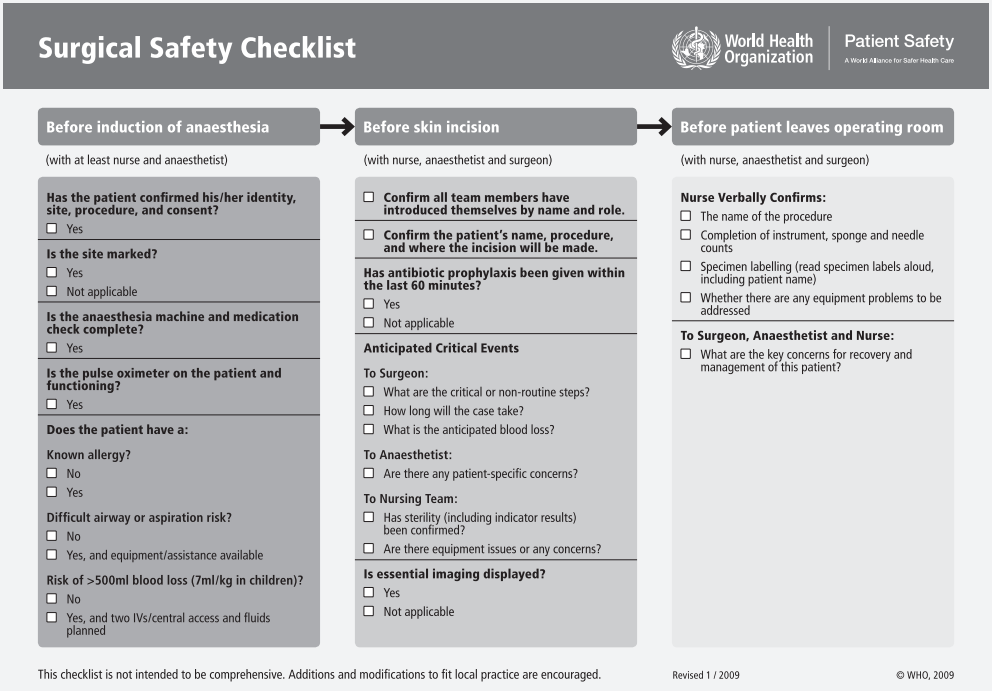
"punishment" or sanctions to members whose behavior deviates from the group's norms. Norms can dictate the performance level of groups (e.g., high- or low-productivity work groups), the appearance of group members (e.g., bankers wear dark suits), or the social arrangement within the group (the chair of the committee sits at the head of the conference table).

Most organizations have formal rules of conduct, which are delineated in their policies and procedures manuals. For example, a hospital would have written policies on clinical research protocols, infection-control procedures for handling blood and other body fluids, the proper attire to be worn in operating room suites, and processes to ensure that the correct patient (and correct body part) is operated on (see **Exhibit 16-2**).

However, in most instances, group norms (i.e., acceptable behavior of group members) are unwritten and learned by members through their interactions with others. For example, Crandall (1988) studied groups of cheerleaders, dancers, and female sorority members with high rates of eating disorders and noted that these groups adopted the behaviors of binging and purging as normal methods of weight control. The most popular members of the group binged and purged at the rate established by the norms of the group, and those who did not binge and purge when they first joined

Exhibit 16-2 Surgical Checklist

The implementation of a surgical checklist that guides the surgical team through a series of tasks and communications before, during, and after the surgery represents an example of written formal rules of conduct. Research by the World Health Organization found that implementing such a checklist reduced postoperative complications and death rates by over 30% (Haynes et al., 2009).



Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia
(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
☐ Yes

Is the site marked?
☐ Yes
☐ Not applicable

Is the anaesthesia machine and medication check complete?
☐ Yes

Is the pulse oximeter on the patient and functioning?
☐ Yes

Does the patient have a:

Known allergy?
☐ No
☐ Yes

Difficult airway or aspiration risk?
☐ No
☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
☐ No
☐ Yes, and two IVs/central access and fluids planned

Before skin incision
(with nurse, anaesthetist and surgeon)

☐ **Confirm all team members have introduced themselves by name and role.**

☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
☐ Yes
☐ Not applicable

Anticipated Critical Events

To Surgeon:
☐ What are the critical or non-routine steps?
☐ How long will the case take?
☐ What is the anticipated blood loss?

To Anaesthetist:
☐ Are there any patient-specific concerns?

To Nursing Team:
☐ Has sterility (including indicator results) been confirmed?
☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
☐ Yes
☐ Not applicable

Before patient leaves operating room
(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
☐ The name of the procedure
☐ Completion of instrument, sponge and needle counts
☐ Specimen labelling (read specimen labels aloud, including patient name)
☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

WHO Surgical Safety Checklist, Retrieved from https://www.who.int/patientsafety/topics/safe-surgery/checklist/en/

the group were more likely to take up the practice the longer they were members of the group. This alignment of behavior within a group is part of an individual's socialization process. This process of socialization explains how unwritten norms become the "standards" for the group, as members begin to internalize the group's norms as their own behavior standards. As such, norms do not just maintain order within the group; they also maintain the group itself (Youngreen & Moore, 2008).

Since most group norms are unwritten, they are usually not easily identified until violated. When group norms are violated, members of the group will attempt to convince the "deviant" to conform to the group's standards of behavior. If the use of persuasion is not successful, the group may punish the member by withdrawing any "special" status that the member may hold, or the group may psychologically reject (e.g., ignore) the member. The final consequence for a member who refuses to conform would be dismissal from the group. Through this process, members learn the range or boundaries of acceptable behavior within a group. For example, Feldman (1984) describes the norms about productivity that frequently develop among factory workers. A person produces 50 widgets and is praised by their coworkers; a person produces 60 widgets and is sharply teased by coworkers; a person produces 70 widgets and is ostracized by coworkers. If the group norm is

Table 16-3 Why Norms Are Enforced

Four Conditions Under Which Group Norms Are Most Likely To Be Enforced	Example
If norms facilitate group survival	Group members do not disclose certain project details so that their work cannot be replicated by another group.
If norms simplify or make predictable what behavior is expected of group members	Employees are expected to be present at the office during the same hours each day so that clients always know where to find team members.
If norms help the group to avoid embarrassing interpersonal problems	Members do not discuss politics at work so that members with strongly held beliefs do not create conflict or ostracize other members.
If norms express the central values of the group and clarify what is distinctive about the group's identity	Long white coats are worn by physicians so that patients know which care provider is their doctor and to symbolize a high level of training and expertise.

"The Development and Enforcement of Group Norms," by D. C. Feldman, 1984. The Academy of Management Review, 9, pp. 47–53.

that producing 50 widgets allows for an acceptable pace of work, the group member who produces 70 widgets may either make the rest of the group look lazy or cause management to raise the target number of widgets to be produced, resulting in an uncomfortably fast pace of work. Not all behavior deviations will be enforced, only those violations that have some significant effect on the group meeting its goals (see **Table 16-3**). Norms are powerful forces not only din affecting the behavior of group members, but also in determining the degree of cohesiveness and conformity of the group.

Cohesiveness

The degree of cohesiveness (e.g., camaraderie) of a group is determined by various factors, which may include members' dependence and physical location/proximity. The more significant factors tend to be (1) the size of the group, (2) experience of success by the group, (3) group status, and (4) outside threats to the group.

Size of the Group

Researchers have determined that the size of the group has a direct impact on the cohesiveness of a group. When there are too many members, it becomes too difficult for members to interact. Luft (1984, p. 23) concluded that "cohesion tends to be weaker and morale tends to be lower in large groups than in comparable smaller ones." What is the acceptable group size? Kameda, Stasson, David, Parks, and Zimmerman (1992) suggest that the optimum group size appears to be five members. Five-member groups are small enough for meaningful interaction yet large enough to generate an adequate number of ideas (Tubbs, 2001). Small groups may also avoid the problem of social loafing.

Social Loafing

Diffusion of responsibility refers to the phenomenon by which an individual feels less responsible for a task when they are part of a group. For example, people are more likely to call for an ambulance when they see a car wreck if there are no other cars on the road. However, if the car wreck

occurs in the middle of a busy highway with lots of other cars around, people are more likely to assume that somebody else in traffic will make the call. Perhaps you ignore the full trashcan, hoping that your roommate will take care of it. A specific consequence of diffusion of responsibility that occurs in working groups is called social loafing.

Social loafing refers to the decreased effort of individual members in a group when the size of the group increases (Tubbs, 2001). Ringelmann (1913) identified this social phenomenon when he noticed that as more and more people were added to a group pulling on a rope, the total force exerted by the group rose but the average force exerted by each group member declined. The reason is that some members' performance became mediocre because they assumed that other members would pick up the slack. Karau and Williams (1993) found that social loafing occurs across work populations and tasks. However, the researchers noted that if the participants' dominant culture emphasized collectivism versus individualism as described by Hofstede's four dimensions of national culture (Hofstede, 1984), the degree of social loafing decreased.

Subsequent studies revealed that when an individual's contribution is identified and the person is held directly accountable for and rewarded for their behavior, social loafing may be eliminated (Kerr, 1983; Kerr & Bruun, 1981; Shepperd, 1993; Szymanski & Harkins, 1987). Beyerlein, Freedman, McGee, and Moran (2003) stress that personal accountability by each group member for their role and responsibilities is required to achieve an effective collaborative team. When accountability is lacking, members will usually act in support of their own self-serving interests. For example, members will sometimes hold back if they believe that other members of their group are not expending equal efforts toward accomplishing the task.

Experience of Success

Prior success of a group in reaching its goals has a direct impact on the degree of cohesiveness. No one wants to stay on a losing team. When a group fails to attain its goals, members display a lack of unity by infighting, finger pointing, and, finally, disassociation.

Group Status

Cohesiveness is more prominent when admission into the group is more difficult to obtain because of various barriers or high criteria, such as education levels. This perception of status, whether real or not, creates a feeling of being in the "in-group" for the individuals who were able to overcome the barriers for admission into the group—for example, a physicians' group.

Outside Threats to the Group

The cohesiveness of a group will increase if its members perceive that an external force may prevent the group from reaching its goals. Members of the group will unite to display a unified front to the opposing force. In addition, cohesive groups will unite against nonconforming members who threaten the esprit de corps of the group. Therefore, cohesive groups exert pressure on members of the group to conform.

Managers should assist their subordinates' development into cohesive work groups because research has shown that cohesive units demonstrate a higher level of productivity than less cohesive groups do. However, managers need to be aware that group norms may mediate the relationship between cohesiveness and performance. On the one hand, if norms support performance-related activities, then cohesiveness is likely to improve performance. On the other hand, if norms support limited output or engagement in irrelevant tasks, cohesiveness may undermine performance (Berkowitz, 1954).

In conclusion, group cohesiveness is a product of social identification. According to Hogg and Abrams (1990), the more positive a member feels about their group, the more motivated the person is to promote in-group solidarity, cooperation, and support. In turn, the more cohesive a group is, the more likely it is that its members will interact socially and influence one another (Turner, 1987). Because of these interactions, we find that more cohesive groups have a tendency to eventually pressure their members toward a higher degree of conformity, and a high degree of conformity can lower the performance level of the group.

Conformity

Strong group norms and high degrees of group cohesiveness can hamper the performance of a group because of conformity pressures. Conformity involves the changing of an individual's perceptions or behaviors to match the attitudes or behaviors of others. This "normative social influence" occurs when we conform to what we believe to be the norms of the group in order to be accepted by its members.

One of the earliest studies in the conformity area was Sherif's (1936) experiment that involved the autokinetic effect. Sherif pointed a light in a dark space that, although stationary, appeared to move. Subjects were asked, both as individuals and as members of a group, to estimate the amount of movement they observed. When in groups, the subjects changed their original estimates to more closely fit the answers of the other members. This experiment demonstrated the individual's urge to conform.

Asch (1952) also conducted conformity studies. In Asch's experiments, eight people were seated around a table. Seven of them were actually the experimenters or confederates. However, the eighth person, the subject, was unaware of this situation. The group was shown two cards; each card contained different lengths of vertical lines (i.e., no two lines matched in length on either card). The participants were asked to say which of the lines matched the length of another. One after another, the participants announced their decisions. The confederates had been told to give an incorrect response. The eighth subject sat in the next to last seat so that all but one of the other participants had given an obviously incorrect answer before the subject gave their answer. Even though the correct answer was obvious (i.e., no two lines matched in length on either card), Asch found that one-third of the subjects conformed to the majority, one-third never conformed, and the remaining one-third gave conforming responses at least once. This experiment was designed to create pressure on subjects to conform to others, which in fact they did.

Although Asch's experiment has been criticized for being unrealistic (i.e., in the real world, individuals would be making decisions on subjects more complex and more important than the length of a line), it did confirm that "humans have the tendency to conform to the goals and ideas of a small group and tend to be unwilling to go against the group even if they know the group is wrong" (Asch, 1960).

Not all people conform. There is evidence that those who do not conform tend to have a healthy level of self-esteem and to have mature social relationships as well as being fairly flexible and open-minded in their thinking. For example, Crutchfield (1955) and Tuddenham (1958) found that there is a correlation between high intelligence and other personality traits and low conformity. Another important aspect of conformity is that it may lead to "groupthink."

Groupthink

Strong conformity pressures reflect members' attempts to maintain harmony within the group. However, conformity may hamper a group's performance by decreasing innovation and increasing faulty decision making. Janis (1982) referred to this situation as "groupthink." Groupthink refers

to conditions under which efforts to maintain group harmony undermine critical thought and lead to poor decisions (Janis, 1982; Janis & Mann, 1977). Janis, as cited by Tubbs (2001, p. 236), identified eight symptoms of groupthink:

Type I: Overestimation of the group—its power and morality

1. An illusion of invulnerability, shared by most or all of the members, which creates excessive optimism and encourages taking extreme risks.
2. An unquestioned belief in the group's inherent morality, inclining the members to ignore the ethical or moral consequences of their decisions.

Type II: Closed-mindedness

1. Collective efforts to rationalize in order to discount warnings or other information that might lead the members to reconsider their assumptions before they recommit themselves to their past policy decisions.
2. Stereotyped views of enemy leaders as too evil to warrant genuine attempts to negotiate or as too weak and stupid to counter whatever risky attempts are made to defeat their purposes.

Type III: Pressures toward uniformity

1. Self-censorship of deviation from the apparent group consensus, reflecting each member's inclination to minimize to themselves the importance of their doubts and counterarguments.
2. A shared illusion of unanimity concerning judgments conforming to the majority view (partly resulting from self-censorship of deviations, augmented by the false assumption that silence means consent).
3. Direct pressure on any member who expresses strong arguments against any of the group's stereotypes, illusions, or commitments, making clear that this type of dissent is contrary to what is expected of all loyal members.
4. The emergence of self-appointed mindguards—members who protect the group from adverse information that might shatter its shared complacency about the effectiveness and morality of its decisions.

Was groupthink the downfall of HealthSouth? (See **Exhibit 16-3**.) Many former senior managers of HealthSouth, a nationwide provider of rehabilitative services headquartered in Birmingham, Alabama, were indicted and in some cases found guilty of fraudulently and systemically inflating the company's earnings and assets by approximately $4 billion during the 1990s.

Managers must be careful because group members sometimes desire to maintain their close team relationships—or, in the HealthSouth case, "the family relationship"—at all costs. When group members operate in a groupthink mode, it may affect their decision making. For example, consider a health care provider who has proposed a new medical procedure for joint replacements. Some team members are initially resistant because of high training demands, even though the new procedure would establish best practices. To preserve harmony in the group, other staff members go along with the resisting members. In this case, the team has succumbed to group thinking instead of critical thinking.

Many researchers studied the culture of the National Aeronautics and Space Administration (NASA) after the *Challenger* disaster and found evidence of this type of groupthink. Engineers did not voice their concerns and criticism because of the strong team spirit and camaraderie at NASA. In other words, it is when groups display a high degree of cohesiveness that it is especially important to be on guard against groupthink.

Exhibit 16-3 Five HealthSouth Officers Charged with Conspiracy to Commit Wire and Securities Fraud

Count 1 of the Information alleges that a conspiracy existed from in or about 1994 until the present between AYERS, EDWARDS, MORGAN, AND VALENTINE and with Owens, Smith, Harris, and others to devise a scheme to inflate artificially HealthSouth's publicly reported earnings and the value of its assets, and to falsify reports of HealthSouth's financial condition. It was part of the conspiracy that Owens, Smith, Harris, and others would provide the Chief Executive Officer (CEO) with monthly and quarterly preliminary reports showing HealthSouth's true and actual financial results. After reviewing these reports, Owens, Smith, Harris, and others would direct that HealthSouth's accounting staff find ways to ensure that HealthSouth's "earnings per share" number met or exceeded Wall Street analyst expectations. After Owens, Smith, Harris, and others issued instructions as to the desired earnings per share number, HealthSouth's accounting staff would meet to discuss ways to inflate artificially HealthSouth's earnings to meet the CEO's desired earnings numbers.

These meetings were known as "family" meetings, and attendees were known as the "family." At the meetings, they would discuss ways by which members of the accounting staff would falsify HealthSouth's books to fill the "gap" or "hole" and meet the desired earnings. The fraudulent postings used to fill the "hole" were referred to as the "dirt." Owens, Smith, Harris, and others would and did direct one or more of the defendants, also members of the accounting staff, to make false entries in HealthSouth's books and records for the purpose of artificially inflating HealthSouth's revenue and earnings. Owens, Smith, Harris, and others would direct one or more of the defendants to make corresponding false entries in HealthSouth's books and records for the purpose of artificially inflating the value of its assets, including, but not limited to, false entries made to (a) Property, Plant and Equipment ("PP&E") accounts; (b) cash accounts; (c) inventory accounts; and (d) intangible asset [goodwill]. When events required that financial records and reports related to units of HealthSouth were called for by auditors, purchasers, and others, Owens, Smith, Harris, and others would direct one or more of the defendants to generate records and reports that would black out the false entries. Owens, Smith, and one or more of the defendants would, for the purpose of deceiving auditors, manufacture false documents for the purpose of supporting false record entries. One or more of the defendants would and did change codes on accounts to deceive auditors.

Reproduced from the U.S. Department of Justice's Press Release dated April 3, 2003.

Suggested safeguards against groupthink include (1) soliciting outside expert opinions during the decision-making process, (2) appointing a devil's advocate to challenge majority views, (3) hypothesizing alternative scenarios of a rival's intention, and (4) reconsidering decisions after a waiting period. Many researchers have questioned the effectiveness of these safeguards. For example, Bennis (1976) argues that a devil's advocate will be ignored if the group perceives the member as only role-playing.

Conclusion

Many factors influence our behavior. Group dynamics is a complex subject that attempts to provide us with some understanding of how individuals interact with one another and how those interactions become visible in our resulting behavior. Burton and Dimbleby (1996) developed a model, using interpersonal communication as the foundation, to help us understand the complexity of group dynamics (see **Figure 16-3**).

The figure is titled "The Interface of Me and Them." Since group dynamics is the attempt to understand how people interact with and influence others within groups, the title is most

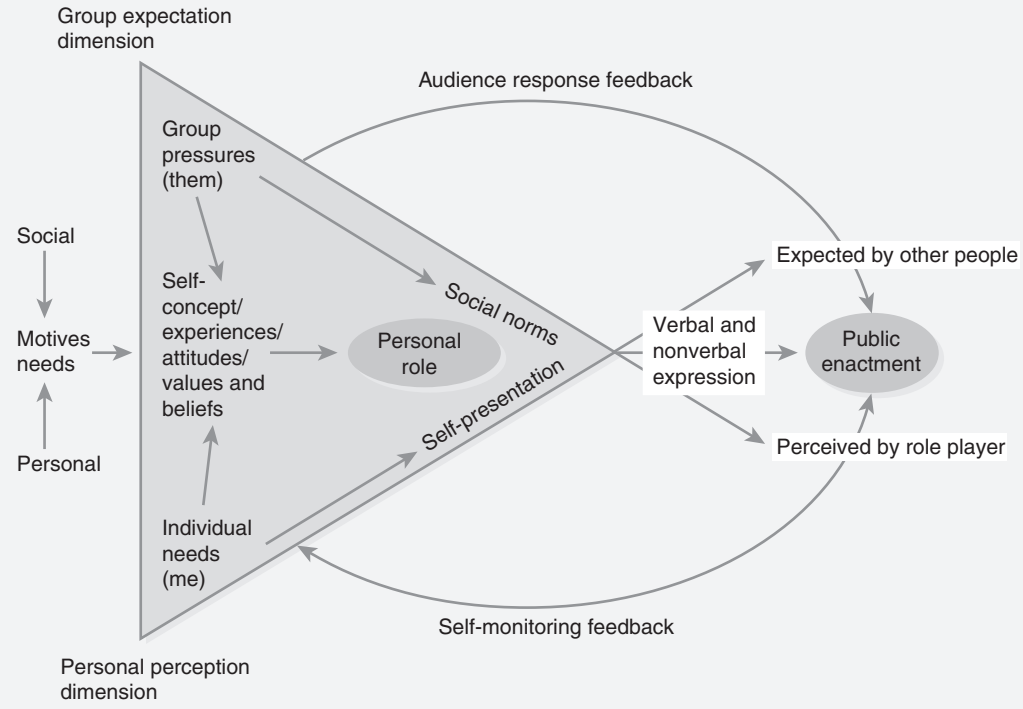


Figure 16-3 The Interface of Me and Them

Reproduced from Burton, G., & Dimbleby, R. (1996). *Between ourselves: An introduction to interpersonal communications* (2nd ed.). London: Edward Arnold.

appropriate. When examining the model, you will notice that the bottom half is concerned with "me" and the top half represents "them." The process begins with an individual's needs or motivation, which triggers the "whole of self." The triangle represents the various interactions we have with our groups that are filtered through our self-concept, which, taken together, form our personal roles. We then communicate our role and receive feedback from both ourselves (did I play the role correctly?) and others (did they confirm my behavior was correct?) to restart the process of redefining who we are as an individual (personal role). Although the model may appear somewhat complex, it only starts to explain the complexity of human behavior.

Discussion Questions

1. Define the study of group dynamics and discuss why it is important to today's managers.
2. Describe the four characteristics that define a group and provide examples of nongroups and groups.
3. Explain what is meant by "group interaction."
4. Discuss how group interactions can be measured.
5. Discuss why people join groups and what sustains their membership.
6. Explain the importance of the various roles that members assume in groups.
7. Discuss how group norms are formed and sustained within groups.
8. Explain how group cohesiveness is developed and sustained.

9. Discuss why conformity can inhibit a group's performance.
10. Explain what behavior is displayed by a group that is engaging in groupthink.

Exercise 16-1

Form small groups of four to five individuals and discuss the following statement:

> Often employees do not act or react as individuals but as members of groups.

When discussing this statement, the group members should share experiences of working in groups. Can you recall an instance in which you gave in because of the pressure to conform? Have you experienced a nonconformist in one of your groups? How did you or other members of your group react to "deviant" behavior in your group?

Exercise 16-2

Form small groups of four to five individuals. Using the worksheet "Be the Best We Can Be Team Norms," discuss how the answers to the questions can assist the group with developing team norms so that each member understands their expected behaviors.

Be the Best We Can Be Team Norms

1. When I am upset with someone I will:
2. One way I can avoid making premature assumptions is:
3. When a member of the group is not contributing, we will:
4. One thing I think we could do to resolve differences among us as a team could be:
5. One thing important to me about how we communicate (e-mail, text, F2F, how quickly should people respond, etc.) is:
6. When someone comes to complain to me about so-and-so on our team I/we will:
7. One way I'd like to be recognized or appreciated is:
8. One thing our group could do when we forget our Team Commitments and want to get back on track could be:

Exercise 16-3

Analyze the level of group cohesiveness in one of the groups to which you belong.

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CHAPTER 17

Groups

LEARNING OUTCOMES

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

- Importance of a group's size.
- Three broad categories of groups.
- Difference between informal and formal groups.
- Different types of task groups.
- Five stages of group development.
- Seven stages of group decision making.
- Different methods for group decision making.

Overview

In this chapter, we discuss the composition, structure, formation, and decision-making processes of groups. The optimum size for a group is five members. However, we will find groups with fewer than five members and groups with more. When a group has fewer than five members, problems may arise relating to an inability to make decisions and lower levels of creativity (Tubbs, 2001). If the group becomes too large, subgroups may form, distracting from the main group's purpose, and a majority of the group's time may end up being used for functioning purposes (e.g., organizing members, assigning roles) rather than the required task (Tubbs, 2001). All these situations can cause frustration among the members and stifle the group's ability to reach its goal.

Types of Groups

Groups can be categorized into three broad groups: primary, secondary, and reference. In the workplace, groups operate under an informal or formal structure.

Primary Groups

Primary groups include one's family and close friends and/or peers. Social psychologists tend to see primary groups as those that (1) involve regular contact between members of the group, whether through direct face-to-face interaction, technology, or other means, and (2) are fairly small (20 members or less) (Blackler & Shimmin, 1984). In addition, primary groups (1) involve cooperation, (2) share common goals, (3) are familiar with all members, and (4) have an understanding of the role(s) of each member.

Primary groups have a powerful influence on a member's self-concept as well as the development of the individual's perceptions and attitudes. During an individual's childhood and adolescent years, the family unit has a strong impact on the development of the individual's personality and future behaviors, both socially and in the workplace.

Secondary Groups

Secondary groups comprise the larger circle of people we associate with. During the adult years, associations with work and professional groups will influence an individual's attitudes and perceptions through various interactions with these different groups. For example, Jane Kerry, RN, is a member of a family group, a member of a group of close-knit friends that meet for dinner once a month (friends Jane has known from high school), the president of her local bridge club, a member of Glen Haven Hospital's neonatal intensive care unit nursing staff, and a member of the hospital's quality improvement committee. Jane is also a member of larger groups: She is a member of the hospital's pediatric department, a member of the hospital's nursing staff, and a member of the community in which the hospital is situated. In addition, she is a member of the American Nurses Association. Some of these group memberships may be short term, and others may be long term. No matter what the time frame, each group will influence Jane's behavior.

Reference Groups

"Reference group" is a term coined by Herbert Hyman (1942, 1968) to designate a group that an individual uses as a point of reference in determining their judgments, preferences, and behaviors. A person uses a reference group as an anchor point for evaluating their own beliefs and attitudes. Even though an individual may or may not be a member and may or may not aspire to be a member of a reference group, the group can have great influence on the person's values, opinions, attitudes, and behavior patterns. For example, one might say, "I'm not like those people" or "I am like those people." A reference group's influence on an individual may be positive or negative. An individual may pattern their beliefs and behavior to be congruent with or opposite to those of the group. Churches, labor unions, and political parties are examples of reference groups that can be positive or negative for specific individuals. The size of a reference group can range from a single individual (e.g., a movie star, athlete, or supermodel) to a large aggregate of persons, such as a political party or a religious institution.

Informal or Formal Group Structure

In the workplace, two types of groups can be found: informal groups and formal groups.

Informal Groups

The informal group (also referred to as a clique) is organized on the basis of the members' common interests or goals. Membership is voluntary and not part of the organization's official structure. Although informal groups usually have a short life cycle, they can have a significant effect on the organization's current and future operations. Informal groups can influence attitudes, perceptions, group norms, and communication networks.

For example, a small group of nurses at a large community hospital were unhappy about their work environment and met daily during lunch to discuss the situation. A recent change in the hospital's senior management was causing a high level of uncertainty among the clinical staff. The nurses also felt overworked as a result of the well-recognized nursing shortage. Their wages and benefits had been stagnant, with no salary market adjustments for the past 3 years. Furthermore, whenever the nurses approached management about these matters, they perceived their concerns as falling on deaf ears, since no changes were ever made. This informal group of nurses decided to contact a labor union. The union began an organizing effort in the hospital shortly thereafter, holding an aggressive campaign over a 6-week period. There was tremendous peer pressure, as some of the well-respected members of the nursing staff became active leaders for unionization, although they had not been among the initial organizing group. The election was held, and the union was voted in by two-thirds of the nursing staff. In the weeks that followed, the clinical nursing staff remarked that they were surprised by the union's victory; they had only wanted to scare management into making changes to their work environment.

Many cliques in the workplace can exist harmlessly, but managers need to be aware that some informal groups can be a powerful force within their organization. With an understanding of their influence, managers can use informal groups to initiate positive changes. Researchers have found that groups with informal leadership were in some instances more productive than groups without informal leaders. This occurs because information often spreads more easily through informal leaders than through formal channels (Marion, Christiansen, Klar, Schreiber, & Erdener, 2016). For example, the administrator of a free-standing outpatient surgical center wanted to begin a cross-training program of the clinical staff to improve the organization's performance. The administrator knew that staff would resist this "new" concept because of their past failures to implement change. Having learned from their past mistakes, they enlisted the support of a group of nurses who had developed into a close-knit group. This was also the nursing group to which other clinical staff members looked for guidance on patient care issues. The administrator secured the support of the informal group by showing how the change would improve the quality of care for the patients (e.g., a more knowledgeable workforce), patient satisfaction (e.g., shorter wait time for procedures to be performed), and job security (e.g., an increase in the organization's financial stability). Because of the support of this group of nurses, the change was successfully implemented with minimum resistance from staff. Furthermore, the good outcomes

CASE STUDY 17-1 Using Informal Groups to Promote Organizational Goals

The clinic's chief executive officer (CEO) was known for consistently seeking, listening to, and incorporating the views of others. While she worked effectively through the formal hierarchy, she also regularly sought the views of both physician and employee influence leaders. These influence leaders were part of a group that met to provide input, shape ideas, and take accurate information forth to those who looked to them for the inside scoop. Their role in helping to sell others on new directions was clearly recognized.

For example, when it came time to consider affiliating the clinic with another health care organization, influence leaders made site visits and came back to share their feelings with a broad cross-section of the organization. Many who listened to them would have been more skeptical if the information presented had come from the lips of the CEO.

Peters, L. H., & O'Connor, E. J. (2001). Informal leadership support: An often overlooked competitive advantage. *Physician Executives, 27*(3), 35–39. Reprinted with permission.

that the administrator predicted would occur did happen. These outcomes positively reinforced the relationship between the informal nursing group and management.

Informal groups meet the needs of individuals and therefore have a strong influence on the members' behaviors. If managers are aware of these groups, they can be enlisted to assist the organization in achieving its goals (see **Case Study 17-1**). There are several ways that managers can incorporate informal leaders into the change process (American Nurse Today, 2013):

- Keep informal leaders informed and encourage them to ask questions and challenge assumptions.
- Give frequent feedback and share results.
- Get buy-in from employees on which informal leaders should be involved in helping to lead the change.
- Incorporate the feedback provided by the informal leader and ask for suggestions.
- Distribute various elements of the change or project to different formal leaders to avoid one person dominating the process.

Formal Groups

Formal groups are created by an organization; therefore, they are part of the organization's formal structure. These groups can be a long-term team (e.g., a functional or command group) or a short-term team (e.g., an ad hoc committee).

A functional or command group is specified and outlined in an entity's organizational chart. For functional groups, members are grouped by similar tasks, such as financial and administrative services, ancillary services, human resources and organizational development, and nursing services (see **Figure 17-1**). For command groups, members are formed into subgroups under the leader's legitimate power position in the organization. For example, all laboratory technicians report to the manager of laboratory services. The manager forms a group of laboratory technicians to discuss the implementation issues of providing clinical support for the hospital's new outpatient clinic.

Task groups include two (a dyad) or more people who are focused on an identified target, a project, or a specific issue or goal. Task groups may be either short term or long term and may be evaluated on the basis of their identified objectives. In contrast to functional or command groups, members of task groups can be from various functional areas and levels of organizational authority,

Figure 17-1 Organizational Chart for ABC Hospital and Health System

depending on the specialized knowledge, experience, or authority that may be required by the group. For example, the CEO of a local hospital forms a multidisciplinary task force to address the organization's disaster preparedness procedures. Members of this group would include all functional areas of the hospital, including administration, patient care, information technology, and physical plant. Task groups can be permanent groups, which may be used for policy making or coordination of activities. Permanent groups can exist for spans of time ranging from 1 year or indefinitely. Ad hoc groups are generally established to deal with a specific issue or problem. These latter groups may exist for a very short period, such as from 1 month up to 1 year, depending on resolution of problems, tasks, and issues.

Group Development

Groups go through five sequential stages of development. Some groups, on the basis of their leadership or members' prior experiences, can move through these stages more quickly than others. Because of the same factors, some groups may never experience all five stages. The five stages of development are as follows:

1. *Forming*: During the forming stage, members try to determine the appropriate behaviors and core values of the group. They focus on exchanging functional information, task definition, and boundary development. They begin to establish tasks and determine how they might meet objectives. During this initial stage, members must gain an understanding of the reason or purpose for joining the group and must find a social niche in the group.
2. *Storming*: The second stage of group development is characterized by high levels of emotion because members are trying to find their group identity and exert their individuality. At this stage, members are claiming their social power within the group, and a hierarchy is established as people question authority, react to what is supposed to be accomplished, and jockey for power within the group. Intermember criticism, scapegoating, and judgments may accompany this struggle for control.
3. *Norming*: In the third stage, the development of cohesion and structure occurs when the group's standards, key values, and roles are accepted. The gradual development of cohesion occurs after the conflict in the second stage. In this third stage, the rules for behavior are explicitly and implicitly defined. There is a greater degree of order and a strong sense of group membership.
4. *Performing*: In the fourth stage, members have found their role(s) within the group, and their energy is focused on the task. The group works through the problems it confronts it, and when the task is near completion, the group moves to the final phase.
5. *Adjourning*: Adjourning is the final stage of group development, representing the dissolution or termination of membership in the group.

Group Decision Making

Group decision making is the process of arriving at a judgment based on the feedback of multiple individuals. Such decision making is a key component of the functioning of an organization because organizational performance involves more than just individual action. Therefore, managers need to understand the ways in which the group process affects group decision making.

Group decision making usually takes longer than an individual decision (Nour & Yen, 1992). However, research confirms that groups produce more and better solutions to problems than do average individuals working alone, and the choices that groups make will be more

accurate and creative (Robbins, 2003). This is due to the higher levels of communication, coordination, and collaboration that occur within groups during the decision-making process (Nour & Yen, 1992).

Four factors play an important part in the quality of a group's decision. First, the group should be diverse; that is, members should have differences in experiences, individual knowledge, talents, skills, culture, and age (Butterfield & Bailey, 1996). Second, the members need to feel that they are in a safe environment so that they can express their ideas freely; this will help the group to avoid conformity and groupthink. This concept is often called psychological safety. Third, the degree of task interdependence must be high; if the task is too simple, members can solve the problem individually with no assistance from other members. Fourth, the group must have the potency for success; that is, the members believe that the group can be effective (Shea & Guzzo, 1987).

Rational Decision-Making Processes

Peterson (1997) and Burn (2004) provide a seven-stage model that illustrates the process by which groups make decisions (see **Figure 17-2**):

- *Stage 1—Problem Definition*: The better informed the group members are, the better they are at formulating the problem or issue at hand. Clarity about the problem is necessary for a high-quality decision.

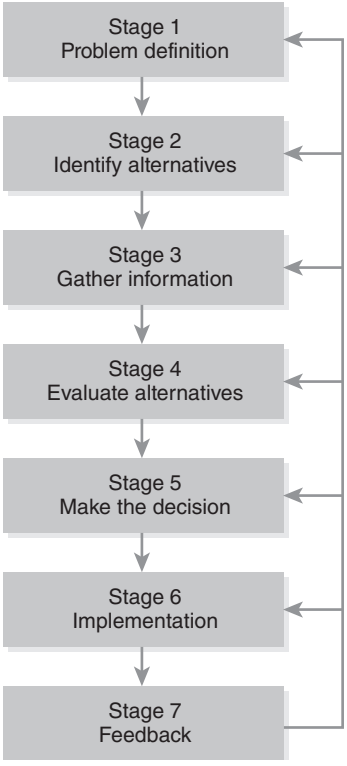

Figure 17-2 Group Decision Process Model

- *Stage 2—Identify Alternatives*: Groups sometimes limit and restrict options on the basis of the ideas and perceptions of only a few members. Inclusivity and careful review of all available options expand problem-solving alternatives. Members sometimes believe that they have to choose the first alternative for the sake of time or that they do not have access to all of the relevant information.
- *Stage 3—Gather Information*: Information needs to be gathered about all possible consequences on the basis of the identified alternatives. Groups often neglect to take the time to gather all of the relevant information and do not develop a process by which all members can contribute to gathering information.
- *Stage 4—Evaluate Alternatives*: The group must objectively analyze all of the available alternatives and potential consequences. The challenges that emerge during this stage include developing processes to ensure that all information is reviewed, that higher-status members do not dominate, and that decisions are not made for any member's personal gain. Group members could choose the first available alternative that meets minimal standards and convince themselves and others that it is the most appropriate. Therefore, rational and objective criteria are needed to prevent flawed decisions.
- *Stage 5—Make the Decision*: The method by which the group chooses to make the decision is extremely important. Some members may try to control and bolster their own ideas without supportive evidence. Lower-status members might vote with higher-status members when the vote is by a show of hands; the vote might change drastically if there is a secret ballot.
- *Stage 6—Implementation*: The challenges at this stage involve the resolution of all of the tasks necessary to fully implement the decision, including identification of all of the needed resources.
- *Stage 7—Evaluate the Outcome*: After implementation, a step that is often disregarded is evaluation of the outcome. Have processes been developed so that the decision group can measure the success or relevance of the outcome? Did the decision meet the goals and objectives? This critical inquiry is essential to learning from the experience.

The collective information processing of a group takes time to develop. This may be due to members not being aware of the information resources of the group or members being hesitant to provide information to the group. Some groups provide structured techniques so that every member participates equally and positive interaction is encouraged. These strategies include brainstorming, the nominal group technique, and the Delphi technique.

Brainstorming

Brainstorming involves taking a designated amount of time (usually 5–7 minutes) to generate as many ideas as possible with no discussion of their feasibility or practicality. The originator of this technique (Osborn, 1957) believed that members' tendencies to judge and criticize other people's offerings deter members from freely expressing creative ideas. Osborn hypothesized that the more ideas a group developed, the greater the chance that the ideas would be of high quality. However, research does not support Osborn's hypothesis. Brainstorming groups do not produce more or higher-quality ideas than those that are generated individually (Mullen, Johnson, & Salas, 1991). Some factors that may reduce the performance of brainstorming groups include social loafing, apprehension about being judged by others, and the tendency for introverted people to withdraw when in the company of extroverted members, who may compete and try to dominate the brainstorming process. People also have a difficult time thinking and listening to others at the same time. Dennis (1996) contends that computer-based brainstorming, a technique in which group members interact electronically, often anonymously and simultaneously, eradicates the interpersonal pressure.

The advantages are that they are less likely to forget what they are sharing as they type; the written record of all contributions can be made available for all and at any time; and because of the anonymity, lower-status members do not feel the pressure of the evaluation of their contribution by other members. Computerized group support systems may also reduce the potential for groupthink.

Nominal Group Technique

The nominal group technique is a brainstorming technique that is implemented on an individual and nonverbal basis. The information obtained is then pooled. This technique is efficient because it does not require a great deal of leadership training, and the group can communicate without the risks involved in verbal communication. A typical five-step process begins with a period of silence, during which group members write down their ideas independently. This is followed by a round-robin recording of ideas. Third, the leader calls on each member to share one idea at a time and writes each idea down in view of the total group. Fourth, there is group discussion of each idea on the list, and all ideas are clarified and evaluated. Fifth, the participants identify and privately rank their ideas in order of preference, and then they vote, the vote is recorded, the voting pattern is discussed, and the highest-ranked idea is discussed. The nominal group technique has been used extensively in business and government because of its efficiency and its capacity to limit emotional arguments.

The Delphi Technique

The Delphi technique is intended to help with the challenge faced by group members who may lack the experience to understand that the information they hold is needed to generate and evaluate options or alternatives. This technique uses a series of written communications to collect and synthesize the opinions of a group of experts into a decision. A carefully devised letter is sent to several experts that defines the problem and asks the experts for advice on a possible solution. The leader collects and collates the responses for each of the experts and sends them back to the experts for commentary and additional solutions. The leader collects the letters and analyzes them for consensus. If a clear consensus emerges, a decision can be made. If not, the process is repeated until consensus is achieved. This process can be time consuming, and the same result may be achieved through a face-to-face meeting of experts.

Irrational Decision-Making Processes

The "Garbage Can" Decision-Making Process

Unlike the rational decision-making model described earlier, in which groups follow a step-by-step process to arrive at the best solution to a problem, the "garbage can" model of decision making is a process that does not begin with a problem and end with a solution. In this process, many types of independently generated problems and solutions are placed in a "garbage can" (see **Figure 17-3**). Managers and other participants then search through the "garbage can" looking for interesting, suitable, or important "problems" and "solutions" (Cohen, March, & Olsen, 1972; Lovata, 1987; Schmid, Dodd, & Tropman, 1987). Although the "garbage can" decision-making approach is not very efficient, the process is appropriate for group decision making in organizations in which the technologies are not clear, the involvement of participants fluctuates in terms of the amount of time and effort given, and choices are inconsistent and not well defined (Cohen et al., 1972; Lovata, 1987; Schmid et al., 1987).

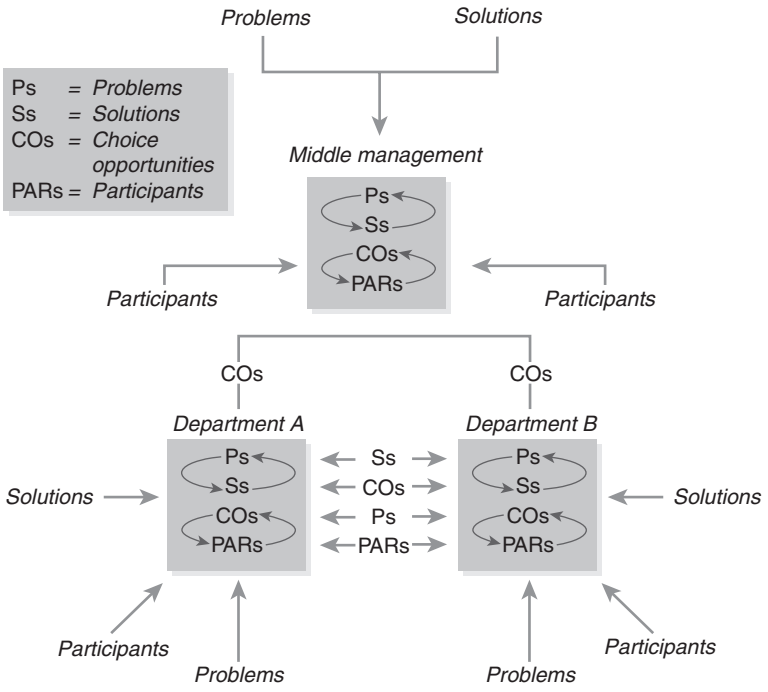

Figure 17-3 Illustration of Independent Streams of Events in the "Garbage Can" Model of Decision Making

Reproduced from Daft, R. L. (2004). *Organization theory and design* (8th ed.). Mason, OH: Thomson South-Western.

The "garbage can" model is often referred to as political or antirational because it disconnects problems, solutions, and decision makers from one another. Cohen et al. (1972) relate that specific decisions (i.e., choices) do not follow an orderly process from problem to solution but are outcomes of several relatively independent streams of events within the organization:

1. Problems identified in organizations usually require attention because there are performance gaps.
2. Solutions are ideas that have been identified to solve one or more problems, which are independent and distinct from the problems that they might be used to solve (e.g., in some cases, solutions are answers looking for a problem).
3. Participants come and go, and levels of participation vary for each problem and each solution depending on the demands on participants' time or on other situational factors.
4. Choices are made only when the combination of problems, solutions, and participants allows the decision to happen (i.e., when they are in alignment).

Consequently, the alignment of the problems, solutions, and individuals often occurs after the opportunity to make a decision about a problem has passed, or it may occur even before the problem has been discovered (Cohen et al., 1972). The "garbage can" model provides a real-world representation of the nonrational manner in which decisions are often made in an organization. In a broad sense, the model provides some clue to understanding "how organizations survive when they do not know what they are doing" (Cohen et al., 1972).

Conclusion

Groups remain the context for most of our social and work activities. The powerful impact that groups have on people and the powerful influence that people have on groups merit our ongoing attention.

Discussion Questions

1. Discuss why the size of a group is important to performance.
2. Explain the different broad categories of groups.
3. Describe the difference between informal groups and formal groups.
4. Discuss the various task groups within an organization and their purposes.
5. Explain the five stages of group development.
6. Discuss the factors that may hinder the effectiveness of a group decision-making process.
7. Explain the seven stages of group decision making.
8. Describe the various methods for group decision making.

Exercise 17-1

Analyze the last poor decision made by a group of which you were a member. What do you think contributed to the group's poor decision? Did the group think of alternative possibilities? Did the group move too quickly through any of the development stages? If so, did this cause lack of cooperation or poor communication?

Exercise 17-2

Form small groups of four or five individuals and, within 10 minutes, brainstorm as many solutions as possible that address the following situation:

> A small nonprofit organization for which you serve as a member of the board of directors needs to raise $500,000 in order to support its programming needs.

After the exercise has been completed, personally reflect on the group interactions. Did you notice any factors that might have reduced the performance of the group (e.g., social loafing, apprehension of being criticized by others, dominant behavior by one or more members)?

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CHAPTER 18

Work Teams and Team Building

LEARNING OUTCOMES

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

- Difference between stable teams and teaming
- Various types of teams.
- Differences between a virtual team and conventional types of teams.
- Various approaches for building team performance.
- Various organizational barriers to effective team building.
- Common characteristics of successful teams.

Overview

What is the difference between groups and teams? Does a group of people who happen to be thrown together in a surgical suite or primary care office constitute a team? No—not all groups meet the definition of a team (see **Case Study 18-1**).

In general, groups are much broader than teams. Teams are special groups that have highly defined tasks and roles and demonstrate high group commitment (Katzenbach & Smith, 1993). We begin this chapter with a discussion of teams. We then examine the various types of teams, their characteristics, and the factors that either promote or hinder the effectiveness of teams in the workplace.

Teams are very popular in the workplace. According to Lawler (1999), almost every organization uses some form of problem-solving team, the most common being the self-managing work teams that are common in a high majority of Fortune 1000 companies. As teams become more of the norm in the workplace, managers need to understand the complexity of teams in terms of their work design, the composition of the members, and the factors that enable teams to achieve high levels of performance and effectiveness.

CASE STUDY 18-1 Halloween in the Trauma Unit

Dr. Andrea Martinelli, a trauma surgeon, loathed working in the trauma surgery unit on Halloween, on any holiday involving fireworks, or after a big win for the local college football team. Drunk drivers, burn victims, and shooting victims seemed to roll in at an unstoppable pace. Although Dr. Martinelli usually worked the day shift, she was required to take some night shifts. She checked in for her Halloween night shift at 6 P.M., and immediately the action got started. "Dr. Martinelli, you've got a patient prepped and ready in Room 6. Major car accident, and he's bleeding out." As she walked into the room, Dr. Martinelli thought, " Who will I be working with this time?" She entered a room that was frenetically busy with nurses, residents, a surgery fellow, two nursing students, a scrub tech, an anesthesiologist, and a nurse anesthetist, and she realized that she didn't know any of them. This was a large hospital, and because of different shift schedules and turnover, she almost never worked with the same configuration of people. She could tell that the patient was crashing and she needed to act fast. "Okay, everyone, I'm Dr. Martinelli. Let's get started."

Teams and Teaming

A team can be defined as a small group of people who are committed to a common purpose, possess complementary skills, and have agreed on specific performance goals for which the team members hold themselves mutually accountable (Katzenbach & Smith, 1993) (see **Case Study 18-2**). On the basis of this definition, a team (1) should be composed of a small number of members (preferably an odd number, such as five or seven) to encourage consensus without discord, (2) must have specific goals, and (3) must contain members with mutual accountability, requiring interdependence and collaboration of efforts (Gordon, 2002).

Many of the groups that we see in health care do not fit neatly into the given definitions of either a group or a team. Recall that one of the defining elements of a group is a stable structure. According to this formal definition, a variety of strangers who are quickly assembled in an operating room, as in Case Study 18-1, does not qualify as a group. Health care is filled with examples of people coming together quickly for a specific purpose and then disbanding to form new configurations. These changes can occur daily, even hourly. For example, an anesthesiologist overseeing four surgical rooms will be working with four different combinations of nurses, surgeons, technicians, residents, and students at any point during the day. Depending on the number of operating rooms in a hospital and staff turnover, it may be weeks or months before a particular configuration is repeated. Similarly, an oncologist, a doctor of internal medicine, a radiation oncologist, and a surgeon from another hospital may convene to determine the best path forward for a cancer patient. Then, for the next patient, that oncologist may be working with a completely different set of specialists. So what shall we call such a collection of people? A group? A team?

Amy Edmondson (2012) of Harvard Business School calls this phenomenon "teaming," which she defines as "teamwork on the fly." She argues that stable teams of people who work together over time can be highly effective, such as a basketball team that practices thousands of hours together and wins a national championship. However, the current reality is that health care teams are often more like players in a game of pickup basketball in the park. Edmondson suggests that when companies face complex and uncertain tasks that need rapid resolution, stable teams are insufficient. Teaming can be highly effective because it allows the right experts from different fields and disciplines to be assembled to accomplish a complex task. With industry changes and

CASE STUDY 18-2 Kaiser Permanente Facilities Use TeamSTEPPS to Improve Obstetrics and Other Patient Care

A Well-Functioning Care Team

As a result of implementing AHRQ's TeamSTEPPS® to improve teamwork and communication, Kaiser Permanente in Northern California has reduced the dosage of labor-inducing drugs by approximately 15 percent, without increasing C-section rates, from 2015 to 2017. Kaiser trained its staff at 16 medical centers and a skilled nursing facility across the State. As a result, perinatal teams have successfully used TeamSTEPPS strategies to standardize and reduce variation in dosing of labor-inducing drugs.

TeamSTEPPS is an evidence-based, customizable program aimed at optimizing performance among teams of health care professionals, enabling them to respond quickly and effectively to whatever situations arise. It was developed by AHRQ in collaboration with the Department of Defense and first launched in 2006.

Initially, Kaiser's main focus was to train teams for three new hospitals prior to their opening and to "build TeamSTEPPS expertise at the regional risk management and patient safety department in Oakland to support the new teams," explained Celia Ryan, M.S.H.A., R.N., executive director of risk and patient safety. Officials were so pleased with the results that they expanded TeamSTEPPS implementation to training teams in emergency departments, operating rooms, and inpatient units in all of Kaiser's Northern California hospitals.

In total, 45 Kaiser teams have completed TeamSTEPPS "train the trainer" programs since 2014. Staff have been trained across a wide variety of units, including emergency departments, intensive care, coronary care, cardiac catheterization laboratories, neonatal intensive care, medical/surgery/telemetry, interventional radiology, environmental services, perioperative (including pre-operative, operating room, and post-anesthesia care), perinatal (labor and delivery, nursery, and mother/baby), and skilled nursing units.

The perinatal teams at Kaiser commonly use the following TeamSTEPPS strategies—

- Huddle—An ad hoc meeting/planning session used to reinforce plans that are already in place. This allows for on-the-spot assessment and reassessment. Huddles are held daily with multidisciplinary teams comprised of obstetricians, certified nurse midwives, residents, registered nurses, anesthesiologists, and pediatric specialists who review the patient's status, any concerns about her condition or treatment, and fetal monitoring.
- Debrief—An after-action review and/or information-sharing session intended to improve team performance and effectiveness. Debriefs help identify and resolve concerns and address timely acquisition of additional staff assistance when needed.
- SBAR—An acronym that stands for Situation, Background, Assessment, and Recommendation. This technique facilitates prompt and effective communications among staff. A "baby SBAR" is used to ensure situational awareness between the obstetrician and neonatal teams to establish the delivery approach and anticipate potential resuscitation needs.

"During times of high volume, huddles have improved workflows and situational awareness," said Paul Preston, M.D., staff anesthesiologist and safety educator for The Permanente Medical Group. "Debriefs have also been critically useful—specifically post-delivery and for real-time learning—and have contributed to improvements in the obstetrics hemorrhage team response and C-section decision-to-incision time," he noted.

Kaiser Permanente Facilities Use TeamSTEPPS to Improve Obstetrics and Other Patient Care, United States Department of Health and Human Services. Retrieved from https://www.ahrq.gov/news/newsroom/case-studies/201716.html

reforms, evolving diseases and treatments, and the explosion of new scientific knowledge, it is no surprise that health care is filled with examples of teaming.

Types of Teams

Cohen and Bailey (1997), after an extensive literature review, determined that teams can be organized into the following four categories: (1) work teams, (2) parallel teams, (3) project teams, and (4) management teams.

- *Work teams* are continuing work units that are responsible for producing goods or providing services. Traditional work teams are directed by managers who make most of the decisions about what is done, how it is done, and who does it. However, an alternative form of work team with a variety of labels—self-managing, autonomous, semiautonomous, self-directing, empowered—is gaining favor. Self-managing work teams involve employees, not managers, deciding how to carry out tasks, allocating the work within the team, and making decisions. Examples include primary care teams, surgical teams, and emergency department teams (Taplin, Foster, & Shortell, 2013).
- *Parallel teams* draw members from different work units or jobs to perform functions that the regular organization is not equipped to perform well. They exist in parallel with the formal organizational structure. They generally have limited authority and can make recommendations only to individuals higher up in the organizational hierarchy. Parallel teams are used for problem-solving and improvement-oriented activities. Examples include quality improvement teams, employee involvement groups, quality circles, and patient satisfaction task forces.
- *Project teams* are time limited and produce one-time outputs. Examples include a new electronic health record implementation team or a new facility design and construction team. Typically, project team tasks are nonrepetitive and involve considerable application of knowledge, judgment, and expertise. The work that a project team performs may represent either an incremental improvement over an existing concept or a radically different new idea. Project teams often draw their members from different disciplines and functional units so that specialized expertise can be applied to the project at hand. For example, a new drug-development team of a pharmaceutical company would draw its members from research and development, marketing, finance, and manufacturing. When a project is completed, the members either return to their functional units or move on to the next project. Cross-functional project teams enhance project success as a result of their capacity to handle multiple activities simultaneously rather than sequentially. This saves time and is important to organizations that are concerned with rapid development of new services and/or products owing to competition.
- *Management teams* coordinate and provide direction to the subunits for which they are responsible, laterally integrating interdependent subunits across key business processes. The management team is responsible for the overall performance of a business unit. Its authority stems from the hierarchical rank of its members. It is composed of the managers who are responsible for each subunit, such as vice presidents of nursing, compliance and security, finance, and medical affairs. At the top of the organization, the executive management team establishes and manages the organization's strategic direction and performance. The use of top management teams is expanding in response to the turbulence and complexity of the current health care environment. Management teams can help organizations to achieve competitive advantage by applying collective expertise, integrating disparate efforts, and sharing responsibility for the success of the organization.

Virtual Teams

The virtual team has emerged along with technology advances. Unlike conventional teams, a virtual team works across space, time, and organizational boundaries through various communication technologies (Lipnack & Stamps, 1997). Roebuck and Britt (2002) note that the primary difference between a conventional team and a virtual team is the dimension of physical space or distance between team members. In virtual teams, employees can be located anywhere in the world. Virtual teams rarely meet face to face and are supported by technology to collaborate (Lurey, 1998). Often, these teams are set up as temporary structures that exist to accomplish a particular task, or they may be more permanent teams that address ongoing organizational issues (Roebuck & Britt, 2002). Virtual teams are on the rise. As of 2018, 70% of workers globally work remotely at least one day per week (Browne, 2018). These numbers may be lower in health care than in other industries because much of the work in health care requires being in the same location as the patient. However, as virtual teams become more common, managers must be able to understand how to facilitate their performance and cohesion.

Organizations can benefit from virtual teams through access to previously unavailable expertise enhanced through cross-functional interaction and the use of systems that improve the quality of the virtual team's work (Lipnack & Stamps, 1997). By using virtual teams, organizations can assign the right person to the job, regardless of where the person lives. However, the dimension of physical distance between members does affect the way in which team members interact. Roebuck and Britts (2002) advise that for a virtual team to be successful, members must be firmly committed to the team's purpose and to each team member. They must want their collaborative work to be successful and be willing to go the extra mile. For example, Rush University Medical Center in Chicago implemented a pilot program known as Virtual Integrated Practice, in which primary care physician practices recruit and organize their own offsite interdisciplinary teams consisting of social workers, dietitians, pharmacists, and other health care providers to manage and coordinate care for geriatric patients with chronic disease. These teams collaborate virtually, using email, phone, and fax to plan and deliver coordinated patient care. A comparison of four practices using the virtual integrated practice model to four similar practices that provided the usual care found that the virtual integrated practice program reduced emergency department visits, enhanced patient satisfaction and understanding of their medical condition(s) and medications, increased physician knowledge, and boosted referrals to interdisciplinary team members (Rothschild & Lapidos, 2009).

One issue that managers must consider when creating virtual teams is the possibility of social isolation. Social interaction with one's team at work can be a positive experience for employees. The workplace is often a place where people make friends, with 76% of Americans reporting that they have met at least one friend through work. However, a 2019 survey found that 30% of millennials report always or often feeling lonely, and 22% report having no friends (Ballard, 2019). Therefore, managers must consider the well-being of virtual team members who may not benefit from social interaction in a traditional work setting.

Building Team Performance

Teamwork does not always come naturally to health care professionals; health care cultures too often emphasize autonomy and working within professional boundaries (Bartunek, 2011). Yet a lack of effective teamwork and communication among and between teams of caregivers can

have serious consequences for patients' safety. To deliver safe and effective care, staff members in high-risk areas such as emergency departments, intensive care units, labor and delivery units, and operating rooms must work as cohesive, high-functioning teams. A highly cohesive team will be more cooperative and effective in achieving the goals that they set for themselves (Oxford Centre, 2011). Daft and Marcic (2009) relate that members of a highly cohesive team focus on the process, not the person; are respectful of one another; are fully committed to team decisions; and hold each member accountable to the team.

Katzenbach and Smith (1993) developed the team performance curve to illustrate how small groups may develop into high-performing teams (see **Figure 18-1**). Katzenbach and Smith (1993, p. 85) found that, "unlike teams, working groups rely on the sum of 'individual bests' for their performance. They pursue no collective work products requiring joint efforts. By choosing the team path instead of the working group, people commit to take the risks of conflict, joint work-products, and collective action necessary to build a common purpose, set goals, approach, and mutual accountability. People who call themselves teams but take no such risks are at best pseudoteams."

Although there is no guaranteed "how-to" recipe, Katzenbach and Smith (1993, pp. 119–127) list eight approaches to building team performance. These steps are most appropriately applied to stable or semistable teams:

1. *Establish Urgency and Direction*: All team members need to believe that the team has urgent and worthwhile purposes, and they want to know what the expectations are. The best team charters are clear enough to indicate performance expectations but flexible enough to allow teams to shape their own purpose, goals, and approach.
2. *Select Members on the Basis of Skills and Skill Potential, Not Personality*: Teams must have the complementary skills needed to do their jobs. Three categories of skills are relevant:

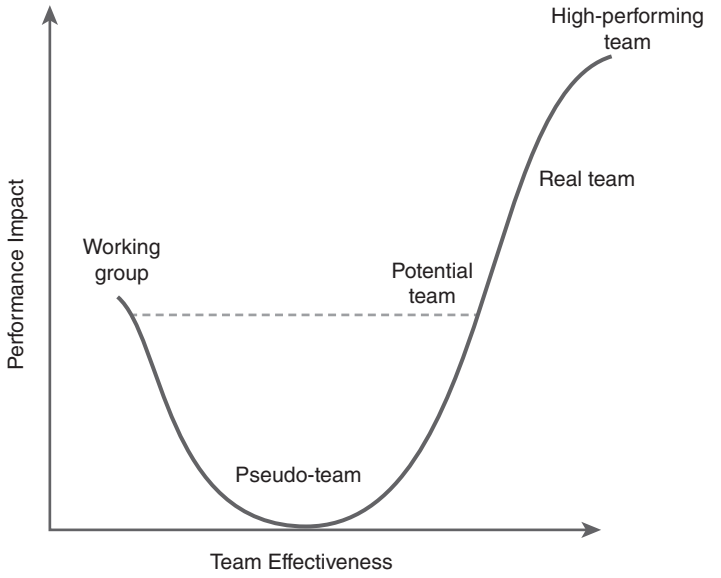

Figure 18-1 The Team Performance Curve

Katzenbach, J. R., & Smith, D. K. (1993). *The wisdom of teams: Creating the high-performance organization* (p. 84). Boston, MA: Harvard Business School Press. McKinsey & Company. Used with permission.

(1) technical and functional, (2) problem-solving, and (3) interpersonal. The key issue for potential teams is striking the right balance between members who already possess the needed skill levels and members whose skill levels will develop after the team gets started. Margerison and McCann (1989) have performed extensive research on the "people" side of successful team-building. On the basis of studies incorporating over 5000 managers, they developed the Team Management Wheel, which assists managers in selecting the right balance for their teams regarding roles (advisers, explorers, organizers, and controllers) and linking skills (e.g., the main role of the team leader) (see **Exhibit 18-1** and **Figure 18-2**).

3. *Pay Attention to First Meetings and Actions*: Initial impressions always mean a great deal. When potential teams first gather, everyone alertly monitors the signals given by others to confirm, suspend, or dispel assumptions and concerns they have going in. They pay attention to the

Exhibit 18-1 The Team Management Wheel

The Margerison–McCann Team Management Wheel defines members' roles and is based on the following eight characteristics:

1. *Reporter–Advisors*: Those who prefer work involving gathering and sharing of information. Supporters, helpers, collectors of information, knowledgeable, flexible.
2. *Creator–Inventors*: Those who prefer work that generates and encourages experiments with new ideas. Imaginative, creative, enjoy complexity, future-oriented.
3. *Explorer–Promoters*: Those who prefer work that involves investigation and presentation of new opportunities. Persuaders, influential and outgoing, easily bored.
4. *Assessor–Developers*: Those who prefer work that involves planning to ensure that ideas and opportunities are feasible in practice. Analytical and objective, idea developers, experimenters.
5. *Thruster–Organizers*: Those who prefer work that allows them to arrange and organize the way work is done. Results-oriented, analytical, organizers, and implementers.
6. *Concluder–Producers*: Those who prefer work that can be implemented systematically to produce regular outputs. Practical, production-oriented, like schedules and plans, value effective efficiency.
7. *Controller–Inspectors*: Those who prefer work involving controlling and auditing procedures and systems. Controller, detail-oriented, inspectors of standards and procedures, low need for personal interaction.
8. *Upholder–Maintainers*: Those who prefer work that involves upholding and conserving processes and procedures. Conservative, loyal, supportive, strong sense of right and wrong, motivation based on purpose.

The hub of the Team Management Wheel is the Linker, and that is often the main role of the team leader, although it is important for all team members to contribute to this activity. The Linker circle can be expanded into a full-range team leadership model that describes three levels of Linking that should be practiced, to varying degrees, by everyone in an organization.

At the first level of Linking are the skills arranged around the outside of the model. These skills are the People Linking Skills. They create the atmosphere in which the team works, by promoting harmony and trust. Thus, everyone in a team has a responsibility to implement this level of leadership.

- Active Listening
- Communication
- Team Relationships
- Problem Solving and Counseling
- Participative Decision Making
- Interface Management

(continues)

Exhibit 18-1 The Team Management Wheel *(continued)*

Inside the People Linking Skills are the Task Linking Skills. These skills create a solid core or foundation on which the work of the team relies. They promote confidence and stability.

- Work Allocation
- Team Development
- Delegation
- Objectives Setting
- Quality Standards

These skills tend to apply more to people on the second rung of the leadership ladder—those in more senior positions in a team, responsible for guiding others. This guiding may be done in either a supportive or a directive way but should not violate the first level of People Linking Skills. The challenge is to find the balance at which the six People Linking Skills and five Task Linking Skills can coexist.

At the core of the Linking Skills Wheel are the two Leadership Linking Skills of Motivation and Strategy. Leadership Linking is the third step on the leadership ladder and applies to leaders who have organizational responsibility for strategy. They need to implement these two skills along with the People and Task Linking Skills to achieve the status of the Linker Leader, a term that is used to describe someone who is effective at implementing all three levels described in the Linking Skills Wheel.

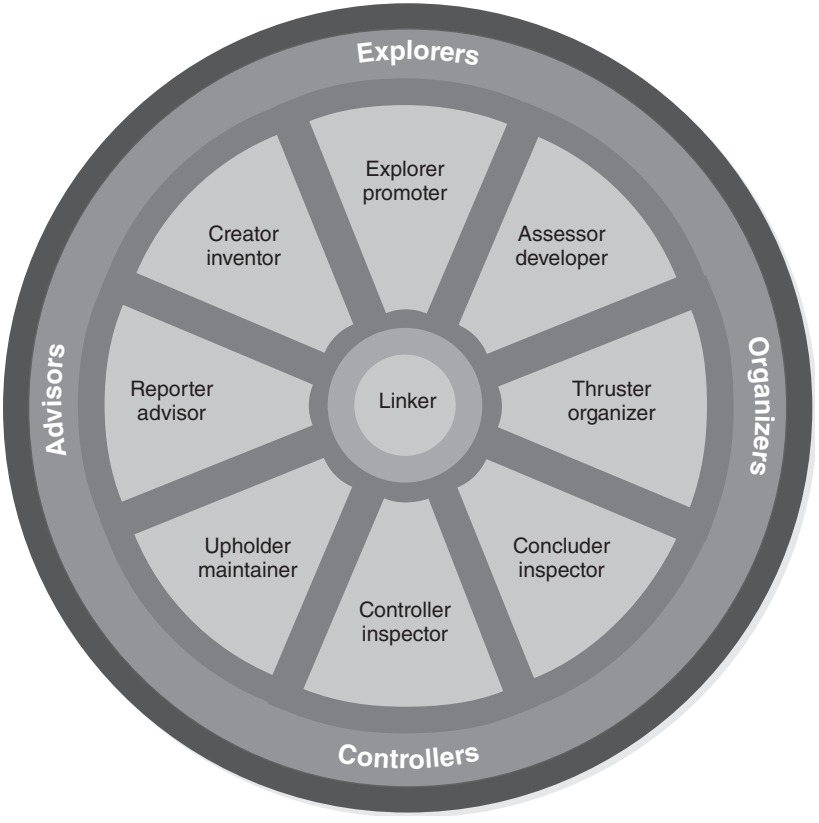

Figure 18-2 The Linking Skills Wheel

Margerison, C., & McCann, D. Team Management Systems (TMS). Reprinted with permission.

people in authority: the team leader and any executive who set up, oversee, or otherwise influence the team. What leaders do is more important than what they say.

4. *Set Some Clear Rules of Behavior*: All real teams develop rules of conduct to help them achieve their purpose and performance goals. The most critical early rules pertain to attendance ("no interruptions to take phone calls"), discussion ("no sacred cows"), confidentiality ("the only things to leave this room are what we agree will leave this room"), analytic approach ("facts are friendly"), end-product orientation ("everyone gets assignments and does them"), constructive confrontation ("no finger pointing"), and often the most important: contributions ("everyone does real work").
5. *Set and Seize upon a Few Immediate Performance-Oriented Tasks and Goals*: Most teams trace their advancement to key performance-oriented events that forge them into a cohesive group. Potential teams can set such events in motion by immediately establishing a few challenging yet achievable goals that can be reached early on.
6. *Challenge the Group Regularly with Fresh Facts and Information*: New information causes a potential team to redefine and enrich its understanding of the performance challenge, thereby helping the team to shape a common purpose, set clear goals, and improve on its common approach.
7. *Spend Lots of Time Together*: Common sense tells us that teams must spend a lot of time together, especially at the beginning. The time spent together must include both scheduled and unscheduled time. Creative insights and personal bonding require impromptu and casual interactions, which are just as important as time spent analyzing spreadsheets, interviewing customers, and so on. These meetings or interactions need not be always face to face. Use of technology is encouraged.
8. *Exploit the Power of Positive Feedback, Recognition, and Reward*: Positive reinforcement works well in a team context. There are many ways to recognize and reward team performance, of which direct compensation is only one. Ultimately, the satisfaction in the team's performance becomes the most cherished reward. Until the goal is reached, however, team leaders must find other ways to recognize and reinforce individual and team contributions and commitment.

Recall that teaming usually involves a group of people who come together (often quickly) to solve a complex problem and then disband. Therefore, some of the steps listed by Katzenbach and Smith might not be possible when teaming takes place, such as spending lots of time together. Edmondson (2012) suggests behaviors that are necessary for successful teaming (**Table 18-1**).

Common Characteristics of Successful Teams

Hackman (2011) has studied teams for many years, and he has identified six enabling conditions for effectiveness. The team must (1) be real, (2) have a compelling purpose, (3) consist of the right members, (4) establish and follow clear norms of conduct, (5) work in a highly supportive context, and (6) receive well-timed team coaching. Elaine Biech, as cited by Gordon (2002, p. 184), outlines the 10 most commonly mentioned characteristics for successful teams:

- *Clear Goals*: Clear goals allow everyone to understand the function and purpose of the team.
- *Defined Roles*: Defined roles allow team members to understand why they are on the team and enable clear individual- and team-based goal setting.

Table 18-1 Behaviors of Successful Teaming

Behaviors of Successful Teaming	Description	Health Care Examples
Emphasizing purpose	Define the purpose of the project or task and how it aligns with shared values.	Clinicians can unite under their shared value of doing what is best for the patient.
Building psychological safety	Create an environment in which it is expected that people can speak up and disagree without being punished. Exhibit curiosity, ask thoughtful questions, and demonstrate "situational humility," which is acknowledging that the project is complex and we don't know all the answers.	The concept of shared governance in health care means that each member of the care team has shared responsibility in decision making for the patient (versus the outdated "Just do what the doctor says" mentality).
Embracing failure	Create an environment in which members know that failures are expected to occur and it is okay to admit failure and ask for additional help.	A nonjudgmental mortality and morbidity (M&M) conference can be held to openly discuss clinical errors and develop solutions.
Putting conflict to work	Encouraging members to develop curiosity and inquire about different viewpoints instead of focusing on winning other people over to a certain point of view.	Doctors and nurses can listen to each other with a spirit of curiosity to avoid professional clashes.

Modified from Edmondson, A. C. (2012). Teamwork on the fly. *Harvard Business Review, 90*(4), 72–80.

- *Open and Clear Communication*: Effective communication is considered the most important aspect of team building. It hinges on effective listening.
- *Effective Decision Making*: Effective decision making is critical, and for a decision to be effective, the team must be in agreement with the decision and must have reached agreement through a consensus-finding process.
- *Balanced Participation*: Balanced participation ensures that all members are fully engaged in the efforts of the team. Participation is also directly linked to leader behaviors. Effective team leaders should not see their role as authoritarian and should strive to be seen as the team's mentor or coach.
- *Valuing Diversity*: The team must recognize each member's expertise and value variety of knowledge, skills, perspectives, and abilities. In the world of teams, diversity consists of more than just race or gender.
- *Managed Conflict*: Managed conflict requires that all team members feel safe to freely state their points of view without fear of reprisal. For teams, managed conflict is almost akin to brainstorming, in that conflict allows the team to openly discuss ideas and decide on common goals.
- *Positive Atmosphere*: A positive atmosphere requires a climate of trust. One way of developing trust is to allow team members to come together in a positive atmosphere. Allowing team

members to become comfortable with one another will generate a positive atmosphere, leading to enhanced creativity and problem solving.

- *Cooperative Relationships*: Cooperative relationships are a must, and team members should recognize that they need one another's knowledge and skill to complete the given task(s).
- *Participative Leadership*: Participative leadership includes having good leadership role models as well as leaders who are willing to share responsibility and recognition with the team.

Reflection and *appreciative inquiry* can be added to Biech's list of successful team characteristics. Teams should be encouraged to allocate time for reflection and debriefing on the results of their actions and decisions. Appreciative inquiry can help with this process by encouraging honest communication and analysis by the group (Drew & Coulson-Thomas, 1996). Appreciative inquiry encourages members to identify and reflect on periods of excellence and achievement. By looking at the past, members can develop a vision of what they want to accomplish in the future. They build on what worked best to reach their goal.

Barriers to Effective Teamwork

The barriers to effective teamwork fall into four categories: (1) lack of management support, (2) lack of resources, (3) lack of leadership, and (4) lack of training (see **Table 18-2**). If these barriers exist in an organization, the likelihood that groups would be given the opportunity to develop into high-performing teams is limited. Teams need management support, proper leadership, adequate resources, and training to reach their full potential.

Table 18-2 Barriers to Effective Teamwork

Category	Description
Management	Lack of sufficient support and commitment from senior management
Management	Pressure for short-term results
Management and leadership	Political meddling and power politics
Management and leadership	Lack of trust among team members and with leadership (i.e., communication is closed and risk taking is not encouraged or rewarded)
Leadership	Lack of clear vision, goals, and objectives
Leadership	Unwillingness to allow teams the necessary autonomy and decision-making powers
Leadership	Poor communication and interpersonal skills
Leadership and resources	Failure to recognize and reward group efforts
Resources	Insufficient release time from other duties for team members
Training	Inadequate training and skills development
Training	Lack of project management skills

Drew, S., & Coulson-Thomas, C. (1996). Transformation through teamwork: The path to the new organization? *Management Decision, 34*(1), 7.

Dunphy's (1996) research supports the idea that teams contribute significantly to the productivity and efficiency of organizations. In today's environment, hospitals and other health care providers are seeking innovative ways to reduce medical errors and costs while increasing quality of care and customer and employee satisfaction. Effective, high-performing teams can help accomplish these goals. However, team building is a process that takes time and resources. Management needs to invest today to reach tomorrow's goals.

Conclusion

In conclusion, Messmer (2004, pp. 13–14) provides an excellent guide to assist managers in the coordination of activities for building an effective team (see **Exhibit 18-2**).

Exhibit 18-2 **Building Effective Teams: A Checklist for Managers**

1. Begin by creating an action plan that specifies the group's mission, the types of expertise required to achieve this objective, and how team members will work together. Critical questions to answer include:
   - How long will the group need to be active?
   - What are the different components of the project and the deadlines for completing them?
   - Is the team responsible for generating and implementing its suggestions?
   - Will the group operate independently, or will any of its activities overlap with those managed by full-time employees currently not on the team?
2. Be sure you have researched how the project impacts the department or company so you can convey its importance at the first team meeting. Also, create a handout (e.g., a timeline) and gather supporting materials that can be used for reference.
3. When selecting the team members, be sure to evaluate their interpersonal and communication skills as well as their individual professional abilities and expertise. A hospital's accountant with solid analytical skills may have the knowledge you need to assess the organization's operations, but if they lack the ability to explain their analysis effectively to colleagues outside accounting or finance, you'll need to either help them develop those skills or appoint someone with a persuasive communication style to co-present.
4. Ask others in your company for recommendations of people who would be appropriate for the project. Always check with each individual's manager before making a final selection to ensure that a potential team member can commit the necessary time and effort to the initiative.
5. In addition to identifying employees who meet specific project needs, you may also want to select a coordinator. This person would periodically collect, organize, and distribute status reports to everyone in the group.
6. After team members have been identified, plan an initial meeting to review the action plan you drafted. Encourage feedback from participants so they feel more connected to the project and upcoming assignments. You may also want to establish protocols for certain practices such as conflict resolution and expenditure approvals to help prevent misunderstandings and encourage more effective collaboration. Once final guidelines and expectations have been agreed upon, distribute a revised action plan to everyone involved.
7. As team leader, you must walk a fine line between coaching and micromanaging. When participants come to you with problems or challenges, encourage them to develop their own

solutions, and reward those who take reasonable risks to make improvements. Sometimes the difficulties encountered during a project can spur innovative ideas that are transferable to other groups or the company as a whole.

8. Evaluate the team's progress periodically to make sure everyone is contributing. If an individual's regular work demands are affecting their ability to complete project requirements, you may need to select a substitute participant who has the necessary time. Also pay attention to the level of interaction during group meetings. Sometimes a few people will speak up more than others. While you want to avoid discouraging their input, make sure that quieter team members don't feel intimidated. An administrative professional should be just as comfortable as a financial executive when sharing ideas that might help the team. You may need to solicit comments from certain employees to prompt their participation.
9. Providing motivation should be an ongoing priority. Even when things aren't going smoothly, do your best to keep the mood upbeat and positive. Try to begin each meeting with a summary of accomplishments before you address problems. Also take time to acknowledge and celebrate project milestones. You will help to maintain productivity and generate ongoing enthusiasm for the initiative.
10. In your role as leader, you play a pivotal role in helping the team get results. Your strategy should include careful consideration of potential participants and sufficient direction and motivation once the team is formed. The right approach will encourage more effective collaboration among participants while maximizing the team's contribution to the organization.

Messmer, M. (2004). Project Teams That Get Results. *Strategic Finance, 85*(8), 13–14. Reprinted with permission.

Discussion Questions

1. Explain why teams and groups are not the same.
2. Describe the various types of teams that are used in today's organizations.
3. Explain the difference between a traditional work team and a self-managing work team.
4. Discuss the positive and negative issues of using a virtual team rather than a conventional-type team.
5. Explain the difference between a working group and a high-performing team.
6. Explain the various approaches managers can use to build team performance.
7. Discuss the various organizational barriers to team effectiveness.
8. Are there other characteristics of a successful team that can be added to Biech's list?

Exercise 18-1

List and describe the types of teams that are most commonly found in your organization. What are the purposes of the teams?

Exercise 18-2

List the teams of which you are a member. Select one of these teams to analyze. Is it a high-performing team? If so, why is it? If not, why isn't it? What changes need to be made to increase the probability that it could become a high-performing team?

Exercise 18-3

Using recent news headlines, describe an example of teaming in which a group of people came together briefly to solve a complex problem.

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PART VI

Managing Organizational Change

In Part VI, we discuss planned organizational change and how to manage it. To manage organizational change, a leader needs to apply all the theories and concepts that have been discussed throughout this textbook. To be successful, the leader, or change agent, must use their knowledge of motivation, leadership, group dynamics, team building, and conflict management in addition to communication and negotiation skills. In Chapter 19, we explain the role of organization development in planned change management. In Chapter 20, we describe the concepts and theories related to change management and explore how health care organizations are accomplishing change.

CHAPTER 19

Organization Development

LEARNING OUTCOMES

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

- Understand the role that organization development (OD) plays in an organization's planned changes.
- Appreciate the function and responsibilities of the OD professional.
- Understand the components of the Action Research Model.
- Identify and understand the OD process.
- Understand the interventions that are used in the OD process.

Overview

Health care has been a dynamic industry in recent years. New reimbursement models, escalating costs, and changing regulations have resulted in an environment fraught with survival struggles. Rapid changes in technology, epidemic levels of clinician burnout, and consolidation among health care systems and insurers have created a challenging environment. These issues have caused health systems to be in a flux of constant change. Health care organizations need the necessary strategies to successfully implement changes, sometimes rapidly, to ensure sustainability and survival. Many organizations have turned to experts in the field of organization development (OD) to assist with change initiatives and to help ensure the long-term viability of the organization.

OD has extensive roots dating back to the early 1900s. Frederick Taylor and his theory of scientific management were extremely influential because the theory advocates exploring ways to increase workers' productivity. The Hawthorne Studies, conducted between 1924 and 1933, also played an important role in paving the way for understanding organizational behavior–oriented change processes (Ott, 1996). As the nation progressed through the Industrial Age, the Great Depression, and two world wars, the emphasis on the way employees were viewed changed as employee motivation became better understood. The popularity of labor unions, especially in

health care, contributed to organizations' motivation for designing a better working environment. The result of more than a century of research and practice has been organizations that understand the need to change in order to remain competitive but also recognize that an emphasis on employee satisfaction is critical for meeting organizational goals. The relationship between needing change and striving to understand how employees will react to change is the focus of the field of OD. Meaningful change is a central deliverable of the OD profession (Hanson, Moir, & Wolf, 2011).

Organization Development

Many things that occur in an organization involve some type of change; however, not all of these are OD initiatives. For example, expanding a service, such as an emergency department (ED), requires long-term planning, a needs assessment determined by increasing volumes or changing market conditions, a thorough cost–benefit analysis, and a strategic plan. However, this type of change may be successfully implemented without an OD intervention. Why? Although the expansion of the service directly affects the functioning of the ED staff as well as various other functional units within the hospital, the organization's culture will most probably not be affected by this change initiative. Most employees will likely understand and probably welcome the expansion; therefore, behavioral science intervention is not needed. One of the components of OD that is fundamental to the definition of the field is the behavioral science application. If the ED expansion requires a culture change for the hospital, then the interrelationship between the expansion and the culture shift may require the expertise of an OD professional.

Cummings and Worley (2009) describe three features of OD that differentiate it from other change initiatives: (1) It applies to an entire system; (2) it involves the impact of behavioral science on the change process; and (3) it includes planned change based on diagnosis, intervention, and redirecting if necessary.

First, OD applies to an entire system, which may include the whole organization or a single division, but OD does not involve change directed at a single person or a single unit. For example, the introduction of a new magnetic resonance imaging (MRI) scanner into the newly expanded ED may require training for the radiologic technologists who will be using the new machine, but this training is targeted to new technology and to the specific individuals who will be working with the new equipment. Therefore, OD would not be involved in this implementation. However, an implementation of a new electronic health record (EHR) system that will be used across the organization would involve OD.

The second feature of OD, outlined by Cummings and Worley (2009), is the impact of behavioral science on the change process. Practitioners in the field of OD recognize the interrelationship of group dynamics, group processes, and culture on the change initiative, and great efforts are made to ensure that this relationship is cultivated throughout the change process to ensure the success of the initiative. In addition, OD practitioners understand the psychological and sociological components of change and work to assist the organization to develop a greater understanding of these dynamics. The importance of the behavioral science approach cannot be overstated. Since OD involves change within an organization, the members of that organization will be directly affected by any changes. If a change initiative is implemented without an understanding of how the people in the organization will react and respond to this change, the change is likely to be

difficult at best and completely unsuccessful at worst. The behavioral science component will help the leadership of the organization to understand the psychology of change, key phases in a successful change, and the importance of critical mass, as well as barriers to be prepared to overcome any anticipated time frames.

The third feature of OD is that planned change is based on diagnosis, intervention, and redirecting if the change efforts are not progressing as planned. Cummings and Worley (2009) state that OD is focused on improving organizational effectiveness and utilizes a variety of process change techniques. Five components of OD work toward achieving the goals of improving organizational effectiveness through process change techniques:

- OD is supported by multidisciplinary theories
- OD views organizations as open systems
- OD recognizes that if one part of the organization is affected by change, effects will be felt in another part of the organization
- OD is based on action research, which is a continuous examination of the progress of the interventions
- OD is based on data (see **Case Study 19-1**).

CASE STUDY 19-1 Doctor's Hospital's Organizational Change

Doctor's Hospital was facing serious financial hardship as health care costs continued to spiral out of control and reimbursements plummeted. A new chief executive officer (CEO) was hired to turn things around in an effort to save the hospital. The CEO was determined to change the organization's culture, which he identified as apathetic and accustomed to mediocrity. He noted that the hospital's financial performance was suffering, and he attributed much of this to a variety of process issues as well as a lack of focus on the core business of patient care.

The CEO immediately took action to look at financial issues and cut costs. A drastic cost and labor reduction strategy was implemented with an aggressive timeline to turn the financial bottom line around. Within a few months, the hospital started to show less of a financial loss, and things seemed to stabilize financially. However, the morale of the staff had taken a significant hit. Turnover increased as the staff's sense of job security decreased, and the impact on the patients began to be seen in an increase in patient complaints and lowered patient satisfaction scores. An employee training program was introduced to re-emphasize the need for customer service, but it had no impact on results. Finally, the CEO hired a consultant who performed an assessment. A multilevel program was implemented that incorporated all levels and all aspects of the hospital. This assisted senior management in understanding the linkages between finances, employee morale, and patient satisfaction. After 2 years, a mindset of accountability started to emerge that began a culture shift to one of service. Finally, all the organizational metrics started moving in the right (and same) direction.

Questions

1. What were the key components of changing the organizational culture?
2. Why wasn't the employee training program effective?
3. Why do you think a culture change was necessary?
4. What steps do you think the consultant recommended in order to effect this change?

The Organization Development Professional

The behavioral science nature of the field requires OD practitioners to have a particular skill set in order to ensure success. The role of the OD practitioner consists of a variety of activities, depending on the relationship between the practitioner and the organization. Gottlieb (2001) suggests that the primary role of the practitioner is assisting clients in achieving clarity and understanding. Other roles consist of assisting with diagnosis, assisting with process, providing information, or providing training activities. Ultimately, the OD practitioner primarily facilitates a change initiative in an organization. The OD practitioner is similar to a therapist who guides someone through a difficult time, recommending strategies and enabling the change process. However, just as a good therapist recognizes that the client must ultimately walk their own road to success, so does the OD practitioner. The OD practitioner provides a map of the road to change, but management must lead the organization along that road. Consequently, the relationship between the organization and the OD practitioner requires a delicate balance. The leaders and members of the organization must ultimately work through the process and are responsible for ensuring the success or failure of the initiative. It is critical that OD practitioners establish a psychological distance and set boundaries to clearly define roles in order to ensure a successful relationship (Browne, Cotton, & Golembiewski, 1977) (see **Case Study 19-2**).

There are many skills that make an OD practitioner successful, including a combination of technical, interpersonal, and consulting skills (Block, 1981). Technical skills include specific education or training in some area. An example might be specific training in statistical process control whereby a particular process improvement was initiated or a Total Quality Management or Six Sigma program was implemented. Specific expertise in the psychology of change management would be another example of appropriate expertise.

CASE STUDY 19-2 What Went Wrong?

Joan was asked to consult with a hospital that was attempting to enhance organizational effectiveness. She was able to meet briefly with the CEO before she embarked on a series of meetings with front-line managers. The managers were quite informative about the issues they observed in their departments, and they provided Joan with what she thought was an honest assessment of the issues. After 2 weeks of these meetings, she met again with the CEO to review the data and recommend a course of action. The CEO seemed genuinely interested in what Joan had to say but disagreed with many of her conclusions and her plan of action. He determined the problem to be poor team dynamics, whereas Joan had suggested that the team issues were a symptom of problem processes that resulted in role ambiguity and apathy. The CEO decided that the easier course of action was to work on the team dynamics and directed Joan to pursue that course of action.

Against Joan's better judgment, she embarked on a team-building initiative involving many months and over 500 employees. As a result of the initiative, there seemed to be some better camaraderie, yet the role ambiguity and other problems persisted. Six months after the completion of the team-building project, the CEO commented at the senior management monthly meeting that it had been a waste of time with no significant outcomes and vowed to never hire an OD consultant again.

Questions

1. What went wrong?
2. What should have been done differently?
3. How effective was Joan in her role?

Another skill set of OD practitioners is interpersonal skills. Listening skills are as critical as the ability to maintain a psychological distance. Marginality has also been identified as a key characteristic of an effective OD practitioner (Browne et al., 1977; Burke, 1982; Gottlieb, 2001); this involves the ability to be involved in an organization without being unduly influenced (Church, Hurley, & Burke, 1992). The ability to be collaborative is another key characteristic (Argyris, 1970) and involves the ability to facilitate rather than direct activities. In a qualitative analysis conducted by Gottlieb (2001, p. 45), clusters of roles were identified for an OD professional. These roles include the following:

1. Assisting in clarification, such as by asking questions, challenging, and confronting.
2. Diagnosing, which includes data gathering and the analyzing and interpreting of data.
3. Designing or assisting with the design and implementation of interventions.
4. Providing expert information on organization theory, change, or business issues.
5. Process identification, which includes assisting clients with understanding process options.
6. Facilitating interventions by guiding and directing groups through process changes or strategies to ensure effective communication during the implementation and intervention.
7. Training activities, which may run the gamut from the training needs assessment through the training design and delivery of training programs.

Overall, depending on the type of initiative, the skill level and role of the OD practitioner will vary. However, one key characteristic is the ability to apply theory to practical application.

Some OD practitioners are professionals who are employed by the organization, serving as ongoing internal consultants. Alternatively, organizations may contract for the services of an external consultant. Each of these options has pros and cons, and the leaders of the organization must be able to identify which type of consultant would be best suited for their organization for the issue at hand. The internal consultant has an advantage over the external consultant because the individual has a working knowledge of the organization, knows the key players, understands what interventions have been attempted previously, and may have access to data without the need to start from scratch. The downside of utilizing an internal consultant is that the consultant might be too close to the individuals working in the organization and might not be able, in the eyes of the leadership, to separate the relationships. Additionally, if the internal consultant has been employed by the organization for a considerable length of time, they may be blind to the issues that are creating the organizational symptoms and thus might not have sufficient objectivity.

In contrast, an external consultant does not have an established psychological connection with the organization, so they may bring the objectivity that the internal consultant might lack. In addition, an external consultant is often skilled at a particular intervention or set of interventions that have been used in other organizations, so the consultant brings experiences in implementing the intervention. Another advantage of an external consultant is that they might have a particular skill set that the internal consultant does not possess. For example, if an organization wants to implement Six Sigma, the internal consultant might not have the training or skill set to assist in the implementation of this complex process. One disadvantage of an external consultant is that there is no prior relationship with the organization in many cases, so the external OD practitioner must begin with rapport and trust-building steps. This lack of a relationship can, in some cases, hamper the data-collection steps, especially if employees are mistrustful of an outside person. However, this may also be an advantage to the data-collection initiatives, as employees often do not want to provide information to an internal person for fear of retaliation.

Action Research

As was mentioned earlier, OD is a systematic process. Most OD practitioners use a model of planned change known as the Action Research Model (Cummings & Worley, 2009). According to Rothwell, Sullivan, and McLean (1995), action research can be used as a model to represent the complex activities that occur in a change process. As **Figure 19-1** illustrates, the Action Research Model contains eight main steps. This model may serve as a road map for change agents to follow as they implement change in an organization (Rothwell et al., 1995). Ultimately, the goal of action research is to base the intervention on initial research, followed by feedback through further data analysis to determine the effectiveness or impact, make adjustments as necessary, and ultimately use the results to support additional research (Rothwell et al., 1995).

Steps in the Organization Development Process

As illustrated in Figure 19-1, traditional OD theorists have identified eight steps in the Action Research Model (Burke, 1982; McLean & Sullivan as cited in Rothwell, Sullivan, & McLean,

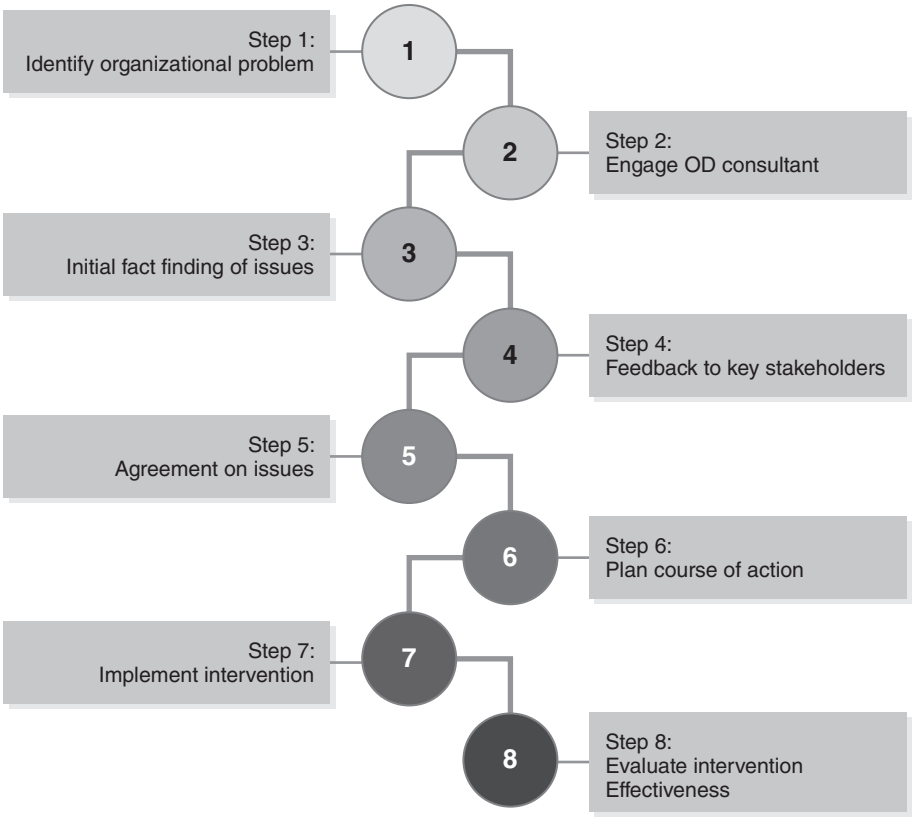

Figure 19-1 Action Research Model

Table 19-1 Comparison of the Two Models for Action Research

Burke (1982); McLean and Sullivan (1989)	Cummings and Worley (1997)	Description
1. Entry 2. Startup	1. Entry and contracting	Key leaders identify a need and work to begin the OD process. An OD practitioner is identified, and the key components of the working relationship between the organization and practitioner are established. Ground rules, mutual expectations, and deliverables are identified.
3. Assessment and feedback	2. Diagnosing	Data-collection techniques are employed to determine the extent of issues identified by the organization. A diagnosis of relevant organizational processes, interpersonal relationships, or group analysis may be made.
4. Action planning		Steps are taken to work with the organization to ensure the long-term success of any intervention. Key relationships are established, and mutual plans are developed. The impact of change on any change initiative is reviewed, and steps are put into place to assist the organization through the change process.
5. Intervention	3. Planning and implementing change	The planning phase is similar to the action planning phase. The plan is implemented and carried out. The process of managing change is implemented, and steps are taken to ensure the success of the intervention.
6. Evaluation 7. Adoption	4. Evaluating and institutionalizing change	The change process is evaluated through data analysis and comparison to previous data. The change becomes part of the organization, and the members of the organization begin to adopt these strategies and take ownership for their success.
8. Separation		The OD practitioner begins the disengagement process from the organization if it is an external consultant or the disengagement of the project if it is an internal consultant.

1995), which has served as the template for OD practitioners to use. However, other practitioners have recommended that the model be consolidated into a smaller number of identified steps. The two models are compared in **Table 19-1**. A few additional points about each of the major steps are worth noting.

Entering and Contracting

The entering and contracting phase is the first critical step in the planned change process. During this stage, a contract is developed between the organization and OD practitioner, during which mutual expectations are identified. These expectations should include the desired outcomes, such as greater employee satisfaction, increased revenues, or lower turnover; the length of the engagement; and communication and reporting arrangements—for example, who is the primary contact at the organization for the OD practitioner, frequencies of reports and updates, and so on. In addition, ground rules need to be established that outline how to handle sensitive issues such as feedback of difficult information, maintaining employee confidentiality (and whether that is an

expectation), and how to terminate the engagement if there are concerns or issues from either party (Cummings & Worley, 1997; Rothwell et al., 1995).

Diagnosis

The diagnosing phase is the second major phase in the general model of planned change. It involves a strategic plan for understanding the organization and gathering, analyzing, and feeding back of information to managers and organization members about the problems or opportunities that exist. When well done, diagnosis clearly points the organization and the OD practitioner toward a set of appropriate intervention activities that will improve organization effectiveness (Cummings & Worley, 2009).

There are various methods of collecting data within the organization. Cummings and Worley (1997) outline the most typically utilized methods. Usually, a variety of methods may be used, the choice being determined largely by efficiency, sample size, and type of information needed. The most commonly used methods are questionnaires, interviews, observations, and unobtrusive methods.

Questionnaires are often the first method used for collecting information within an organization (Cummings & Worley, 1997). Questionnaires are often utilized because of their relative ease of administration and the ability to collect information from large groups of people while providing some response anonymity. Additionally, if developed correctly, questionnaires enable efficiency in quantifying and analyzing information. An experienced OD practitioner understands how to construct an effective tool for capturing the information that would be relevant for performing an organizational analysis. Such expertise is needed because it is important to understand the statistical properties of sample size, the power of results, and scale construction as well as how to create a nonbiased instrument. Additionally, in the current litigious world, it is important to ensure that any questionnaire that is used in an organization has a high level of validity and does not seem to target any particular group of individuals with a biased result.

The construction of a questionnaire with an appropriate scoring scale is critical to the ability to effectively analyze the data. All too often, new OD practitioners create an open-ended questionnaire and send it out to 300 employees in the hopes of collecting a variety of responses, only to discover that there is no easy way to analyze the results, since every employee has written something different. Another difficulty in using a questionnaire method is that it is rare that everyone who receives a questionnaire completes it. It is likely that you have received many e-mail requests to complete a satisfaction survey, only to delete them or fail to complete them in their entirety. The reality is that there is typically a relatively low response rate for questionnaires, and the missing data mean that a piece of the puzzle is missing. This nonresponse bias is impossible to interpret but exists and makes an impact on analysis. Therefore, OD practitioners commonly attempt to send questionnaires to as many employees as possible in an attempt to ensure a sample with enough respondents to reduce statistical error of the results.

A second type of data-collection tool is the use of interviews (Cummings & Worley, 1997). Occasionally, interviews are used as a follow-up to results obtained from a questionnaire, but this method is also used to capture data that cannot be readily obtained in questionnaires. Through a two-way communication approach, an effective interviewer can delve into issues identified by the employee and attempt to get to the heart of any issue that has been identified. However, coding of responses is a hurdle for analyzing the results of the interview. Additionally, the interviewer hears whatever responses the interviewee chooses to give, which might not be true or accurate.

This response bias may make it difficult to obtain valid results, but it can be overcome to some degree through effective rapport building and reassurance of confidentiality from the interviewer. The final disadvantage of this approach is that it is very difficult to conduct a large number of interviews, so the sample size tends to be small.

Another method of data collection is observation (Cummings & Worley, 1997). Observation is designed to allow the OD practitioner to see firsthand what is occurring with either a particular group of people or a process. For example, one organization might be concerned about the lack of teamwork among a group of employees, and data collected from a questionnaire revealed a variety of possible reasons for this. Because the data-collection results were somewhat ambiguous, the OD practitioner might decide to go in and observe the interpersonal dynamics occurring among the team members. This might reveal communication patterns, leadership issues, or ineffective conflict-resolution strategies within the team that might not be discovered through traditional data-collection strategies. In another example, a process might be observed in order to determine whether there are inherent inefficiencies that might not be recognized by the employees performing the various tasks in the process because they are so accustomed to performing those tasks regularly. Thus, the observation method of data collection has some distinct advantages.

However, as with all data-collection techniques, the observation method also has some pitfalls. The most apparent downside is that employees behave differently than they ordinarily would simply because they are now being observed (known as the Hawthorne Effect, based on the Hawthorne Studies; see Roethlisberger & Dickson, 1939; Homans, 1950). Many employees become concerned that they will face some outcome if, during the observation, some negative data are collected regarding their work performance. Since the main goal for many employees is job security, it is probable that in some cases the employees will alter their behavior simply to "look good." Additionally, observers face considerable difficulty in coding observed behavior into some type of aggregate result. Observers must also guard against having preconceived ideas of what should occur so that they are in fact recording actual behavior rather than either an ideal or a judged version of what actually occurred.

One additional type of data collection that is frequently utilized by OD practitioners is the unobtrusive method (Cummings & Worley, 1997). The interesting component in this type of data collection is that the data are obtained directly from preexisting information. These types of data exist in various formats throughout every organization. Examples include financial reports; human resources information such as turnover, vacancy rates, performance appraisals, and exit interviews; safety reports; and customer satisfaction information, to name a few. The advantage of this method is that the data are relatively easy to utilize once they have been obtained, although in some organizations, the information systems or mechanisms by which organizations collect information are cumbersome or in some cases nonexistent. A second advantage is that the data are typically free of biases that may be introduced in using other data-collection strategies.

Planning and Implementing Change

OD practitioners make use of an enormous variety of interventions. According to Cummings and Worley (1997, p. 141), three major criteria are needed for an effective intervention: "(1) the extent to which it fits the organization, (2) the degree to which it is based on casual knowledge of intended outcomes, and (3) the extent to which it transfers competence to manage change to

organization members." Essentially, the types of OD interventions that are typically utilized fall into several broad categories (Cummings & Worley, 1997). A brief overview of these interventions is outlined here, although some are discussed in greater detail later in the chapter. These interventions include the following:

1. *Strategic Interventions*: Strategic interventions deal with large-scale organizational strategic issues, such as ensuring that the organization maintains a competitive advantage, and marketing strategies as well as other organizational performance issues. Assessing the organizational environment and external factors that affect performance may identify an intervention whereby a diversification in products or change in geographic location may be the key to long-term organizational success.
2. *Technostructural Interventions*: Technostructural interventions deal with structural issues within an organization, such as organizational design issues or work design issues. An example of this might be the recognition through data collection that an organization with a functional structure is no longer efficient in its business strategy. The structure is providing some limitations that are ultimately affecting coordination between products and services and resulting in customer service or quality issues.
3. *Human Process Interventions*: Human process interventions deal primarily with issues between people within an organization. Often, there are distinct communication barriers, a negative history between employees, or perhaps ineffective leadership. In these interventions, the data might point to a problem involving fundamental communication processes, and the recommended intervention might be a strategy to assist the group in improving interpersonal relationships. An intervention such as communication training involving the Johari Window (Luft, 1984) or a team-building strategy might be appropriate in these cases.
4. *Human Resource Management Interventions*: Human resource management interventions deal with larger-scale human resource issues. Interventions in this area might be based on data suggesting that there is an exodus of good employees from the organization. Exit interviews might reveal that employees are disenchanted with reward programs or with organizational succession planning. Interventions such as a career planning system might be ways to address such concerns.

Evaluating and Institutionalizing Change

The true test of the effectiveness of an OD intervention is the outcome. In order to truly know whether there is an effective outcome, there has to be some sort of follow-up evaluation and measurement. The follow-up evaluation should be determined at the outset and agreed upon by both parties as part of the original contract. Feedback to managers about the intervention's results provides information about whether the changes should be continued, modified, or suspended (Cummings & Worley, 2009). Institutionalizing successful changes involves reinforcing them through feedback, rewards, and training.

It is critical that the OD practitioner be viewed solely as the facilitator of the new process rather than as the owner. It is therefore extremely important that the impact of the intervention be transferred back to the organization. In other words, the organization must transfer responsibility and accountability from the OD practitioner to the organization and ensure that the proper steps have been taken to weave the new strategy into the fabric of the organization.

Organization Development Interventions

The following are some typical OD interventions suggested by Rothwell, Sullivan, and McLean (1995) that might be utilized by OD practitioners:

1. *Team Building*: Team building can be done in a variety of ways, including providing assessments to team members, team-building workshops, or in-depth group analysis. Regardless of the strategy that is utilized, the goal is to increase the effectiveness and cohesiveness of either an intact work group or a project team.
2. *Process Improvement*: The process improvement intervention is designed to look at work processes and improve the way in which individuals work within the process. The goal is to improve efficiency.
3. *Total Quality Management*: The total quality management intervention is designed to enable groups of people to work together on a single problem and, through a regimented process utilizing specific problem-solving tools, work to solve the issue at hand. Some of the many tools that the team is trained to use are Pareto diagrams, cause-and-effect diagrams, brainstorming, and flowcharts. Teams typically meet regularly over a long period of time in an effort to solve the problem or mission that they have been given. This intervention not only is an effective intervention for problem solving or process improvement, but also affects team dynamics and provides opportunities for employee involvement.
4. *Work Redesign*: The work of Hackman and Oldman (1980) suggests that there are significant relationships between core job dimensions (skill variety, task identity, task significance, autonomy, and feedback) and critical psychological states (experienced meaningfulness of work, experienced responsibility for outcomes of work, and knowledge of actual results of work activities). These relationships produce personal and work outcomes (internal motivation, high-quality work performance, high satisfaction, and low absenteeism and turnover). On the basis of this model, OD practitioners may opt to look at the design of the job to determine what core job dimensions are inherent in the work. Depending on the outcome of the analysis, a redesign of the job may be recommended so that specific psychological states are addressed in the core job.
5. *Structural Change*: As was mentioned earlier, it is possible to change the organizational structure if the current structure is determined to be ineffective. Changing the structure essentially changes reporting relationships to streamline and improve quality outcomes.
6. *Training*: Training is often seen as the only intervention needed. Often, organizations fall into the trap of assuming that a training program will be the panacea that addresses and solves all of its organizational issues. This is an unrealistic assumption, but training is considered to be a very effective intervention when conducted with the correct goal in mind or as an adjunct to an additional initiative. The goal of training should be to improve a skill base.
7. *Performance-Management Systems*: Performance-management systems intervention is one of the Human Resource Management Interventions. A performance-management system consists of goal setting, appraisal, and reward systems. Some organizations have none of the components in place; some have one or two components; some have all. This intervention may involve designing a performance-management system in an organization where none exists or the redesign of one in an organization that has an ineffective system. The goal of this strategy is to identify the appropriate mechanisms, specific to an individual, for measuring employee performance.

Appreciative Inquiry

A relatively new approach or process for planned change is appreciative inquiry (AI). Whereas the Action Research Model is primarily deficit based, focusing on the organization's problems and how they can be solved so that it functions better, AI focuses on what the organization is doing right (Cummings & Worley, 2009; Fitzgerald, Murrell & Newman, 2002). AI suggests that for organizational change to take place, the organization needs to begin with the recognition of its positive attributes and then ask questions that will take it along the path toward the organization it visualizes itself becoming (Cooperrider & Srivastva, 1987). Similar to an athlete using visualization to prepare for an upcoming competition, whereby the athlete mentally reviews every step of the competition and visualizes success, so does AI challenge the organization to capitalize on its strengths. AI is a change process guided by an OD practitioner who is adept at maneuvering through the maze of possibilities that might be exposed by examining the positive issues that are identified (see **Case Study 19-3**). The OD practitioner essentially helps the organization to see the future and then sets the organization on a path to make that visualization a reality (Cummings & Worley, 2001).

CASE STUDY 19-3 Creating Positive Conversations Around Exceptional Health Care Dining Services

Focus of the Appreciative Inquiry: To have a group of 20 Foodservice Directors discuss and identify their experience with exceptional dining services and transfer that learning to their health care facilities.

Client Organization: UHF Purchasing is a group purchasing organization that provides prime vendor contracts, product supply contracts and services to health care facilities through a national purchasing agreement. The majority of the participants worked in long-term care facilities or small community hospitals throughout the state of Wisconsin. The Food Service Directors meet quarterly to discuss trends and issues affecting the foodservice departments. The AIC consultant was invited in to create positive conversations around the dining experience and to teach the Foodservice Directors to train their staff in an appreciative approach.

Client Objectives/Specific Goals

- Build energy around training regarding excellent customer satisfaction
- Educate the Foodservice Directors on an appreciative approach to learning versus gap analysis
- Create a dialogue in which Foodservice Directors can share and learn from others in the Purchasing Group

What Was Done: UHF Purchasing created a learning seminar "Breakfast for Champions" in which Foodservice Directors could get together for four hours. An interview guide was developed to explore in detail the elements that make up an excellent dining experience. The participants paired up for interviews and then shared with the group the stories and their key learning from the interviews. The participants identified themes and elements that contributed to their exceptional dining experience. The participants shared with each other how they could use a similar process for training their staff.

Outcomes

- Collectively the Foodservices Directors created a list of elements for an exceptional dining experience
- Foodservice Directors were exposed to an appreciative process for training

AI is often explained by using the five Ds: Define, Discover, Dream, Design, and Deliver (Fitzgerald, Murrell, & Newman, 2002, pp. 209–211).

Phase 1: *Define*—The most critical phase of the process is defining the topic(s) for an appreciative inquiry.

Phase 2: *Discover*—This step typically begins with paired appreciative interviews exploring participants' peak experiences of each topic and what made those experiences possible. Participants look for the best of what happened in the past and what is currently working well. In this phase, questions are designed to get people talking and telling stories about what they find is most valuable or appreciated and what works particularly well.

Phase 3: *Dream*—During this phase, the best of the past is amplified into collectively envisioned and desired futures. In other words, the participants dream of "what might be."

Phase 4: *Design*—In this phase, participants identify key facets of organizational systems and structures that will be needed to support the realization of their collectively generated dreams. During this step, members determine the types of systems, processes, and strategies that will enable the dream to be realized.

Phase 5: *Deliver*—During the fifth or implementation phase, participants self-select projects or tasks that they would like to work on or otherwise support. Actions are implemented over time in an iterative, appreciative learning journey. The overall results are changes that occur simultaneously throughout the organization, all serving to support and sustain the dream.

Conclusion

In general, organizational development (OD) is one of the most popular and widely used approaches for implementing organizational change (Waclawski & Church, 2002). Many types of interventions are available and at the disposal of a well-trained OD practitioner. A successful OD initiative will be based on a thorough analysis of any symptoms of problems, and this analysis will be based on a thorough analysis of data. The partnership with the organization is critical, and the OD practitioner must ensure that the organization ultimately understands and accepts that the responsibility for the success of any intervention lies with management, not the OD practitioner.

Discussion Questions

1. Identify and discuss the various characteristics of OD.
2. Describe the unique features of OD that differentiate it from other change initiatives.
3. How would you describe the role of the OD professional? What skills are necessary for an OD practitioner?
4. Explain the various components of the Action Research Model.
5. Identify and explain the steps necessary in the OD process.
6. Why is data collection so important to the OD process?
7. Identify and explain the various interventions used in the OD process.
8. What is appreciative inquiry, and how is it used in the OD process?

CASE STUDY 19-4 Prescription for Change—Opioid Crisis

Kaiser Health News

Doctors Can Change Opioid Prescribing Habits, but Progress Comes in Small Dose

By Julie Appleby and Elizabeth Lucas
AUGUST 14, 2019

When they started practicing medicine, most surgeons say, there was little or no information about just how many pain pills patients needed after specific procedures.

As a result, patients often were sent home with the equivalent of handfuls of powerful and addictive medications. Then the opioid crisis hit, along with studies showing one possible side effect of surgery is long-term dependence on pain pills. These findings prompted some medical centers and groups of physicians to establish surgery-specific guidelines.

But questions remained: Would anyone pay attention to the guidelines and would smaller amounts be sufficient to control patients' pain?

Yes, appears to be the answer to both — in some measure — according to a study that encompassed nearly 12,000 patients in 43 hospitals across Michigan. The researchers published details of their work in a letter Wednesday in the New England Journal of Medicine.

Seven months after specific guidelines for certain operations were issued in October 2017, surgeons reduced by nearly one-third the number of pills they prescribed patients, with no reported drop in patient satisfaction or increase in reported pain, according to the research.

"We're not trying to deny patients narcotics," said Dr. Joceline Vu, one of the paper's authors and a general surgery resident at the University of Michigan." But there's an acceptable level where people are still happy and still have their pain under control, but we have dropped the number to a minimum."

Overall, doctors prescribed eight fewer pills per patient—from 26 to 18—across nine common surgical procedures, including hernia repair, appendectomy and hysterectomy, based on guidelines from the Michigan Opioid Prescribing Engagement Network (Michigan OPEN), a collaboration of hospitals, doctors and insurers.

Patients also reported taking fewer pills, dropping from 12 to 9 on average across those procedures, possibly because they were prescribed fewer in the first place.

Still, while researchers say the study offers considerable reason for encouragement, it illustrates how hard it is to change prescribing habits. In May 2018, at the study's conclusion, the average number of pills prescribed exceeded the most up-to-date recommendations for all nine procedures.

And that's in Michigan, where there has been a concerted push to change prescribing habits. Most states don't have such a broad effort ongoing.

"There is a misconception that this is all fixed," said Dr. Chad Brummett, co-director of Michigan OPEN and one of the researchers on this study. "I do think people are still overprescribing. Definitely."

The guidelines come amid ongoing concern about the opioid crisis and a continued examination of the role prescription drugs played in its escalation.

The likelihood of persistent opioid use rises with the number of pills and the length of time opioids are taken during recuperation from surgery. But there's another avenue of concern. When doctors write scripts with a generous number of pills, the chance that patients won't take them all increases, along with the potential for the unused pills to make their way from medicine cabinets to the street, or to fall into the hands of other family members.

"That can be a bigger concern for many of us," said Vu. "It seems that in surgery, for whatever reason, we wrote prescriptions for a lot more opioids than people actually needed."

The Michigan OPEN guidelines recommended amounts based on how much pain medication patients actually took following surgery.

Other institutions developed their own surgery-specific prescribing principles, including Johns Hopkins Medicine in Baltimore and the Mayo Clinic in Minnesota. Although they use different methods to determine the number of pills, most ended up with similar parameters, often in the range of 0–20 pills, depending on the procedure.

All the prescribing directives apply to patients with acute pain, such as those who had surgery, not people with chronic pain, Vu and other researchers emphasized. Even so, chronic-pain patients argue that the focus on setting postsurgical prescribing levels has made it far more difficult for them to get treatment.

"These patients feel besieged ... and say, 'I need these pills to get out of bed in the morning'," said Vu. "This project and study is not about chronic pain. It's about preventing harm to healthy people coming in for surgery."

What are some of the guidelines? Michigan, in its initial recommendation, called for no more than 10 pills equivalent to 5 milligrams of oxycodone for a minor hernia repair, and no more than 20 for a minimally invasive hysterectomy.

The resulting changes offer important context.

Before the guidelines, for instance, patients with minor hernia repair operations were being prescribed 29 pills, according to the study. That fell to 14 by May 2018, which is still four more pills than the guidelines suggest.

For a hysterectomy, though, patients received 31 pills before the guidelines and 19 after, just below the "no more than 20" recommended. And following their initial guidelines, Michigan OPEN revised its recommendations, further lowering the range amounts to 0–10 for hernia repair and 0–15 for a hysterectomy.

In sheer numbers, opioid prescribing rates in the U.S. peaked in 2010, but remain among the highest in the world, according to studies and other data. The postsurgical prescribing falloff seen in Michigan does not likely reflect a broader trend, especially where there is less emphasis on such guidelines.

The KHN/Hopkins analysis originally found that prescribing from 2011 to 2016 was well above levels now recommended by organizations like Michigan OPEN and the Hopkins medical center. For example, Medicare patients took home 48 pills in the week following coronary artery bypass; 31 following laparoscopic gallbladder removal; 28 after a lumpectomy; and 34 after minimally invasive hysterectomies.

According to postsurgical guidelines spearheaded by Hopkins last year, those surgeries should require at most 30 pills for a bypass; 10 pills for minimally invasive gallbladder removal, lumpectomy and minimally invasive hysterectomy.

In July, when 2017 Medicare data became available, KHN and Hopkins did an additional analysis, which showed, on average, small decreases in the number of pills taken home from the pharmacy by patients in the first week after leaving the hospital. But the drop was smaller than the reductions seen in Michigan.

For example, nationwide prescribing following bypass surgery averaged 45 pills, a drop of three; after a hysterectomy, the drop was four pills from the 6-year average, to 30; and lumpectomy patients took home five fewer pills, for an average of 23.

"Those reductions are not sufficient," said Dr. Marty Makary, the surgeon who spearheaded the development of guidelines at Johns Hopkins Bloomberg School and whose staff helped perform the Medicare analysis for KHN. "The data represents prescriptions as recent as a year and a half ago, and we're three years into the opioid crisis. We're talking about mopping up the floor while the spigot is still on."

You have been hired as an external OD consultant to work with pain specialists, surgeons, the emergency department, and administration to change opioid prescribing habits at Oak Bluff Hospital.

Discussion Questions

1. Describe what specific activities you would you would take using an action research approach.
2. How could you use appreciative inquiry to approach the problem?

Reproduced from Doctors can change opioid prescribing habits, but progress comes in small doses. Available from https://khn.org/news/doctors-opioid-prescribing-habits-change-comes-in-small-doses.

CASE STUDY 19-5 Gateway Hospital

Gateway Hospital is a 500-bed tertiary-care hospital located in a busy metropolitan area. In a recent employee satisfaction survey, the hospital scored well below the national norms on most scales. It has been experiencing higher than average turnover and vacancy rates. Recruitment for professional positions is very difficult because the hospital has gained a reputation as a bad place to work, especially for new employees; the term "eat their young" seems to be a prevalent description. Salaries are below the local market, as are annual pay increases. Many departments seem to have a critical shortage of staff, and closing services has been a recent topic of discussion.

Additionally, the financial picture of the organization is bleak. The payor mix has changed; Medicare cutbacks are affected the bottom line, as are changes in private insurance funding. Key physicians are beginning to take their services elsewhere as they sense the inefficiency of the hospital processes.

The various stresses appear to be having a significant impact on the overall morale of employees. Poor teamwork is rampant, and communication breakdowns seem to occur often. Several leaders have been let go in an effort to address issues.

The leadership of Gateway Hospital is extremely concerned about the organization's prognosis and has decided to begin to address the issues by enlisting the assistance of a consulting team. One member of the team is a financial expert who has been hired to address the significant financial issues affecting the hospital in a short timeframe. Because the environment is changing rapidly, the consultant must get a handle on how to help the hospital operate successfully, given the current financial downslide.

A second member of the team has been hired to address the morale and employee issues. A review of the employee opinion survey is conducted, and trends are identified in exit interviews. Employee interviews and focus groups are held in an attempt to determine the root cause of the morale issues and the reasons for the breakdown in teamwork and communication.

After the data have been collected and analyzed, the team presents the results to the hospital leadership. After a series of discussions, leadership admits that many of the financial pressures have created a knee-jerk reaction to staffing issues. Employee hours are often cut back dramatically, which creates a crisis mode and the need to ask employees to work harder. This has created a significant lack of trust from the employees' perspective, coupled with the fact that employees have not felt that they have been apprised of the reasons for the rollercoaster changes and have not been offered any words of appreciation when they have either reduced their hours or worked in a crisis.

The consultant team and the leadership agree that in order to fix the "people" issues of the organization, there will need to be a culture shift in leadership and employee interactions so that trust can be rebuilt.

Discussion Questions

1. On the basis of these issues, what OD interventions do you think should be utilized to address the problems this hospital is facing?
2. How would you proceed if you were the consultant in this case?
3. What skill set do you think the OD practitioner will need in order to be effective in this organization?
4. What timeline would you establish if you were this consultant?

CASE STUDY 19-6 City Hospital

City Hospital is a growing hospital in a large metropolitan city. The hospital is currently experiencing an issue that many other organizations also face: that of the multigenerational workforce. The senior leaders of this hospital are almost all Baby Boomers, but the population of employees is slowly becoming a younger workforce. The leadership is struggling to deal with issues such as social media use at work, texting during important meetings, requests for remote-working arrangements, excessive non-work-related Internet use, tattoos, body piercings, and so on. Equally troublesome is a different perceived

commitment to the job and frequent breakdowns in communication. Leadership has decided to hire an outside consultant to help the organization understand the impact of the multigenerational workforce and to help the hospital to become a more cohesive organization.

Discussion Questions

1. Which type of OD intervention is the leadership using in this situation?
2. What obstacles do you see in this situation that may make this intervention more difficult than other types?
3. What recommendations do you have for the hospital in this situation?
4. What other interpersonal issues exist in organizations besides generational ones that may create a need for an OD intervention?

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CHAPTER 20

Managing Resistance to Change*

LEARNING OUTCOMES

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

- Identify the drivers of change.
- Understand the various change models.
- Identify the various barriers to change.
- Understand the step-by-step change process.

Overview

Planned change arises from a single change or series of changes in organizational goals and objectives (e.g., increased patient satisfaction). These changes may originate from an organization revising its mission, creating a new vision, or responding to other internal or external forces. Unplanned change arises from the unexpected, which impinges on the well-being of the organization. Unplanned changes occur because of things like sudden shifts in the marketplace, reduced demand for a product or service, the emergence of more competitive products or services, changes in technology, depressed economic conditions, natural disasters, or the death or impairment of a senior manager.

Whether planned or unplanned, many changes within an organization will meet with resistance because, as Lippitt (1973, p. 3) noted, "change is a very complex phenomenon involving the multiplicity of man's motivations in both micro and macro systems and that a man gets satisfied with his equilibrium and is resistant to changing his status quo." Resistance to change is not limited to clinical or entry-level administrative staff. Resistance may also be expressed by middle managers, senior executives, and even board members. Therefore, it is a top priority for managers

* We wish to acknowledge and thank Dr. Jeffrey Ritter, who was the contributing author of an earlier version of this chapter, which appeared in *Organizational Behavior in Health Care* (2014), Jones & Bartlett Learning.

to understand the factors involved in change management. If managers understand these factors, they can increase employees' readiness for change, thereby reducing the resistance to organizational change.

Drivers of Change

Organizations function within three identifiable environments: external/social, industry/task, and internal (see **Figure 20-1**). The primary forces creating the need for change originate in an organization's external and industry environments. Change occurs as the organization attempts to respond and adapt to the new demands from these environments.

Today's organizations face many challenges. In the external/social environment, war and terrorism are viewed as powerful political and legal forces that affect organizations worldwide. Economic forces include other countries' economic threats of inflation, deflation, and recession; trade wars; and sanctions. Advances in technology and big data availability are major forces affecting today's businesses. The internet has dramatically empowered consumers and has enabled buyers and sellers to come together with drastically reduced transaction and intermediary costs, creating much more robust marketplaces for the purchase and sale of goods and services. These external forces affect all organizations, and they have had a direct impact on changes in the health care industry/task environment. For example, patients have become informed consumers of health care services' value and costs; cloning and gene modification capabilities have challenged an organization's ethical practices; special interest groups, such as insurance companies and employer-sponsored health consortiums, have directly affected the way health services

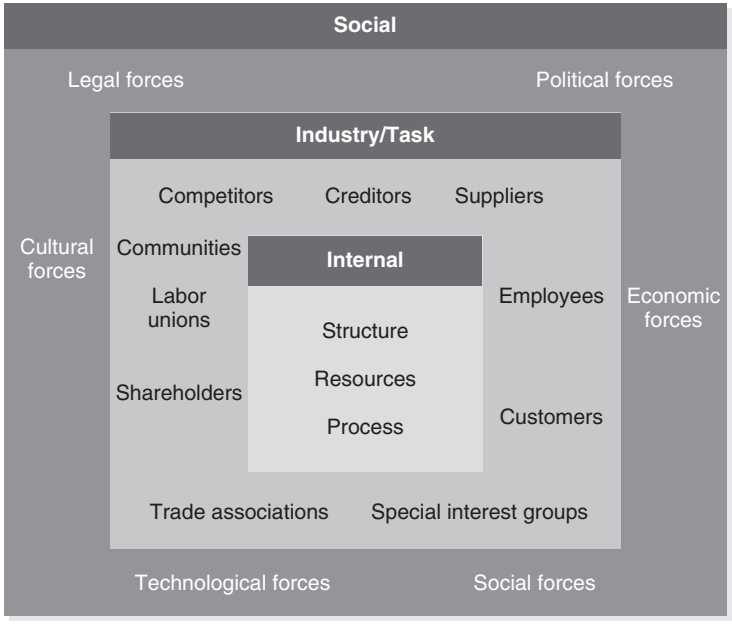

Figure 20-1 Environments

Wheelan, T. L., & Hunger, J. D. (1997). *Strategic management and business policy* (6th ed., p. 10). Upper Saddle River, NJ: Addison-Wesley. Used with permission.

organizations do business; and technological advances in robotic surgery, new drugs and treatments, and telemedicine as well as security breaches have had far-reaching effects on the health care industry. Federal, state, and local governments, with their ever-changing health policies and regulations, have had a direct and major impact on the industry, and the politicization of health care means that major swings can be felt industry-wide.

In addition to external forces, internal forces are influencing change within health services organizations. Internal forces are related to an organization's structure, processes, and resources. Because of the many external factors cited above, health care organizations are experiencing decreasing reimbursements and increasing costs, resulting in smaller profit margins. In addition, the organizations are being challenged to deliver patient-centered care with value-based outcomes. As a result, health care systems are considering and engaging in redesign to include more alignment and inclusion across systems (Fischer, Berwick, & Davis, 2009), such as vertically integrated models along the continuum of care, Accountable Care Organizations, and joint ventures with insurers and employers. Whatever the reasons that create a need for change, a planned response must be developed and implemented by management to ensure the organization's future effectiveness.

Resistance to Change

Although resistance to change is often deeply embedded in organizations, there are situations in which individuals will embrace change. This generally occurs when they perceive that the change will benefit them in some way. Kirkpatrick (2001) identified change outcomes that would cause individuals to react positively to change:

- *Security*—The change may increase demand for an individual's skill set.
- *Money*—The change may involve salary increases.
- *Authority*—The change may involve promotion.
- *Status/prestige*—There may be changes in titles, work assignments, and additional decision-making responsibilities.
- *Better working conditions*—The physical environment may change, including new equipment and updated technology.
- *Self-satisfaction*—Individuals may feel a greater sense of achievement and challenge.

However, managers need to be aware that most organizational change efforts will be met with resistance. Resistance to change may arise from two sources: organizational barriers and individual barriers. Organizational barriers may include (1) lack of a change agent, (2) inadequate finances and/or capacity, (3) poor leadership (4) resistance to change by senior management, (5) lack of the necessary technology, (6) time restraints, or (7) poor market conditions. Overcoming organizational barriers to change may be beyond the control of the manager and is usually a topic in a strategic management course. Because our concern is to understand the behavior-oriented change process, our focus will center on understanding the individual's barriers or resistance to change.

Individuals' Barriers to Change

For individuals, resistance to change may involve affective, behavioral, and cognitive components (Palmer, Dunford, & Akin, 2009). The affective component relates to how an employee feels

about the change, the cognitive component relates to how the employee thinks about the change, and the behavioral component relates to what the employee does when confronted with the need to change (Palmer et al., 2009). For most individuals, it is contextual factors that determine how they will react (Bareil, Savoie, & Meunier, 2007).

The results of the famous Hawthorne Studies showed that employees behave differently simply because they are being observed. Roethlisberger (1941) proposed that an individual's attitudes affect their response to change. In other words, how a person feels about a change determines their response. Feelings are not random. Feelings and/or attitudes toward an object are based on the collective experience of one's life; thus, different employees may be affected differently when faced with the same change in the workplace.

As illustrated in **Figure 20-2**, Roethlisberger's X model suggests that two primary forces are influencing an individual's perception, attitude, and response toward change. The first force consists of the worker's cumulative life experiences. The second, which functions within the formal organizational setting, is the influence of the social forces or informal groups. The identification of these social forces subsequently led to considerable research efforts in the area of group dynamics. These studies revealed the great potential for social forces to directly influence an individual's behavior and beliefs, which in turn serve as the foundations for establishing or changing an attitude.

Employees may resist change as a result of many issues. Palmer et al. (2009, pp. 163–168) provide us with some of the commonly cited barriers:

- Discomfort with uncertainty
- Perceived negative effects on interests
- Perceived breach of psychological contract
- Lack of clarity as to what is expected
- Excessive change

Discomfort with Uncertainty

Employees require a stable psychological condition in the workplace. When changes occur, issues of professional and personal insecurity are kindled primarily by a lack of knowledge and understanding of what changes are taking place and the official causes for the change. Management's

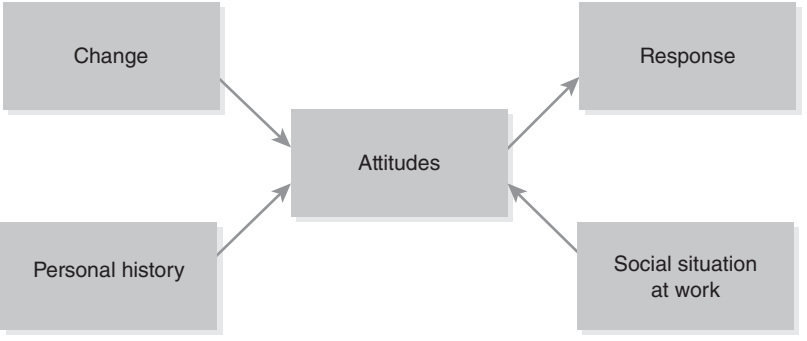

Figure 20-2 Roethlisberger's X Chart (Model for Change)

Reproduced from Roethlisberger, F. J. (1941). *Management and morale* (p. 21). Cambridge, MA: Harvard University Press.

failure to furnish realistic information in a timely fashion adds to employees' uncertainty. This uncertainty often results in lower morale, increased absenteeism, and reductions in both the quality and quantity of output.

Perceived Negative Effects on Interests

Employees may lack an understanding of the likely effect of the change on their interests, which can relate to numerous factors, such as their level of authority, status, salary, autonomy, and job security. Employees find it easier to be supportive of changes that they perceive as nonthreatening to their interests and will resist those that are seen as damaging to these interests.

Perceived Breach of Psychological Contract

Employees form beliefs about the nature of the reciprocal relationships between them and their employers—that is, a "psychological contract." Change often leads to a disruption of employees' expectations. The employee–employer psychological contract becomes unbalanced as historical feelings of trust and perceptions of honest relationships become questionable.

Lack of Clarity as to What Is Expected

Resistance to change may be the result of management's failure to provide a clear message at the organizational level about the behavior expected of employees. As Gadiesh and Gilbert (2001, p. 74) noted, "A brilliant business strategy … is of little use unless people understand it well enough to apply it."

Excessive Change

Resistance to change can be characterized as having two forms. The first form occurs when an organization is pursuing several change initiatives simultaneously and employees perceive them as unrelated or in conflict. The second form occurs when the organization is introducing numerous change projects before other changes have been completed and employees feel that their resources (including their time) are being spread too thin, not allowing for the initiatives to be effectively implemented. Such "waves of change" may cause employee initiative fatigue and burnout.

Creating and influencing readiness for change within an organization help managers to prevent or minimize the likelihood of resistance to change (Armenakis, Harris, & Mossholder, 1993). Readiness for change refers to organization members' shared determination to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy) (Weiner, 2009). Armenakis et al. (1993) identified five elements for developing organizational readiness for change: (1) create a clear and compelling message for the need for change (discrepancy), (2) demonstrate that it is the right change (appropriateness), (3) ensure that employees demonstrate self-efficacy (i.e., confidence in skills and ability) supported by the required organizational infrastructure (i.e., technology, policies, procedures, managerial talent) for successful change implementation and continued sustainability (efficacy), (4) ensure that key leaders, both formal and informal, visibly support the change (principal support), and (5) help employees to understand how the change benefits them (personal valence).

Lewin's Change Model

To fully understand the influence of group dynamics on an individual's attitude toward change, consider the work of Kurt Lewin (1947) and his model of Force Field Analysis. Lewin's model permits us to view change as a series of forces working in different directions. In effect, some forces and interests within an organization that push for change may be offset by forces and interests that are striving to maintain the status quo (see **Figure 20-3**).

For implementation of change, there must be an increase in the strength of the forces for change (i.e., driving forces), and the strength and position of opposing forces (i.e., restraining forces) must be reduced or removed. Employing this model requires an improved managerial understanding of the external and internal environments. By identifying each force, it becomes possible to distinguish between forces and issues that may be changed and those that cannot be changed.

According to Lewin (1947), change can be enacted in one of two ways: by increasing the force for change in the desired direction or by reducing the strength of any opposing forces. Borkowski and Allen's (2002) research on physicians' nonacceptance of clinical practice guidelines in their medical practice illustrates the application of Lewin's Force Field Analysis in the change process. Clinical practice guidelines are viewed as important tools to reduce variances of medical services received by patients and to improve the quality of care by establishing "best practices." As such, there is great concern as to why these guidelines have been unsuccessful in significantly influencing physician practice patterns. Borkowski and Allen suggested that the driving forces for acceptance and implementation of clinical practice guidelines represented knowledge and attitudinal change and were viewed positively by physicians, whereas the restraining forces represented changes being imposed by some external force that were viewed by physicians with resentment and negativity (see **Table 20-1**).

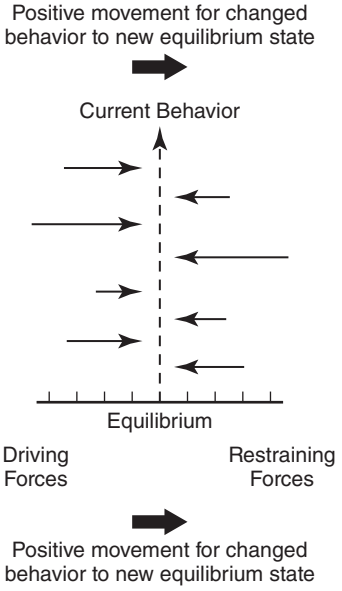

Figure 20-3 Lewin's Force Field Analysis

Table 20-1 Suggested Driving and Restraining Forces Regarding Physicians' Acceptance of Clinical Practice Guidelines

Driving Forces	Restraining Forces
High-quality patient care (e.g., professional competence)	Administrative edicts (e.g., cost control)
Best practices (e.g., evidence-based findings)	Legislative mandates (e.g., laws and regulations)
Effective use of limited resources	Financial penalties/incentives
Good educational tools	Licensing and accreditation mechanisms
Convenient sources of advice	Utilization review

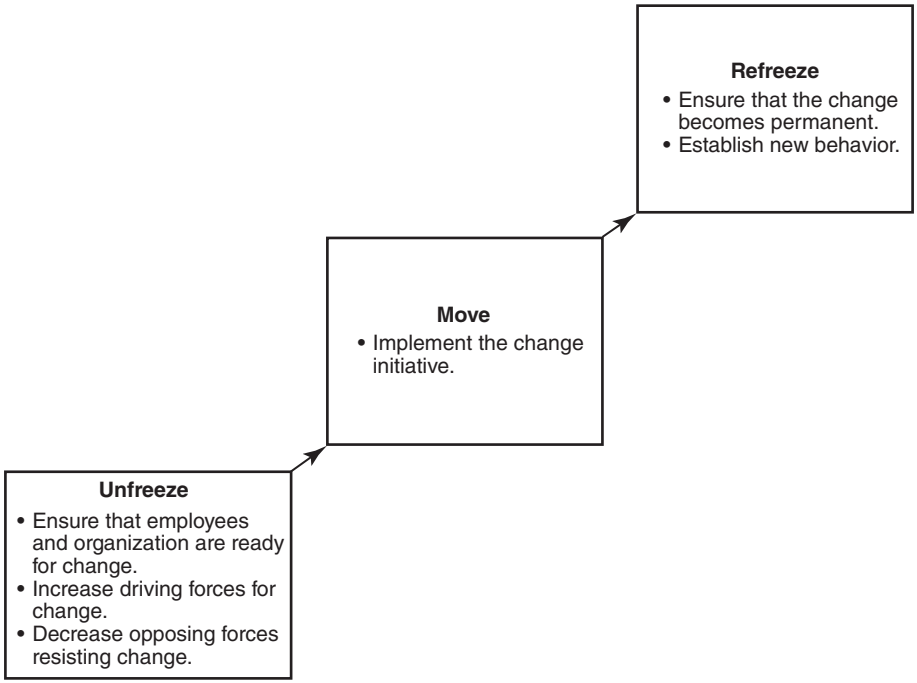

Figure 20-4 Lewin's Three Step Change Process

When these forces or variances are understood, a realistic approach to planning change can be undertaken. As reflected in **Figure 20-4**, Lewin provides us with a three-step process for implementing planned change:

1. *Unfreeze*: Workers who are involved in perpetuating resistance acquire an understanding of variances that exist between current practices and behavior and desired activities and

behavior. Using the clinical guidelines example, unfreezing may occur when managers effectively communicate the need for change (driving forces), such as mortality and/or morbidity rates, hospital readmission data, and best practices benchmarks.

2. *Change*: On the basis of new objectives, a series of revised policies, procedures, and operating practices is implemented. It is important that members of the affected workforce understand the reasons for change and participate in the design of new approaches. Participating in the change design, followed by appropriate training and reorientation, presents each worker with the opportunity to buy into the new approaches. Physician participation (whether directly or indirectly) in the development of a clinical practice guideline does increase the acceptance of it, as measured by hospitals' reduced length of stays and inpatient costs (Borkowski & Allen, 2002).
3. *Refreezing*: Changes are implemented and monitored, and they are adjusted where necessary. New organizational goals are reinforced by subsequent changes in daily activities. Continuous monitoring ensures successful operating practices. For example, audit of and feedback on physicians' practice patterns is a common reinforcement used by managers.

Kotter (1995, 1996), building on Lewin's change model, identified eight steps for managers to follow for successful organizational change. The first four steps change the status quo (i.e., unfreezing), steps 5 through 7 introduce new policies (i.e., change), and step 8 institutionalizes the changes (i.e., refreezing). The eight steps, as described by Kotter and Cohen (2002), are listed in **Table 20-2.**

Table 20-2 Steps for Organizational Change

Lewin's Change Model—Steps for Successful Organizational Change	
Unfreeze	1. *Establish a Sense of Urgency*: The first step must be to unfreeze the organization's current state and establish a sense of urgency about the need for change (i.e., the desired new state). Managers need to increase the feeling of urgency (e.g., by discussing crises, potential crises, or major opportunities) so that employees start telling each other that something must be done about the problems and opportunities. 2. *Create a Powerful Guiding Coalition*: Management needs to create a powerful guiding coalition, a group that spans both the functions and levels of the organization (i.e., includes members who are not part of senior management). This requires pulling together the right people with the right characteristics and sufficient power to drive the change effort. 3. *Develop a Vision*: Management must create a vision to direct the change effort and develop strategies for achieving that vision. In other words, management must create the right compelling vision to direct the effort and assist the guiding team to develop bold strategies for making the vision reality. 4. *Communicate the Vision*: Management must use every vehicle possible to communicate the new vision and strategies, including teaching new behaviors by the example of the guiding team. Managers need to send clear and credible messages about the direction of the change, using words, actions, and technology to open communication channels and overcome confusion and distrust.
Change	5. *Empower Others to Act on the Vision*: Management must eliminate barriers to change and must encourage risk taking and creative problem solving. Management must change systems, structures, processes, and procedures that create barriers for employees to achieve the vision.

	6. *Plan for and Create Short-Term Wins*: Management must plan for visible short-term performance improvements to diffuse cynicism, pessimism, and skepticism. In addition, employees who are involved in the improvements must be recognized and rewarded. These strategies build momentum by "speaking" to what employees deeply care about. 7. *Consolidate Improvements and Produce More Change*: Management should use the credibility achieved by short-term wins to create more change. This may include hiring, promoting, and developing employees who can reinvigorate the change process with new projects and themes and assume change agent roles.
Refreeze	8. *Institutionalize New Approaches*: Management must reinforce changes by highlighting connections between new behaviors and organizational success. Managers should use the employee orientation and promotions processes as well as the power of emotion to enhance new group norms and shared values.

Modified from Kotter, J. P., & Cohen, D. S. (2002). *The heart of change.* Boston, MA: Harvard Business Review Press.

Transformation of Health Care Organizations

Many health care entities are implementing change management to transform their organizations for delivering high-quality patient care. For example, VanDeusen Lukas et al. (2007) examined 12 health care systems that either were participants in the Robert Wood Johnson Foundation's Pursuing Perfection program or have reputations for having long-standing commitments to improvement and high-quality care. The researchers identified five interactive elements as being critical for the successful transformation of a health care organization (see **Figure 20-5**):

1. *Strong impetus to change*: The impetus to change can be external or internal to the organization. In most cases, external pressure for change is the strongest impetus (e.g., regulatory, changes in reimbursement schemes).
2. *Leadership commitment to quality*: Leadership is a critical element for organizational transformation. Leaders must demonstrate authentic passion for and commitment to quality and must steer the change through the organization's structures and processes to maintain urgency, set a consistent direction, reinforce expectations, and provide resources and accountability to support the change.
3. *Improvement initiatives that actively engage staff in meaningful problem solving*: Improvement initiatives must actively engage staff across disciplines and hierarchical levels in problem solving focused on objective, meaningful, urgent problems (e.g., eliminating never events and reducing unnecessary readmissions). These initiatives, such as clinical redesign and improved operations, must be built into routine new work practices that are visible as well as easier to perform, more reliable, and more efficient than old practices.
4. *Alignment to achieve consistency of organization goals with resource allocation and actions at all levels of the organization*: Changes must be aligned with the organizational mission and strategic direction. Therefore, changes need to be consistent with the organization's plans, processes, information technology, resource decisions, actions, results, and analysis to support key organization-wide goals.
5. *Integration to bridge traditional intraorganizational boundaries among individual components*: For an organization to succeed, change initiatives must be integrated across intraorganizational

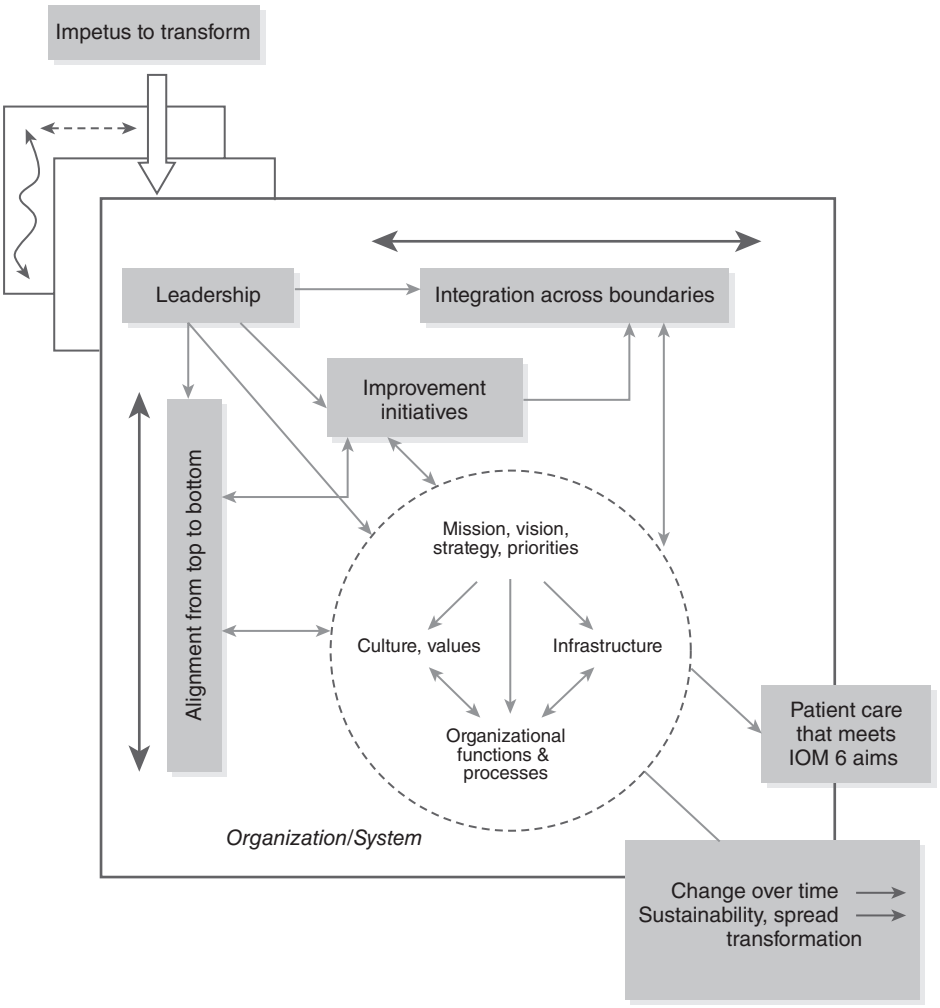

Figure 20-5 Key Elements of Organizational Transformation to Deliver High-Quality Patient Care

Reproduced with permission of the Turning Point Program, which was funded by the Robert Wood Johnson Foundation, Princeton, NJ.

boundaries to improve coordination and continuity of care (e.g., patient flow, case management, electronic medical records). Extensive integration is needed to break down barriers between departmental silos so that the system operates as a fully interconnected unit to support organization-wide goals.

Summary

The primary objective of change is to ensure the future competitive sustainability of an organization. The rationale and need for change rise from both external and internal forces. For successful implementation, managers need to recognize and appreciate employees' attitudes, taking into

consideration the various organizational and individual barriers that are likely to create resistance to the required change. In addition, management should use a documented, step-by-step process that includes specific opportunities for feedback, evaluation, and adjustments. As Peter Senge (1990) advocates, organizations must develop the capacity to adapt and change continuously. Senge (1990) relates that organizations must learn to create attributes and implement practices that (1) dismiss old ways of thinking, (2) share ideas freely, (3) create an organizational vision, and (4) establish a collective effort to design a plan to achieve the vision. To become a continuously learning organization requires management to establish a commitment to change and develop an open organizational culture.

Discussion Questions

1. Identify and describe the drivers of change.
2. Explain the components of Roethlisberger's X model.
3. Explain the concept of Lewin's change model.
4. Identify and explain the various barriers to change.
5. Describe the steps used by managers in the change process.

CASE STUDY

Case Study 20-1 Smyrna University Hospital Department of Internal Diseases: Finally Walking Side by Side

Smyrna University

Smyrna University was founded as the fourth university of Turkey and the first university of the Aegean region, in accordance with the decision of the "Turkish Ministry of Education" with the requirement of law numbered 6595 in May, 1955. The rapidly growing university was not only eliciting the well-educated workforce of the Aegean region but also it was the *only* research and education institution that contributed to the commercial, health, social and cultural development of the Aegean region. Soon after the establishment of the Turkish Higher Education Council in 1981,[1] the university had separated into two universities. While the Smyrna University continued its academic activities under the same name, a new government university named September University[2] was founded in 1982. This new university was the second state university of the Aegean region and founded with faculties that were transferred from Smyrna University.

Since the establishment of new universities in 1982, Smyrna University played a vital role during the establishment and development of the new universities. The university played a fundamental position in education for the Aegean region and in 2001 it had become the guarantor for the foundation of the first private university in Izmir. Today Smyrna University is representing Turkish universities in the

1 The Council of Higher Education was established in 1981. It is a fully autonomous supreme corporate public body responsible for the planning, coordination, governance and supervision of higher education within the provisions set forth in the Constitution (Articles 130 and 131) and the Higher Education Law (Law No. 2547). It has no political or governmental affiliation. At present, there are 139 universities in Turkey, 45 of which have foundation status: www.yok.gov.tr

2 September University was founded on 20 July 1982. Seventeen previously founded institutions of Smyrna University and other various higher education institutes were affiliated to the university in the same year. The number of its academic units reached 41 by1992. Presently September University owns10 faculties, 5 schools, 5 vocational schools, 5 graduate schools, and 5 institutes: www.deu.edu.tr

(continues)

Case Study 20-1 Smyrna University Hospital Department of Internal Diseases: Finally Walking Side by Side *(continued)*

"500 Leading Universities of World" and according to the evaluation of "University Ranking by Academic Performance," the university is the fifth leading education institution in Turkey (http://www.hurriyetegitim.com /kurum/1004015144/izmir/onlisans-lisans/ege-universitesi.aspx).

Soon after the founding of the Smyrna University, it started its first academic year (1955–1956) with 90 students. Today, more than 50,000 students are educated in 11 faculties, 8 institutes, 13 vocational schools, 1 state conservatory, and 26 research centers. There are more than 3,200 academicians and 4,000 administrative staff employed by the university.

Smyrna University Faculty of Medicine and Hospital

Smyrna University Faculty of Medicine[3] was one of the first two faculties of Smyrna University, which was founded in 1955. During the early years of its foundation, education for fundamental sciences was conducted in several buildings, prefabs, and temporary structures around Bornova,[4] where other subunits of faculty, including internal diseases, child care, and chest diseases were continuing education in buildings belonging to various hospitals around the city. In 1971, the university was moved to their permanent campus, which was located in Bornova, and since then Smyrna University Faculty of Medicine has been maintaining its academic, research, and healthcare activities in this campus. In 1981, the university had restructured its academic activities as a result of the Higher Education Law numbered 2547 (Official Gazette No: 17506; Date: November 6, 1981; http://www.resmigazete.gov.tr/default.aspx).[5] With this new regulation, all departments of Smyrna University Faculty of Medicine were grouped under three major scientific divisions. Under each division were included major medical departments.

Beside its academic activities as a medical school, the faculty has been sustaining healthcare services under the name of Smyrna University Faculty of Medicine Hospital (www.egehastane.ege.edu.tr). All of the academic staff in the university are, at the same time, working as physicians in the Smyrna University Faculty of Medicine Hospital. Therefore "Smyrna University Hospital" is often referred to as a "university hospital" whose duties are well ahead of just patient care as:

1. **Medical Education**: Training current and future doctors and resident physicians, and provide clinical education.
2. **Research Center**: Creating new knowledge through conducting basic science and clinical investigation.
3. **Patient Care**: Delivering comprehensive healthcare services to patients through one or more hospitals.

As a result of all these duties Smyrna University Faculty of Medicine Hospital always keeps in track with the recent development in patient care and treatments. Today, the healthcare services are operated in three different hospitals stretched through the campus as:

1. Smyrna University Faculty of Medicine Children's Hospital
2. Smyrna University Faculty of Medicine Adult's Hospital
3. Smyrna University Faculty of Medicine Oncology (Cancer Care) Hospital

The future physicians who completed their theoretical "clinical education" are then tasked to work as interns in the university hospital. Among these interns who preferred to continue their career in internal diseases will be the future members of Department of Internal Diseases of the "adult hospital" of the

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3 Symrna University Faculty of Medicine will be abbreviated as faculty for the rest of the case.

4 Bornova is one of the counties of Izmir, which is located very close to the city center.

5 Date of enactment: November 4, 1981. Published in the Turkish Official Gazette No: 17506; Date: November 6, 1981. For the full body of act see the official site of Turkish Official Gazette http://www.resmigazete.gov.tr/default.aspx. and please refer to http://www.cepes.ro/services /pdf/Turkey3.pdf for the English translation.

university. Department of Internal Diseases (DID)[6] has been developing patient care services since 1958 and today it is operating in 4 different buildings stretched through the campus with 52 academic staff, 100 medical staff, 65 nurses, and 370 employees. DID was the largest clinic of the hospital and, moreover, in terms of academic members, it would not be an exaggeration to compare the department with the other faculties of the university.

Internal Diseases Department Needed a New Head, Early Elections, and an Unexpected Candidate: Prof. Dr. Selim

Since the establishment of the DID as a separate department under the Medical Sciences Division,[7] one after another, there were nine individuals elected in succession for the head position. Prof. Dr. Selim acted as a vice head for the Department of Internal Diseases during the illness of the ninth head, Prof. Dr. Gurhun. Unfortunately, the illness was so deleterious, that Selim's temporary agency position had lasted for nearly a year. In that trial period, he had found that he was ready for responsibility and that there was much to be done in the DID. Acquiring the head position would enable him to impose his ethical codes on the team of DID, including patients, nurses, residents, and medical staff. After the mourning of Prof. Dr. Gurhun, Prof. Dr. Selim decided to stand as a candidate for the head of DID. However, he had discovered that people were ready to protest and were not very pleased with his candidacy. There had been one other candidate, but Selim had won the race with a one vote margin.

This large department had been managed by Prof. Dr. Selim since 2002. He felt at home there, having spent time in DID as a physician, as an academician, as a manager, and all at once for most of the time. He had been working in the faculty since his graduation from the Smyrna University Faculty of Medicine in 1981. His admirable commitment to the faculty was not only because he had been a member of the faculty for 30 years but it was also because his father—the mayor of Izmir in 1955—was the one who signed the foundation protocol and worked hard to establish the university in its early years.

Both the local and national press had started to talk about the changes in the DID of Smyrna University Hospital. What was happening there? In order to evaluate the antecedents and consequences of this change under the supervision of the new head, a meeting was arranged with Prof. Dr. Selim.

When the meeting started it was nearly 7 p.m. in the evening. Although a tired man was expected, who would not be able to interview for more than 30 minutes, Prof. Dr. Selim was standing with an inspiring smile and he was full of vim. On sight, he greeted the interviewers with a glad hand and made sure that everybody was comfortable in this hospitable room. The room was elegant and cozy, with one of the walls decorated with photos of previous department heads. He offered tea and cookies and smoothly gave the permission to record the whole interview, which took nearly 2 hours.

As of 2011 Prof. Dr. Selim had been continuing his third period as DID's head. Since his first days he spent hours walking around the patient rooms, talking to them and listening as they poured out their grievances. He nearly spent all his time at the hospital. He said that "We are more than physicians. The white coat we wear means treating all patients equally, regardless of their status, race, gender, and any other features." Patients were not his only concern; he also stayed in touch with students, academics, and medical and administrative staff of DID. It sometimes took him nearly an hour to reach to his office from the other end of the "20 meters" corridor that leads to his own consulting room, because on the way he answered any question directed to him, shook each hand offered, and listened to any problems without any refusal. He stated that it was very important for him to be in touch with everybody around him believing that he could learn important details about the department that might have been missed through formal communication. For example; in one of his long walks, Prof. Dr. Selim felt completely helpless with what he heard about a promising young lady: she had abandoned her medical education in her second year due to some financial problems. This event triggered Prof. Dr. Selim, and there had been established a charitable fund in the faculty that supported the education of the poor students. With the

6 The name of the "Department of Internal Diseases" will be abrivated as DID for the rest of the case.

7 As mentioned in the text, before the faculty had been restructured with the law number 2547 and all academic activities are grouped under 3 major divisions.

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voluntary contribution of the doctors, nearly 230 students received scholarships from this fund in the last 10 years. However, each scholarship student must have worked for faculty where needed according to their academic programs and competencies. Some worked in the library and some of them helped the administrative staff with new technology such as computers, thus these students were aware that they received this scholarship in return for their efforts.

The Main Problems of Department of Internal Diseases: When Prof. Dr. Selim Had Acquired the Head Position

In the very early days of Prof. Dr. Selim's promotion as head, there were several problems to be addressed at the DID. The staff, even the doctors, avoided Prof. Dr. Selim, choosing to walk in the opposite direction when they saw him. By doing this they were barring the most important communication channel that Prof. Dr. Selim prefers, face to face. Besides, no one had taken the accountability of what they did. The problems were all around but nobody had undertaken them. Therefore, DID was unable to find solutions and fell into a vicious circle where the same problems repeatedly emerged.

On the other hand, everybody was complaining to one another about a variety of problems at DID. Whether from habit or not, nurses, employees, and doctors—thus, nearly all members of DID—were complaining about each other. Some were for trivial reasons but some were destructive to their relationship, such that personnel were criticizing and comparing the working hours, attendance periods, reward systems, promotions, etc. Academic promotion of some physicians had been delayed for years for personal reasons in the department. Although the procedures and requirements for the promotions must follow the faculty laws and regulations, these rules are ignored in most of the cases. However, according to Prof. Dr. Selim, any kind of academic appellation could not be under the control of one person; rather, it depended on the merit of that person who decisively and worked hard for it. Thus the academic promotion of doctors could not be directed by personal closeness to the head, or value attributed to their "surnames" by the society.

Another challenge faced by Dr. Selim was in financing the department. The Turkish government allocated a determined amount of financial funds for hospitals. Each hospital then allocated those financial funds among departments. However, the financial funds that had been designated to DID had never been a sufficient amount to maintain Prof. Dr. Selim's ideal department. The overall physical structure of the DID was not sufficient to satisfy contemporary health services. The patient rooms were inadequate to meet the moderate hospitalization services, and the equipment supplied to the administrative and academic staff was so limited that it was even slowing down the daily routine of the department. The assistant doctors, doctors, and nurses were not allowed to use the printers in the department to print their educational materials, such as academic papers, due to the limited number of papers supplied to DID. They were only using these papers for routine administrative activities and for patient reports.

The Consequences of Management Alteration and Leadership Style: Things Started to Change at DID

This section summarizes significant phrases from the interview with Prof. Dr. Selim that highlights the work he did at the Department of Internal Diseases.

The professor's agency position for one year was a great chance for him to draw up his road map. During this period he saw the deficiencies of the department. Therefore, the main concern of Prof. Dr. Selim was to make radical changes in the department when he decided to be a candidate for the head position as the overall management principles were not overlapping with the working and ethical principles held by Prof. Dr. Selim. As soon as the professor became the head of DID, his main concern was showing the deficiencies of the current state. Organizational members were no longer seen as negative factors; rather they were the solution centers. This new role model, who was fair, hardworking, devoted, and open-minded, started to inspire the whole department. The winds of change had started to be felt at all levels of

the department. At the end of his first year as the head, the number of complaint petitions had started to decrease and in the last 9 years no petitions were forwarded to head of the DID. As it was mentioned above for some of the academic promotions, the faculty laws and regulations were ruled out; however, during those 9 years no one had lost any academic promotion due to a conflict of interest or personal reasons.

With Prof. Dr. Selim, they started to feel free to visit the head office whenever something went wrong within the DID, knowing that the door was always open to them with a genuine listener behind it. He allowed the organizational members to take active roles in decision-making processes and kept communication channels open all the time. He aimed to raise the awareness of organizational members about improper applications. Therefore, members of DID were ready to take any responsibility for their mistakes, believing that problems needed a solution for the well-being and success of DID. At last they were walking side by side in the corridors. The best example of the positive effects in the DID could had easily been interpreted from the latest newspaper account entitled "Halil Ibrahim Library Lends Books to Patients in DID at Symrna University Hospital." An employee named Halil Ibrahim was distributing books to patients in DID at the end of working hours from his "mobile library." He had been working as a sanitary in DID for 15 years when Prof. Dr. Selim had acquired the head position in the department. He tried to distribute books and newspapers to patients in the past but he could not continue this attempts with his limited income. Soon after he shared his idea with Prof. Dr. Selim he was given a book cart where he could place books and walk around the corridors easily. Prof. Dr. Selim also started a second-hand book campaign for the Halil Ibrahim Mobile Library. With this campaign, all nurses, doctors, academicians, and even patient relatives brought books to him. There was no such service in any other department of the faculty; moreover, not in any other private or public hospital around Izmir. All these examples were major indicators of the multidimensional effects of all staff, from the head to janitor, on the development of organizations with effective projects and valuable staff contributions.

Soon after he started to work as the head, he began to look for new financial resources for the department, although it was not his area of responsibility. The initial funds raised were used to meet the daily administrative needs of the department. Thus, for example, scarcity of paper for both assistants and administrative staff was no longer a problem for the department.

As mentioned above in DID, the patient rooms had not been meeting the requirements of modern physical health conditions, with 6–8 beds in less than 20 square meters and a communal toilet at each floor. In fact, this is the leading problem of the Turkish healthcare sector. Thus, as of 2007 in Turkey, the total number of doctors per 100,000 people is only 123. However, this number is 567 in Italy, 330 in France, and 287 in Armenia. On the other hand, the total number of patient beds per 10,000 people is 25, (http://www.biyoetik.org.tr/files/hekim%20sayisi%20yetersiz%20mi.pdf:19.09.2011) which means that in Turkey the attainability and fair distribution of healthcare services was very limited. The need of beds for patients was a more tremendous problem for university hospitals where nearly 60–70% of all teaching hospital patients entered because of serious illnesses that required long-term treatment (Yi_it, & A_ırba_, 2004). Therefore in order to increase the number of patients treated, the hospital administration preferred to increase the number of patient beds per room. However, on the other side, this increase decreased the quality of healthcare services supplied to patients. As mentioned above, Smyrna Hospital was one of those university hospitals that experienced the similar patient bed problem because of the huge gap between supply and demand of healthcare services in Turkey. Probably the solution found for rooms has been the leading contribution of Prof. Dr. Selim to both DID and the Faculty of Medicine. Prof. Dr. Selim's offer for two-bed patient rooms with air conditioning and a private toilet had initially increased the tension in the academic committee at those days where the general belief was to hospitalize as many patients as possible regardless of the number of nurses and health conditions. In Turkey the majority of the hospitals tried to increase the number of patients treated and therefore, regardless of the insufficient healthcare services due to the inadequate number of doctors and nurses they employed, they chronically invested in increasing the number of beds. However, Prof. Dr. Selim interpreted that, "I always believe the number of nurses is the main determinant of the number of patients as each person deserve the best condition for hospitalizing."

With the help of donations and different sources of financial aid, DID started to make modifications in patient rooms. At each stage of the construction the professor had asked for the assistance of end users of these modifications. During the construction of new patient rooms, he always collaborated with the

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Case Study 20-1 Smyrna University Hospital Department of Internal Diseases: Finally Walking Side by Side *(continued)*

organizational members, knowing that they were the ones who would work under renewed conditions. For example, for the location, ergonomics, and decoration for nursing centers, he held long discussions with the nurses and modified the existing centers according to the feedback he received from them. Soon after they had started to renovate the patient rooms, the microbiology department complained to the Dean about the modification, accusing the DID of causing infection for hospitalizing patients. The unavoidable fallout of such modifications like the smell and dust, and chemicals such as paints and polishes were impeding the hygiene of the entire building where DID operated. Prof. Dr. Selim stated that, "I am sure that they were all right about their complaints. Although we have taken all the necessary precautions, the dust and the noise spread around had bothered the other departments. Especially the microbiology department was very sensitive to it, as they were operating on the ground floor of our building." The Dean, who considered that the arguments of Prof. Dr. Selim were reasonable, had not taken any legal action about the complaints of the microbiology department, and the renovation continued. This was the very best proof of the administrative support given to Prof. Dr. Selim for his longstanding efforts to transform DID into an enhanced place for both patients and healthcare staff.

The hospital administration assigned additional rooms for DID in the existing building. However, all these rooms needed similar modifications. As mentioned above, due to insufficient financial position, DID had to raise its own funds for the modification of these rooms. This time the required fund was reasonably more than the hospital could support individually, therefore Prof. Dr. Selim had talked to the rector about his ideas and got the permission to take this subject to the Izmir representative of the governing political party. By chance, the Izmir representative was trying to contact Prof. Dr. Selim for a health problem at that time, and he promised to help him; although due to his heavy schedule was not able to head the fundraising drive himself. Prof. Dr. Selim continued to search for other sources of donations and contracted two of Izmir's philanthropic families. Both agreed to help Prof. Dr. Selim and did more than they promised to do at the very beginning of the project. One of these families granted to help him just because Dr. Ali Selim, Prof. Dr. Selim's father, was the person whom the family admired. Prof. Dr. Selim added that "There again I felt the admirable inheritance I took over from my father. Thank god I had those wonderful traces and the powerful shadow of my father in my life." So the modification of patient rooms was finished and ever since then the DID had been operating in two floors with facilities that best suit proper health conditions and the demands of patients.

> . . . then the rooms were ready to meet the proper health conditions. Thus, there was no doubt that we made a successful change! But it was just the beginning and unfortunately the easiest part of an organizational change. I am very sure that all those changes might turn out to be a waste of time, energy, and money if the staff would not appreciate the things done in the department. That was the newest and the most difficult problem of our department that I had experienced. When I acquired the head position I also acquired the team that I have been working with. They were sharing the vision and principles of the previous head and they were far away from adopting my principles and sharing my desire for change.

As stated above by Prof. Dr. Selim, in Turkey, in governmental bodies, when you had acquired a position you also acquired the staff. Thus, the managers were not involved in the decision process of hiring and selecting the people they were going to work with. Rather, they had to work with selected employees before they had been promoted to that position, and furthermore they had to choose among candidates that were sent to them whenever a position must be filled. However, he believed that sustainable development could only be achieved if and only if the new structure of the DID was internalized by all members of the department. So he kept in touch with the organizational members all the time, listened to them, and tried to be a solution partner for problems in DID.

Despite the insufficient HR policies discussed above, the head nurse, Alaz, was his instant counselor and best supporter during those hard days. He vaguely recalled their first meeting with her and how he tested her personality and compatibility with his ethical codes.

> There was no doubt that Alaz was a very young "head nurse"; however, she was the one whom I was looking for. The smile on her face and the light in her eyes gave me an instant impression of an honest personality. Her wide sense of perspective under different circumstances and sense of justice soon justified my first thoughts about her.

Thus the harmony between them had triggered Prof. Dr. Selim to think of transferring daily routine businesses to the control of the head nurse. From then, only strategic projects and/or complex problems related to DID were discussed with the DID's head. DID was no longer a place where "the head orders and the rest obeys." Prof. Dr. Selim said that

> Her existence in the head nurse position made me feel comfortable because from the "director's chair" things might have been blurred or you saw them only from the point that they were shown to you. Soon after I delegated the leading of a reasonable amount of daily routines to Alaz, I realized that by doing this I was both indirectly kept in touch with the nurses and their problems, and caught any detail that may have been missed if I had worked alone. Finally, I have created an organizational climate of my dreams that was very supportive and open to new ideas for better conditions.

Prof. Dr. Selim was not only executing the administrative duties, rather he was a full-time physician and an academician. He carefully considered university education and its major objectives. Education could be achieved through transferring knowledge, encouraging the students by developing their competencies and enlightening the exact nature of attitudes and behaviors. The first two could easily be done by words, but the latter could only be achieved by exemplifying.

The following quotation from the interview proved that Prof. Dr. Selim was the follower of the opinion mentioned above:

> Today we are living in the age of technology, where everybody could easily access knowledge. So, successful educators or managers helped their followers to use the knowledge and transfer it into competencies that distinguished them from others. I have been working very hard to make DID a better place for all stakeholders. We renovated the rooms, redesigned the job descriptions, reorganized the working conditions, and reapplied the rules and principles of the hospital. The best thing about all those changes is that, this team is ready to survive in this new system. Thus if I leave the position today, without any question, they will allow the sustainability of "new DID." This is not because I established a perfect system; rather it is all about the cooperation and coordination. My major role during this great transition was distributing justice and sustaining the fair progress of the change. Today, I am very pleased with the atmosphere we finally achieved. However, I now started to think that there is a life outside the walls of this clinic, which is very precious. I have been devoted myself to DID but doing this caused me to miss the life out there.

Discussion Questions

1. Using the "Lewin's Force Field Analysis," illustrate the change process in DID.
2. Analyze the change process of DID according to the most appropriate model(s) of a "Planned Organizational Change" giving examples from the case.
3. According to John Kotter, there are eight pitfalls to be avoided for the success of a change program. Discuss whether Prof. Dr. Selim made any of these mistakes, supporting your answer with examples from the case.
4. Discuss the leadership practices of the Prof. Dr. Selim during the change process of DID. Which leadership theory (theories) do you think best describe(s) his leadership style?
5. According to the major concerns and definitions of an organizational change process, what may happen to DID if Prof. Dr. Selim is not a candidate in the coming election?

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