THIRD EDITION

Organizational Behavior in HEALTH CARE

Nancy Borkowski



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To my husband

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Preface

In 2005 with the first edition of this book, I wrote, "the U.S. health care industry has grown and changed dramatically over the past twenty-five years." That was an understatement! Since the passing of the Patient Protection and Affordable Care Act of 2010, the industry has experienced some of the most dynamic changes health care managers have seen. In the coming years, more system-wide changes will occur as we continue our push forward to achieve value-based health care. Health care managers are quickly learning that what worked in the past may not work in the future. As such, I was compelled 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 I 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, it employs more than 15 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 my goal that this book will give you a greater understanding of why and how people and groups behave the way they do in the workplace. With this knowledge, you will be able to predict and thus effectively influence the behavior of those you lead. Please let me know if I accomplish my goal! You can reach me at nborkows@uab.edu.

In addition, I tried to ensure that I referenced all the individuals whose work contributed to the development of this book. However, if by chance I failed to give credit to someone along the way, please contact me so I may make the necessary correction.

At this time I wish to acknowledge individuals without whose efforts and

support I would not have been able to complete this book. First, I wish to thank my colleagues and third edition contributors, Jean Gordon, Paul Harvey, Mark Martinko, and Jeff Ritter. Second, I thank my wonderful family for their patience, understanding, and support over the years. Finally, I wish to thank the many wonderful and caring people employed throughout the health care industry that I have had and will have the opportunity to work with. My life continues to be blessed by these dedicated individuals!

Thank you for purchasing (and reading) my book. I welcome your comments and suggestions.

With personal regards,

Nancy M. Borkowski, DBA, CPA, FACHE, FHFMA

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About the Author

Nancy M. Borkowski, DBA, CPA, 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 20 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 a certified public accountant, board certified in health management, and 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 decade, Dr. Borkowski has served in various leadership roles for the 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, 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 Reeves Silver Merit Award from the Healthcare Financial Management Association (2014).

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 deals with attitudes and perceptions, which are the "backbone" to understanding organizational behavior. You will find the terms "attitude" and "perception" frequently referred to within the various organizational behavior theories. Finally, Chapter 4 discusses the importance of communications. Recent surveys revealed that 70 percent of small to mid-size businesses claim that ineffective communication is their primary problem. Sentinel event data from The Joint Commission estimates that communication failure was the root cause of patient harm 70 percent of the time in 2,400 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.

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 difference 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 within an organization 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 meet regularly in the company's lunchroom)?

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. Reproduced by permission.

There are three goals of OB. First, OB attempts to explain why individuals and groups behave the way they do within the organizational setting. 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 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 18 million individuals. The industry will account for almost a third of the nation's projected job growth through 2022, adding almost 5 million jobs. The projected 2.6 percent-per-year growth rate is the fastest among all major service producing sectors (Bureau of Labor Statistics, 2013).

Each segment of the health care industry (e.g., hospitals, home health, rehabilitation facilities) employs 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). As such, today's health care managers need to possess 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 within 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, thus, influence the behavior of employees to achieve

organizational goals.

Given the service-related intensity of the industry, the understanding of individuals' behavior and group dynamics within health service organizations is critical to a health care manager's success. Research indicates that the primary reasons managers fail stem from difficulty in handling change, not being able to work well in teams, and 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. Since readers are probably familiar with most of these changes from either 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 impact tomorrow's health care industry.

Past changes and future trends are interrelating forces that have or will shape tomorrow's health care organizations, whether they occur at the system level or the organizational level. Declining reimbursement and changes in payment schemes for services has 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, along with 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, such as the Health Insurance Portability and Accountability Act of 1996; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; the American Recovery and Reinvestment Act of 2009; and most recently, the Patient Protection and Affordable Care Act of 2010 (ACA). With an increased focus on chronic disease management, patients are living longer and are 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, as such, have increasingly higher expectations of health care professionals. This trend has changed the way health care services are delivered, with a focus on patient satisfaction and safety, as well as on quality of services. Physician–patient relationships have changed because patients are beginning to understand that much of the responsibility for wellness lies with them. The economics of health care is 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. There are changes 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 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 that contributes to the overuse and misuse of hospital emergency departments.

To deal with these changes, we have seen a number of health care organizations restructure 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 there were numerous hospital acquisitions 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. In addition, not-for-profit hospitals have merged with for-profit health systems as a result of competition and the need to reduce cost by 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 been required to change the way they and other employees carry out their job responsibilities. These changes have been forced upon 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. 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 maximize their ability to motivate staff and lead their organizations effectively.

HISTORY OF ORGANIZATIONAL BEHAVIOR

The beginnings of OB can be found within 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 discussed a concern for workers within 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. There were four phases to the Hawthorne Studies: the illumination experiments, the relay-assembly group experiments, the interviewing program, and the bank-wiring observation-room group studies. 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 by 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, it 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 five years. During the first part of the experiment, the working conditions of employees 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 their 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 previous high level (when they had 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 their productivity and group dynamics could be studied. The workers were paid with 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 such, 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 his 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 that 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 upon (1) the personal social conditioning (values, hopes, fears, expectations, etc.) they brought to the workplace, formed from their previous family or group associations, and (2) the human satisfaction 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. In addition, 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 or 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), but in modern society those needs were mostly satisfied and thus no longer acted as a motivator 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 of 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 behavior was nothing more than self-fulfilling prophesies. The manager's assumptions caused the staff's "unmotivated" behavior.

However, at the opposite end of the spectrum from Theory X, McGregor proposed Theory Y, where managers created opportunities, removed obstacles, and encouraged growth and learning for their employees. McGregor stated that participative or Theory Y managers supported decentralization and delegation of decision making, job enlargement, and participative management because they allowed employees degrees of freedom to direct their own activities and to assume responsibility, thereby satisfying their higher-level needs (see **Figure 1–1**).

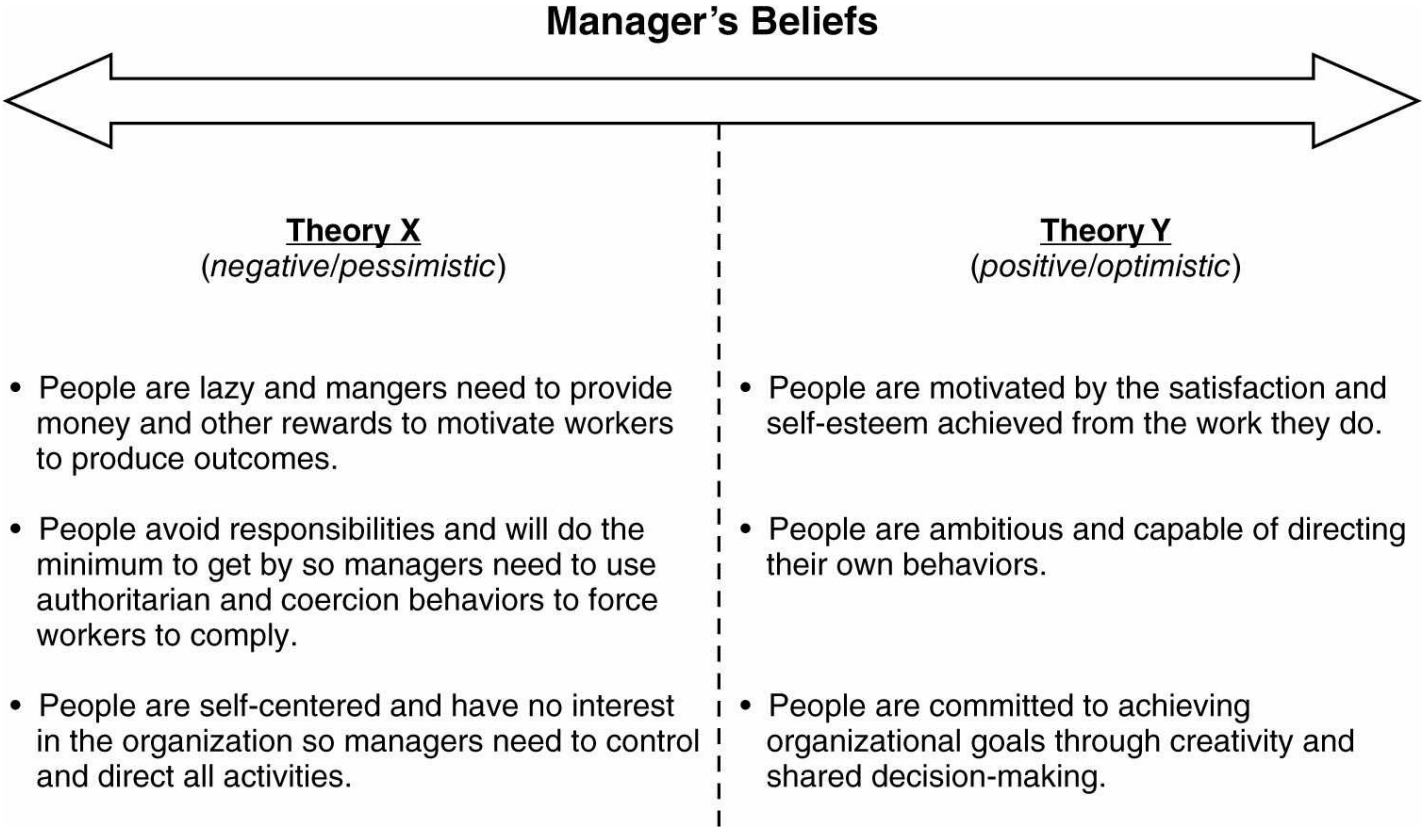

Figure 1–1 McGregor X-Y Theory Diagram

SUMMARY

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 teambuilding. Part VI provides an overview of managing organizational change within the context of organizational development.

Before we conclude this chapter, I 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 noted previously, 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 so forth for personnel management and is usually housed in a functional unit within organizations.

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.

X-Y THEORY QUESTIONNAIRE

What Do You Know About Organizational Behavior?

Question	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, and therefore we do not currently have ways to measure an employee's attitude about their jobs.	_____
4. Extroverts do best in quiet, non-social 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 towards 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 the behavior may be influenced, if necessary.	_____
8. An employee's degree of job satisfaction is proportionate to the actual amount of rewards he or she 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 oppositional.	_____
15. Due to stress being a complex and highly personalized	

process, some individuals see a specific situation as a threat, whereas other individuals 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 needs. _____
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. True
8. True
9. False
10. True
11. False
12. True
13. True
14. False
15. False
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 only represent a very small part of organizational behavior. If you didn't score high – don't be concern. 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.

REFERENCES

Benjamin, M. (2003, February 24). Fads for any and all eras. *U.S. News & World Report*, 134, 74–75.

Bureau of Labor Statistics, U.S. Department of Labor. (2013). Industry employment and output projections to 2022. Available at: www.bls.gov/opub/mlr/2013/article/industry-employment-and-output-projections-to-2022.htm

Daft, R. L. (2004). *Organization theory and design* (8th ed.). Mason, OH: Thomson South-Western.

Homans, G. C. (1950). *The human group*. New York, NY: Harcourt, Brace and Company.

McGregor, D. M. (1957). The human side of enterprise. *Management Review*, 46, 22–28.

McGregor, D. M. (1960). *The human side of enterprise*. New York, NY: McGraw-Hill Book Company.

Ott, J. S. (1996). *Classic readings in organizational behavior* (2nd ed.). Albany, NY: Wadsworth Publishing Company.

Roethlisberger, F. J., & Dickson, W. J. (1939). *Management and the worker*. Cambridge, MA: Harvard University Press.

Taylor, F. W. (1911). *The principles of scientific management*. New York, NY: Harper and Brothers.

Diversity and Cultural Competency in Health Care

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LEARNING OUTCOMES

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

- Define diversity.
- Define cultural competency.
- Define diversity management.
- Understand why changes in U.S. demographics affect the health care industry.

OVERVIEW

Demographics of the U.S. population have changed dramatically in the past three decades. These changes directly impact the health care industry in regard to the patients we serve and our workforce. By 2050, the term "minority" will take on a new meaning. According to the U.S. Census Bureau, by midcentury the white, non-Hispanic population will comprise less than 50 percent of the nation's population. As such, the health care industry needs to change and adopt new ways to meet the diverse needs of our current and future patients and employees.

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) provided us with a more specific definition of diversity. She defined 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). For our discussions, we will focus on the following diversity characteristics: (1)

race/ethnicity, (2) age, and (3) gender.

This chapter is presented in three parts. First, we discuss the changing demographics of the nation's population. Second, we examine how these changes are affecting the delivery of health services from both the patient's and 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 how these changes will affect the health services workforce, and more specifically the current and future leadership within the industry.

CHANGING UNITED STATES POPULATION

There is no doubt that the demographic profile of the U.S. population has undergone significant changes within the past 10 years regarding age, gender, and ethnicity (see **Table 2–1**).

Table 2–1 Population of the United States by Age, Gender, and Race/Ethnicity[a]

	2000		*2010*	
	Number	*Percent*	*Number*	*Percent*
Total population	281,421,906	100.0	308,745,538	100.0
Under age 19	80,473,255	25.7	83,267,556	26.9
Ages 19 to 64	165,956,888	61.9	185,209,998	60.0
Ages 65 and over	34,991,753	12.4	40,267,984	13.0
Males	138,053,563	49.1	151,781,326	49.2
Females	142,368,343	50.9	156,964,212	50.8
White	211,460,626	75.1	196,817,552	63.7
Black	34,658,190	12.3	37,685,848	12.2
Hispanic	35,305,818	12.5	50,477,594	16.3
Asian	10,242,998	3.6	14,465,124	4.7
American Indian	2,475,956	0.9	2,247,098	0.7
Some other race	15,359,073	0.5	1,085,841	0.1
Two or more races	6,826,228	0.2	5,966,481	0.2

[a]Percentages do not add up to 100 percent due to rounding and because Hispanics may be of any race and are therefore counted under more than one category.

Data from U.S. Census Bureau, 2010 Census. DP-1 - United States: Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data: U.S. Census Bureau 2000 Census Data as shown in the 2009 Population Estimates table; U.S. Census Bureau: National Population Estimates; Decennial Census.

Data from the 2010 Census provide insights to our racially and ethnically diverse nation (Humes, Jones, & Ramirez, 2011). According to the 2010 Census, 308.7 million people resided in the United States on April 1, 2010—an increase of 27.3 million people, or 9.7 percent, between 2000 and 2010. The vast majority of the growth in the total population came from increases in those who reported their race(s) as something other than White alone and those who reported their ethnicity as Hispanic or Latino. For the first time in the 2000 Census, individuals were presented with the option to self-identify with more than one race, and this continued with the 2010 Census. Using the five race categories (White, Black/African American, American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islander) required by federal agencies, there are 57 possible multiple race combinations that could have been selected by individuals in addition to "some other race." In fact, over 7 million or 2 percent of the U.S. population did so in the 2010 Census by identifying with and choosing "some other race" or "two or more races." It is predicted that the number of Americans reporting themselves or their children as multiracial will increase in the future. In addition to the changing ethnic and racial composition of America, another issue is the aging population. According to the 2010 Census, 40 million people (13 percent of the U.S. population) are 65 years of age or older. This is 12.3 million more people than in 2000 (see **Figure 2–1**).

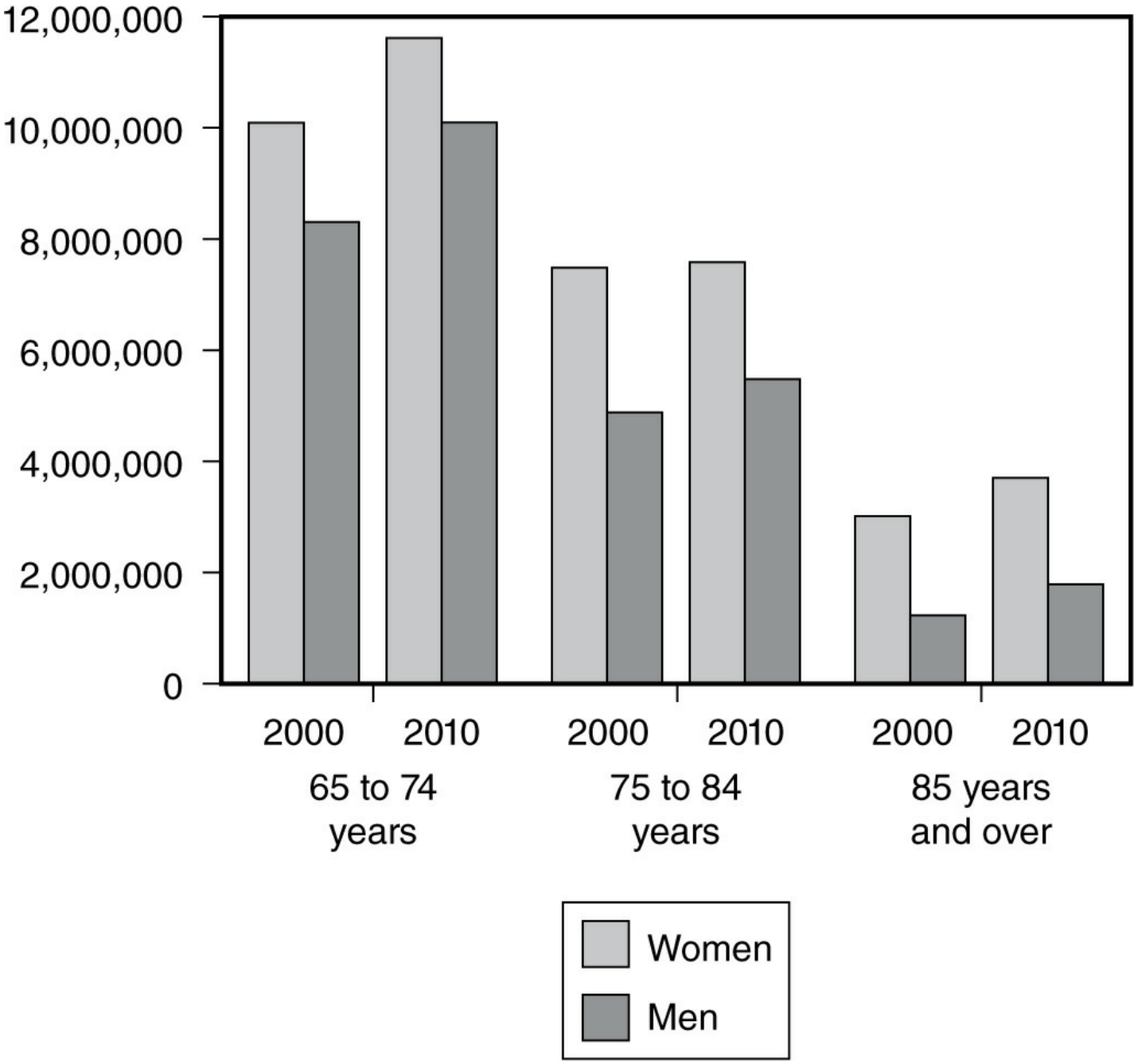

Figure 2–1 Population 65 Years and Over by Age and Sex, 2000 and 2010 (numbers in thousands)

Data from U.S. Census Bureau, 2010 Census. DP-1 - United States: Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data: U.S. Census Bureau 2000 Census Data as shown in the 2009 Population Estimates table.

During the past decade, the population aged 65 and over grew at a faster rate (15.1 percent) than the population under age 45. This trend was expected as the Baby Boomers (those born between 1946 and 1964) began reaching age 65 in 2011 (see **Figure 2–2**).

In addition to the increasingly older population, there is a declining

number of young people in America. From 1940 to 2010, the percentage of the American population under the age of 18 fell from 31 percent to 24 percent (U.S. Census Bureau, 2012). This decline in America's younger population will have a direct effect on the industry's ability to recruit health care professionals to provide sufficient services in the future. Young people of all ethnicities must be attracted to the health care industry as a career choice in order to meet the health care needs of the country's growing population.

Males and females are almost evenly divided for the total population, representing 49.2 percent and 50.8 percent, respectively; however, in the population under 25 years, males dominate females, with 105 males for every 100 females. Among older adults, the male–female ratio reverses, with women outnumbering men. However, there was an interesting change in the male–female ratios for the population aged 60 and older between 2000 and 2010 (Howden & Meyer, 2011). A greater increase in the male population relative to the female population for these age groups was noted. Males aged 60 to 74 increased by 35.2 percent, while their female counterparts increased by 29.2 percent. A narrowing of the mortality gap between men and women at older ages in part accounts for this difference.

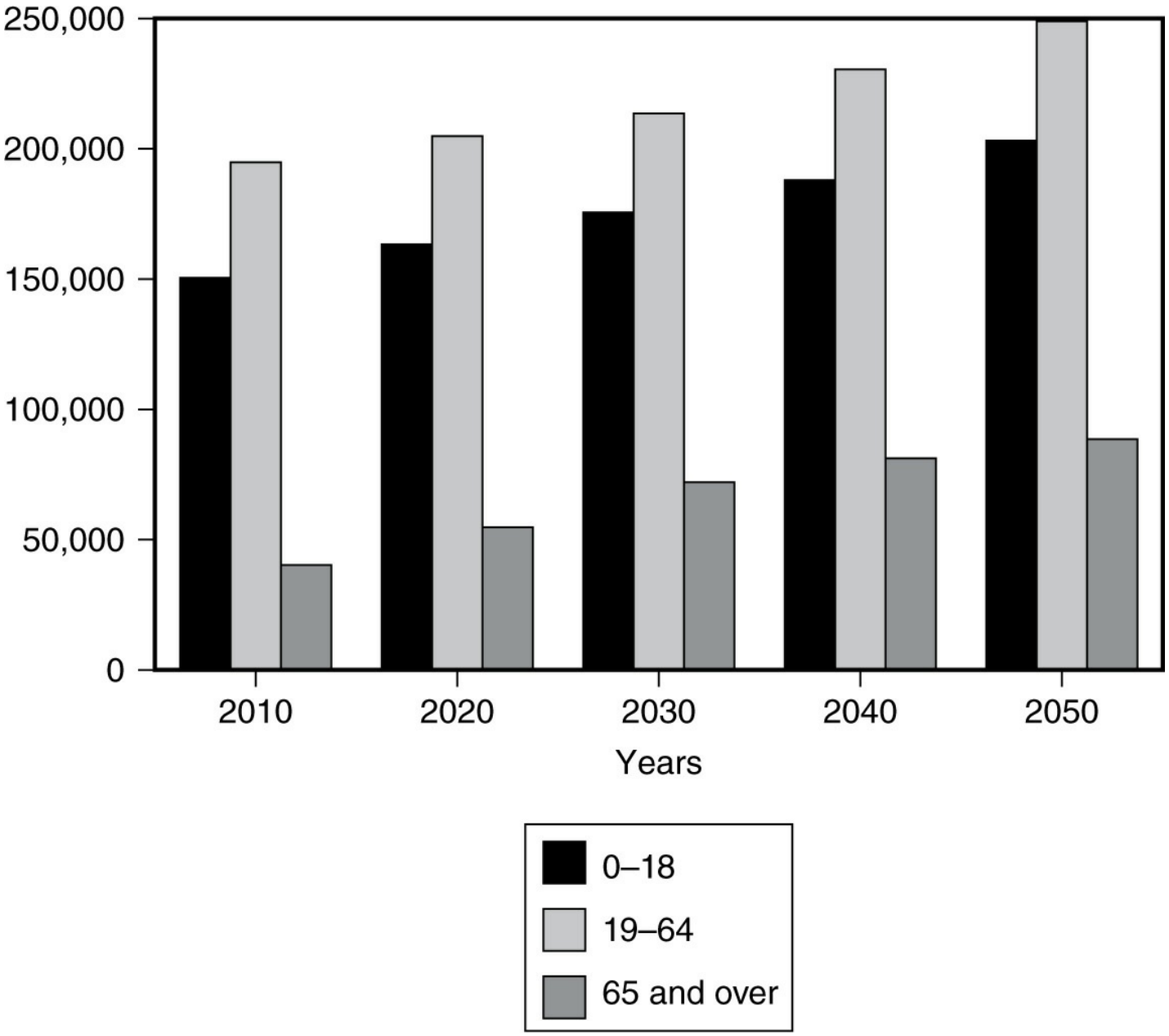

Figure 2–2 Projected Population of the United States by Age, 2000–2050 (Numbers in thousands)

Data from Population Division, U.S. Census Bureau.

Race/Ethnicity

The U.S. population has continued to diversify during the past 10 years, as minority populations continue to increase at a faster rate than the White population. Although the White population still represents the largest group (63.7 percent) of the U.S. population, this is down from 75.1 percent in 2000 (see **Table 2–1**).

In 2010, the Hispanic population represented the largest minority in the United States, 16.3 percent of the population. This is up from 4.5 percent in

1970, the first census in which Hispanic origin was identified. The remaining population is composed of 12 percent Black, 5 percent Asian and Pacific Islanders, 1 percent American Indians and Alaska Natives, and 3 percent those who identified 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 those people who identified themselves as being Asian (either alone or in combination with another race) grew 43.3 percent, while the total population grew only 9.7 percent (see Table 2–1)

Aging Population

The world's population is aging. According to the United Nations (2013), slow population growth brought about by reductions in fertility leads to population aging; that is, it produces populations where the proportion of older persons increases while that of younger persons decreases. Globally, the number of persons aged 60 and over is expected to more than triple by 2100, which will represent 34 percent of the world's population, or more than 3 billion individuals. Of this group, the number of persons aged 80 and over is projected to increase almost sevenfold by 2100, representing just under one-third of the world's population aged 60 and over.

The United States is experiencing the same as the world's aging population. As reported by Howden and Meyer (2011), the 2010 Census reflects that the number of people under age 18 was 74.2 million (24.0 percent of the total population). The younger working-age population, ages 18 to 44, represented 112.8 million persons (36.5 percent). The older working-age population, ages 45 to 64, made up 81.5 million persons (26.4 percent). Finally, the 65 and over population was 40.3 million persons (13.0 percent). Between 2000 and 2010, the population under the age of 18 grew at a rate of 2.6 percent. The growth rate was even slower for those aged 18 to 44 (0.6 percent). On the opposite side, the country is experiencing substantially faster growth rates for older ages. For example, the population aged 45 to 64 grew at a rate of 31.5 percent. The large growth in this age group is primarily attributable to the aging of the Baby Boom population. As noted previously, the growth rate (15.1 percent) of the 65 and over population was faster than the population under age 45.

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 for men and

women, where women tend to live longer than men. As such, there are more females then males at older ages. However, over the past decade an increase in the male population relative to the female population has been noted. For example, in 2010, there were 96.7 males per 100 females, representing an increase from 2000, when the ratio was 96.3 males per 100 females (Howden & Meyer, 2011). This lowering of male mortality may be attributible to technological advances, more preventive screening, and healthier lifestyles.

While the elderly population is not as racially and ethnically diverse as the younger generations, it is projected to increase in its racial and ethnical makeup over the next four decades. As in the past, the highest proportion of the U.S. population aged 60 and over is White (78.8 percent). However, within the racial composition of the older population, White is projected to decrease by 10 percent by 2050, and all other race groups will increase in their own populations. This change is already being seen. In 2000, the aged White population was 82.5 percent, a 7 percent decrease compared with 2010. The remaining makeup of this population group is 8.8 percent Black, 7.3 percent Hispanic, and 3.6 percent Asian, with other races forming the remainder. As noted, this population group's racial composition will continue to change over the next 40 years.

Gender

As previously noted, according to the U.S. Census Bureau, in 2010, 50.8 percent of the U.S. population was female, and 49.2 percent was male—almost identical to 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 25 in 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. For men and women aged 25 to 54, the number of men for each 100 women in 2010 was 99. Among older adults, the male–female ratio continued to fall as women increasingly outnumbered men. For people 55 to 64, the male–female ratio was 93 to 100, but for those 85 and older, there were only 48 men for every 100 women. These male–female ratios reflect a new trend that has been occurring since 1980. From 1900 to 1940, there were more males. Beginning in 1950, there were increasingly more females due to reduced female mortality rates. This trend reversed between 1980 and 1990 as male death rates declined faster than female rates and as more men

immigrated to the United States than women (United States Department of Commerce, 2003).

When we look at education, it appears that females are outpacing men. Among the population aged 25 and older, 88 percent of both men and women were high school graduates. But of this group, 39 percent of men had graduated from college, as compared with 61 percent of women. However, even with college degrees, only a high minority (44 percent) of women are employed in management or professional positions.

Exhibit 2–1 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:

- *Individualism–Collectivism*: Individualism–collectivism measures culture along a self-interest versus group-interest scale. 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 large Power Distance societies accept hierarchical order in which everybody has a place, which needs no further justification. People in small Power Distance societies 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 one in which the society creates institutions to create security and minimize risk. Strong Uncertainty Avoidance societies maintain rigid codes of belief and behavior and are intolerant toward deviant personalities and ideas.
- *Weak Uncertainty*: Avoidance societies 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 ones 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. Therefore, the resultant behavior emphasizes the issue avoidance or the importance of planned and well-managed activities. Other countries, such as Sweden, Canada, and the United States, are able to tolerate change because of the potential for new opportunities that may come with change.

The question 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 1,800 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 et al., 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.

IMPLICATIONS FOR THE HEALTH CARE INDUSTRY

The changing demographics of America's population affect the health care industry twofold. 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, cultural competence 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 2–1**). Linguistic competence 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 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." (United States Department of Health and Human Services, 2013).

Second, 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 it serves, both clinically and managerially. As noted by Weech-Maldonado et al. (2002), 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.

DIVERSITY ISSUES WITHIN THE CLINICAL SETTING

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 came 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 she'd get through this fine. The young interpreter translated, "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!"

These may seem rather humorous misunderstandings, but real-life experiences such as these happen every day in the United States (Howard, Andrade, & Byrd, 2001). For example, 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 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 percent versus 16 percent) 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 percent of black non-Hispanics experience similar communication difficulties.

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 her 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 that only recognized the scientific necessities, but ignored their personal belief 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 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.

Because of our increasingly diverse population, health care professionals need to be concerned about their cultural competency, which is more than just cultural awareness or sensitivity. Although formal cultural training has been found to improve the cultural competence of health care practitioners, Kundhal (2003) reported that only 8 percent of U.S. medical schools and no Canadian medical schools had formal courses on cultural issues. However, changes are occurring within the industry (see **Exhibit 2–2**) to assist health care practitioners in the developing of their cultural competences as they encounter more diverse patients. For example, in 2000 the Liaison Committee on Medical 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 competence 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).

Exhibit 2–2 Unequal Treatment

A study in 2002 by the Institute of Medicine, entitled *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 U.S. racial and ethnic minorities receive even fewer routine medical procedures and experience a lower quality of health services than the majority of the population. For example, 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 receive 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.

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 under-served populations, has also 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 World's 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 because:

1. Racial and minority health care professionals 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, racial and ethnic minority patients 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 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 quality health care by diverse populations. In 2013, these standards were expanded to reflect the growth in the field of cultural and linguistic competency. 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

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

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as

interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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

Another diversity area that has shown progress since 2007 is the use of the Healthcare Equality Index (HEI) of the Human Rights Campaign (HRC) Foundation by hospitals and other organizations. This survey is a resource for health care organizations seeking to provide equitable, inclusive care to lesbian, gay, bisexual, and transgender (LGBT) Americans—and for LGBT Americans seeking health care organizations with a demonstrated commitment to their care (HRC, 2014). In 2013, facilities in all 50 states and most U.S. veterans hospitals participated in using the HEI, with 93 percent and 87 percent reporting that sexual orientation and gender identity were included in their patient nondiscrimination policies, respectively. 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 gender identity. Furthermore, 96 percent and 85 percent of participants reported that sexual orientation and gender identity, respectively, were also included in their employment nondiscrimination policies. 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. 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.

AGING POPULATION

In addition to the changing ethnic and racial composition of America, another area of concern is the growing elderly population. Technology has given us the ability to enhance longevity; the challenge now is whether or not the health care profession can learn how to best serve this growing population of patients.

Table 2–2 Health Care Equality Index's Core Four Leader Criteria

Criteria	
Patient Nondiscrimination	a. Patient nondiscrimination policy (or patients' bill of rights) includes the terms "sexual orientation" and "gender identity" b. LGBT-inclusive patient nondiscrimination policy is communicated to patients in at least two documented ways
Equal Visitation	a. Visitation policy explicitly grants equal visitation to LGBT patients and their visitors b. Equal visitation policy is communicated to patients in at least two documented ways
Employment Nondiscrimination	Employment nondiscrimination policy (or equal employment opportunity policy) includes the terms "sexual orientation" and "gender identity"
Training in LGBT Patient-Centered Care	Staff receive training in LGBT patient-centered care

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As our citizens grow older, more services are required for the treatment and management of both acute and chronic health conditions. The profession must devise strategies for caring for the 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 American 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, M.D., a pioneer in geriatric medicine and a founding director of the National Institute on Aging (NIA). Butler 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."

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 three-year residency training programs, only 9 percent required six weeks or more of training. As in 2002, the residency programs continue to depend on nursing home facilities, geriatric preceptors in nongeriatric 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 continue 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, due to 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 re-hospitalizations, and improved care coordination, as well as annual screening for cognitive impairment, will assist with changing attitudes toward elderly patients.

Before moving to our next discussion regarding diversity management, 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 (RWJF, 2014). These quality measures are the first endorsed by NQF that specifically address health care disparities and cultural competency.

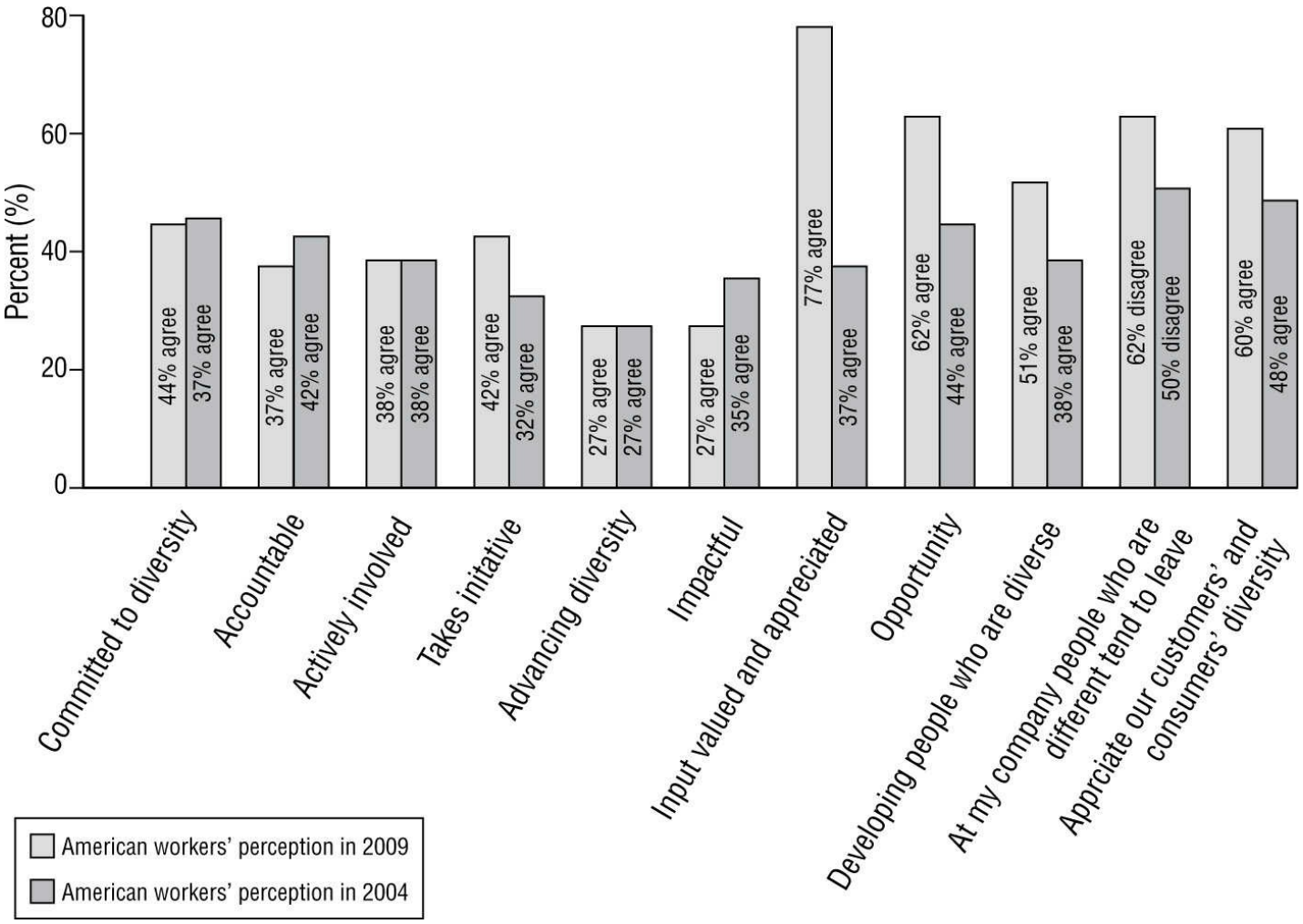
DIVERSITY MANAGEMENT

Diversity management is a challenge to 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 et al., 2002). In 2004, the National Urban League published its first study on employees' perceptions regarding the effectiveness of their companies' diversity programs. The results of the organization's 2009 follow-up survey found that progress has been made over the past five years in certain areas. However, leadership commitment to diversity and companies clearly communicating their platform on how they value diversity are still lagging (see **Table 2–3**).

As reflected in Table 2–3, 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 the American worker. As reported by the National Urban League (2009), 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 regard to increasing diversity in the field of health care management, recent studies continue to 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 that was disclosed in a 1992 study that minorities held less than 1 percent of top management positions within 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 percent of health care workers in six Midwest hospitals felt that their institutions had a program to improve employee skills in dealing with people of different cultures, and only 38.9 percent felt 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 with employing diversity management practices, and equal employment requirements were the main driver of diversity management policy. Five years later, Weech-Maldonado and colleagues (Weech-Maldonado, Elliott, Schiller, Hall, Dreachslin, & Hays, 2007; Weech-Maldonado, Elliott, Schiller, Hall, & Hays, 2007) continued to find low levels of diversity management activity within California hospitals. Since that time, the Institute for Diversity in Health Management, in collaboration with other organizations, 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.

Table 2–3 American Workers' Perception



Data from National Urban League. Diversity Practices That Work: The American Worker Speaks II, 2009 Highlights.

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 2009 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 completed in 1992, 1997, and 2002. The study, completed in 2008, was based on a random-sample survey of 1,515 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 2–4**).

Although the results of the 1997 study reflected improvements in

diversity over the 1992 study (see: www.ache.org—Race and Ethnic Study 2002), the 2002 and 2008 results indicated that the health care industry did not do as well in promoting minorities and women in chief executive officer (CEO) and chief operating officer (COO)/senior vice president positions. In the 2008 ACHE study, as noted by the authors of the study (p. 12) and reflected in **Tables 2–4** and **2–5**, 34 percent of CEOs are white men, compared to 28 percent of them being Hispanic men, 16 percent black men, and 5 percent Asian men. However, these disparities are not apparent among women, where all racial/ethnic groups hold between 10 and 13 percent of CEO positions. When all senior executive positions are considered, including chief executive officer and chief operating officer/senior vice president, the proportion of white men in such positions continues to exceed that of minority men. However, among women, a higher proportion of Hispanic women than others are in senior executive positions. The two factors of race/ethnicity and gender are evident especially when comparing blacks and whites. For both blacks and whites, only about half as many women attained CEO or COO/senior vice president posts as their male counterparts.

In the 2013–2014 Benchmarking Survey by the Institute of Diversity, the results highlighted that while 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 percent of hospital board members (unchanged from 2011)
- 12 percent of executive leadership positions (unchanged from 12 percent in 2011)
- 17 percent of first- and mid-level management positions (up from 15 percent in 2011)

Table 2–4 American College of Healthcare Executives 2008 Diversity Study

Population, Sample, and Response Rates

	2002					2008			
	Black	*White*	*Hispanic*	*Asian*	*Native American*	*Black*	*White*	*Hispanic*	*Asian*
Population	2,033	13,601	449	240	153	2,761	16,929	650	586
Sample	1,573	1,608	449	24	153	1,554	1,602	633	582
Response	779	215	118	68		492	654	250	237
Response Rate (%)	33.4	48.4	47.9	49.2	44.4	31.7	40.8	39.5	40.7
Analyzed	742	204	114	64		436	641	219	219
Males	359	125	65	37		205	321	130	119
%	44.7	48.4	61.3	57	57.8	47	50	59	54
Females	383	79	49	27		231	320	89	100
%	55.3	51.6	38.7	43	42.2	53	50	41	46

SOURCE: American College of Healthcare Executives. Reprinted with permission.

Table 2–4 American College of Healthcare Executives 2008 Diversity Study

Position by Race/Ethnicity and Year (Males)[a]

	2002					2008			
	Black	*White*	*Hispanic*	*Asian*	*Native American*	*Black*	*White*	*Hispanic*	*Asian*
CEO	19%	37%	23%	11%	32%	16%	34%	28%	5%
COO/Senior Vice President	25	25	24	23	14	23	22	15	17
Vice President	24	19	23	20	16	20	22	20	19
Department Head	22	10	20	31	30	27	14	22	31
Department Staff/ Other	11	9	10	15	8	13	7	15	29
	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(216)	(355)	(123)	(65)	(37)	(205)	(321)	(130)	(118)

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

Table 2–5 American College of Healthcare Executives 2008 Diversity Study

Position by Race/Ethnicity and Year (Females)[a]

	2002					2008			
	Black	*White*	*Hispanic*	*Asian*	*Native American*	*Black*	*White*	*Hispanic*	*Asian*
CEO	11%	13%	9%	9%	12%	10%	13%	12%	10%
COO/Senior Vice President	15	27	16	15	16	10	18	25	11
Vice President	19	28	24	17	8	16	26	12	18
Department Head	39	19	32	34	44	39	25	27	25
Department Staff/ Other	17	14	20	26	20	25	17	23	35
	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(266)	(381)	(76)	(47)	(25)	(231)	(320)	(89)	(99)

[a] Responses may not total to 100 because of rounding.
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Dreachslin and Curtis (2004) noted that career advancement of women and racially/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/ethnically diverse individuals: (1) leadership and strategic orientation (i.e., senior management's commitment to successful implementation of diversity initiatives), (2) organizational culture/climate (i.e., the depth and breadth of the organization's strategic commitment to diversity leadership and cultural competence), and (3) human resources practices (i.e., establishing best practices in advancing the management careers of women and racially/ethnically diverse individuals, such as formal mentoring programs, professional development, work/life balances, and flexible benefits).

On the basis of Dreachslin's and others' research, the NCHL, ACHE, IFD, and the American Hospital Association developed the Diversity and Cultural Proficiency Assessment Tool for Leaders (see **Exhibit 2–3**). 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 competence to enable their organizations to develop competent interventions, thereby improving the quality of health care (Betancourt, Green, & Carrillo, 2002).

Exhibit 2–3 A Diversity and Cultural Proficiency 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? _____ _____
- When your hospital partners with other organizations for community health initiatives or sponsors community events, do you have a strategy in place to be certain you work with organizations that relate to the diversity of your community? _____ _____
- As a purchaser of goods and services in the community, does your hospital have a strategy to ensure that businesses in the minority community have an opportunity to serve you? _____ _____
- Are your public communications, community reports, advertisements, health education materials, websites, etc. accessible to and reflective of the diverse community you serve? _____ _____

Culturally Proficient Patient Care

- Do you regularly monitor the racial and ethnic diversity of the patients you serve? _____ _____
- Do your organization's internal and external communications stress your commitment to culturally proficient care and give concrete examples of what you are doing? _____ _____
- Do your patient satisfaction surveys take into account the diversity of your patients? _____ _____
- 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 review of quality assurance data take into account the diversity of your patients in order to detect and eliminate disparities? _____ _____
- Has your hospital developed a "language resource," identifying qualified people inside and outside your organization who could help your staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds? _____ _____
- 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 the racial and ethnic minorities in your community? _____ _____
- 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? _____ _____

- Have you made diversity awareness and sensitivity training available to your employees? _____ _____
- 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? _____ _____

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 you designated a high-ranking member of your staff to be responsible for coordinating and implementing your diversity strategy? _____ _____
- 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? _____ _____

© Used with permission of the American Hospital Association. Strategies for Leadership: a Diversity and Cultural Proficiency Assessment Tool for Leaders. 2004. http://www.aha.org/aha/content/2004/pdf/diversitytool.pdf

In order 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 is dependent upon the following factors: organizational culture, human resource practices, and strategy. In other words, the impact of diversity is directly related to the organization's ability to walk their talk and can have a negative impact if not followed. For example, the Witt/Kieffer's 2011 national survey of 454 health care professionals, with 54 percent representing senior executives, provides a deeper understanding of how diversity is connected to measurable business benefits:

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

Dreachslin (2007) reinforces the need for mass customization of diversity practices to be inclusive of disparities that are represented within 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 into 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) reinforces the need for senior staff to "manage" diversity and invest in professional development so that team members have the tools they need to navigate their differences. As Dreachslin notes, "if left unmanaged, demographic diversity will interfere with team functioning." Managers need to provide employees with training to enhance their conflict-management skills, self-awareness, understanding of cultural differences, and methods to effectively manage bias.

THE FUTURE WORKFORCE

For the first time in modern history, our workforce consists of four separate generations working side by side—and the differences among them 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.”

Adapted from Stokowski, L. A. (2013). The 4-generation gap in nursing. Medscape. Available at: www.medscape.com/viewarticle/781752

These different reponses are typical of the four different generations of nurses currently working side by side at the bedside. The first response was 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, those born between 1943 and 1960 who are viewed as optimistic, productive, and workaholics. The third response is from Generation X, born between 1961 and 1981, typically referred to as cynical, independent, and informal. The fourth response is reflective of the Millennial generational cohort, born between 1982 and 2000, which is viewed as confident, inpatient, and social. Becton, Walker, and Jones-Farmer (2014) point out that although much has been written about their differences, there still remains a gap in our understanding of each generational cohort’s values and beliefs. As such, generational differences may best be explained by “age, life stage, or career stage effects” (Becton, Walker, & Farmer, 2014, p. 176).

As part of diversity management, health care managers need to devise strategies for attracting younger workers to enter 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? Although this generational cohort has only recently begun to enter the workforce, Millennials will be the fastest-growing segment of the working population—they grew from 14 percent of the workforce to 21 percent over the past four years, to nearly 32 million workers (Armour, 2005). Although it is impossible to generalize about the wants and needs of millions of people in each generation, workplace experts tend to use the following characteristics to describe the 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 they can build up ownership of tasks.

In addition to the younger workers, 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 seeking to recruit and retain older nurses need to implement 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).

SUMMARY

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.

Similarly, 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 competence 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. Discuss what the term "diversity" means.
2. Explain the meaning of cultural competency.
3. What do we mean when we say "diversity management"?
4. Explain why and how changes in U.S. demographics affect the health care industry.

EXERCISE 2–1

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 percent level to 40 percent over the next five years. How does your task force define diversity? What recommendations would you make as a member of the task force?

EXERCISE 2–2

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 2–3

Visit the Hofstede Centre (http://geert-hofstede.com/countries.html) and review the scores by country for the various cultural dimensions that Hofstede identified. In light of these scores, think about some interactions you've had with people (colleagues, patients, friends, etc.) born and raised in other countries. Do your interactions make more sense given this newly found insight?

EXERCISE 2–4

View the video titled *Improving Patient-Provider Communication: Joint Commission Standards and Federal Laws* at www.jointcommission.org/multimedia/improving-patient-provider-communication---part-1-of-4/. The video was a joint project of The Joint Commission and the U.S. Department of Health & Human Services (HHS) Office for Civil Rights to support language access in health care organizations.

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. What recommendations would you make as a member of the task force?

EXERCISE 2–5

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 men and women 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 2–6

In April 2013, *Modern Healthcare* published its fourth biennial recognition of the Top 25 Women in Healthcare. The previous lists appeared in 2005, 2007, and 2009 and can be found on ModernHealthcare.com under "Recognitions." In small groups, discuss the changes (if any) over the past nine years of the selected awardees population (i.e., employed in what sectors of the health industry, what positions do/did they hold, race/ethnicity groups, and so on).

REFERENCES

Alliance for Aging Research. (2003). Ageism: How healthcare fails the elderly. Available at: www.agingresearch.org

American College of Healthcare Executives. (2008). A race/ethnic comparison of career attainments in healthcare management, Summary Report—2008. Available at: www.ache.org

American Nurses Association, Cultural Diversity in Nursing Practice, 1991. www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/prtetcldv14444.html

Armour, S. (2005, November 6). Generation Y: They arrived at work with an attitude. *USA Today*. Available at: www.usatoday.com/money/workplace/2005–11-06-gen-y_x.htm

Association of American Medical Colleges. (2005). Cultural competence education. Available at: www.aamc.org/download/54338/data/culturalcomped.pdf

Barney, S. M. (2002). A changing workforce calls for twenty-first century strategies. *Journal of Healthcare Management, 47*(2), 61–65.

Beach, M. C., Saha, S., & Cooper, L. A. (2006). The role and relationship of cultural competence and patient-centeredness in health care quality. The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/fund-reports/2006/oct/the-role-and-relationship-of-cultural-competence-and-patient-centeredness-in-health-care-quality

Becton, J. B., Walker, H. J., & Jones-Farmer, A. (2014). Generational differences in workplace behavior. *Journal of Applied Social Psychology, 44*(3), 175–189.

Betancourt, J., Green, A. R., & Carrillo, E. (2002). Cultural competence in health care: Emerging frameworks and practical approaches. The Commonwealth Fund. Available at: www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.section=4039

Bowling, A. (2007). Honour your father and mother: Ageism in medicine. *British Journal of General Practice, 57*(538), 347–348.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic racial health disparities? A review and conceptual model. *Medical Care Review, 57*(Suppl. 1), 181–217.

Butler, R. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9*, 243–246.

Ceijka Search and Solucient, LLC. (2005). Hospital CEO Leadership Survey. St. Louis, MO: Ceijka Search and Solucient, LLC.

Clipper, B. (2012). *The nurse manager's guide to an intergenerational workforce*. Indianapolis, IN: Sigma Theta Tau International.

Commonwealth Fund. (2002). International health policy survey of adults with health problems. Available at: www.cmwf.org

Commonwealth Fund. (2003). Worlds apart: A film series on cross-cultural health care. Available at: www.cmwf.org

Dobson, E. (2012). Setting the stage for a business case for leadership diversity in healthcare: history, research, and leverage. *Journal of Healthcare Management, 57*(1), 35–46.

Dreachslin, J. L. (1998). Conducting effective focus groups in the context of diversity: Theoretical underpinnings and practical implications. *Qualitative Health Research, 8*(6), 813–820.

Dreachslin, J. L. (2007). Diversity management and cultural competence: Research, practice and the business case. *Journal of Healthcare Management, 52*(2), 79–86.

Dreachslin, J. L., & Curtis, E. F. (2004). Study of factors affecting the

career advancement of women and racially/ethnically diverse individuals in healthcare management. *Journal of Health Administration Education, 21*(4), 441–484.

Fadiman, A. (1998). *The spirit catches you and you fall down*. New York, NY: Farrar, Straus and Giroux.

Goode, T. & Jones, W. (2004). Increasing awareness and implementation of cultural competence principles in health professions education. *Journal of Allied Health, 29*(4), 241–245.

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

Hatcher, B., Bleich, M. R., Connolly, C., Davis, K., O'Neill Hewlett, P., & Stokley Hill, K. (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace*. Princeton, NJ: The Robert Wood Johnson Foundation. Available at: www.rwjf.org/files/publications/other/wisdomatwork.pdf

Hofstede, G. (1983). The cultural relativity of organizational practices and theories. *Journal of International Business Studies, 14*(2), 75–89.

Hofstede, G. (1991). *Cultures and Organizations: Software of the Mind*. London, UK: McGraw-Hill.

Hofstede, G., Van Deusen, C. A., Mueller, C. B., & Charles, T. A. (2002). What goals do business leaders pursue? A study in fifteen countries. *Journal of International Business Studies, 33*(4), 785–803.

Howard, C., Andrade, S. J., & Byrd, T. (2001). The ethical dimensions of cultural competence in border healthcare settings. *Family and Community Health, 23*(4), 36–49.

Howden, L. M., & Meyer, J. A. (2011). Age and sex composition: 2010. U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, Washington, DC.

Humes, K.R., Jones, N.A. & Ramirez, R.R. (2011). Overview of race and Hispanic origin: 2010. U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, Washington, DC.

Human Rights Campaign (2014). Healthcare Equality Index. Available at: http://www.hrc.org/hei

Institute for Diversity in Health Management. (2014). About the Institute. Available at: www.diversityconnection.org/diversityconnection/about-us/About-the-Institute.jsp

Institute of Medicine. (2004). *In the nation's compelling interest: Ensuring diversity in the health care workforce*. Washington, DC: National

Academy Press.
Kochan, T., Bezrukova, R., Jackson, A., Jehn, K., Leonard, D., & Thomas, D. (2003). The effects of diversity on business performance: Report of the diversity research network. *Human Resource Management, 42*(5), 3–21.
Kundhal, K. K. (2003). Cultural diversity: An evolving challenge to physician-patient communication. *Journal of the American Medical Association, 289*(1), 94.
Martin, C., & Tulgan, B. (2006). *Managing the generation mix* (2nd ed.). Amherst, MA: HRD Press.
Motwani, J., Hodge, J., & Crampton, S. (1995). Managing diversity in the healthcare industry. *Healthcare Supervisor, 13*(3), 16–25.
Nahavandi, A., & Malekzadeh, A. R. (1999). *Organizational behavior: The person-organization fit*. Upper Saddle River, NJ: Prentice Hall.
National Urban League. (2009). Diversity practices that work: The American worker speaks II. Available at: nul.iamempowered.com/sites/nul.iamempowered.com/files/attachments/Di
Patel, C. (2003). Some cross-cultural evidence on whistle-blowing as an internal control mechanism. *Journal of International Accounting Research, 2*, 69–96.
Perry, D. (2012). Entrenched ageism in healthcare isolates, ignores and imperils elders. *Aging Today, 33*(2), 1.
Robert Wood Johnson Foundation. (2014). Improving health care by measuring it. Available at: www.rwjf.org/content/dam/farm/reports/program_results_reports/2014/rwj
Svehla, T. (1994). Diversity management: Key to future success. *Frontiers of Health Services Management, 11*(2), 3–33.
The Joint Commision. (2014). A crosswalk of the national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care to The Joint Commission Hospital Accreditation Standards. Available at: www.jointcommission.org/assets/1/6/Crosswalk-_CLAS_-20140718.pdf
Traxler, A. J. (1980). Let's get gerontologized: Developing a sensitivity to aging. *The multi-purpose senior center concept: A training manual for practitioners working with the aging*. Springfield, IL: Illinois Department of Aging.
United Nations. (2013). World population prospects: The 2012 revision—Highlights and advance tables. New York. Available at: esa.un.org/wpp/Documentation/pdf/WPP2012_HIGHLIGHTS.pdf
United States Census Bureau. (2012). A look at the 1940 Census. Available

at: www.census.gov/newsroom/cspan/1940census/CSPAN_1940slides.pdf
United States Department of Commerce, Bureau of the Census. (2003). Chartbook on trends in the health of Americans. Retrieved March 21, 2004, from InfoTrac online database.
United States Department of Commerce, Bureau of the Census. (2004). U.S. interim projections by age, sex, race, and Hispanic origin. Available at: www.census.gov/ipc/www/usinterimproj/
United States Department of Health and Human Services, Office of Minority Health [HHS OMH]. (2013). National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS Policy and Practice. Retrieved from www.thinkculturalhealth.hhs.gov
Warshaw, G. A. (2002). Academic geriatrics programs in US allopathic and osteopathic medical schools. *Journal of the American Medical Association, 288*, 2313–2319.
Warshaw, G. A., Bragg, E. J., Thomas, D. C., Ho, M. L., & Brewer, D. E. (2006). Are internal medicine residency programs adequately preparing physicians to care for the Baby Boomers? A national survey from the Association of Directors of Geriatric Academic Programs Status of Geriatrics Workforce Study. *Journal of the American Geriatrics Society, 54*(1), 1603–1609.
Wasserman, I. (2007). Generations working together. *Entrepreneur*. Available at: www.entrepreneur.com/article/183720
Weech-Maldonado, R., Dreachslin, J. L., Dansky, K. H., DeSouza, G., & Gatto, M. (2002). Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management, 47*(2), 111–124.
Weech-Maldonado, R., Elliott, M. N., Schiller, C., Hall, A., Dreachslin, J. L., & Hays, R.D. (2007). Organizational and market characteristics associated with hospitals' adherence to the CLAS standards. Presentation at the APHA Annual Meeting in Washington, DC, on November 5.
Weech-Maldonado, R., Elliott, M. N., Schiller, C., Hall, A., & Hays, R. D. (2007). Does Hospitals' adherence to the CLAS standards influence diverse patients' experiences with inpatient care. Presentation at the APHA Annual Meeting in Washington, DC, on November 5.
Weil, P., & Mattis, M. (2001). Narrowing the gender gap in healthcare management. *Healthcare Executive 16*(6), 12–17.
Wilson-Stronks, A., & Mutha, S. (2010). From the perspective of CEOs: What motivates hospitals to embrace cultural competence? *Journal of*

Healthcare Management, 55(5), 339–351.
Witt/Kieffer (2011). Building the business case. Healthcare diversity leadership: A national survey report. Institute for Diversity in Healthcare Management, Institute Resource Center. Available at: www.diversityconnection.org/diversityconnection/membership/Institute-Resource-Center.jsp?fll=S12

OTHER SUGGESTED READING

Lantz, P. (2008). Gender and leadership in healthcare administration: 21st century progress and challenges. *Journal of Healthcare Management, 53*(5), 291–304.
Institute of Medicine. (2004). In the nation's compelling interest: Ensuring diversity in the healthcare workforce. Available at: www.nap.edu/catalog/10885.html
A full list of reference texts discussing cultural beliefs and influences, issues, and how to identify/develop materials can be found on the National Center for Cultural Healing, at: www.culturalhealing.com/patientedu.htm
Information relating to Anne Fadiman's book, *The Spirit Catches You and You Fall Down*, may be viewed at: www.spiritcatchesyou.com
Learn more about how language and culture affect the delivery of quality services to ethnically diverse populations at: www.diversityrx.org

Attitudes and Perceptions

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 assist 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 perception 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., person, place, or thing) due to both an individual's experience and

temperament.

Typically, when we refer to a person's attitudes, we are attempting to explain his or her behavior. Attitudes are a complex combination of an individual's personality, beliefs, values, behaviors, and motivations. As an 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 his or her point of view about the topic (e.g., thought) and how he or she feels about this topic (e.g., emotion), as well as the actions (e.g., behaviors) he or she engages in as a result of attitude to preventing health problems. This is the tri-component model of attitudes (see **Figure 3–1**). An attitude includes three components: an affect (a feeling), cognition (a thought or belief), and behavior (an action).

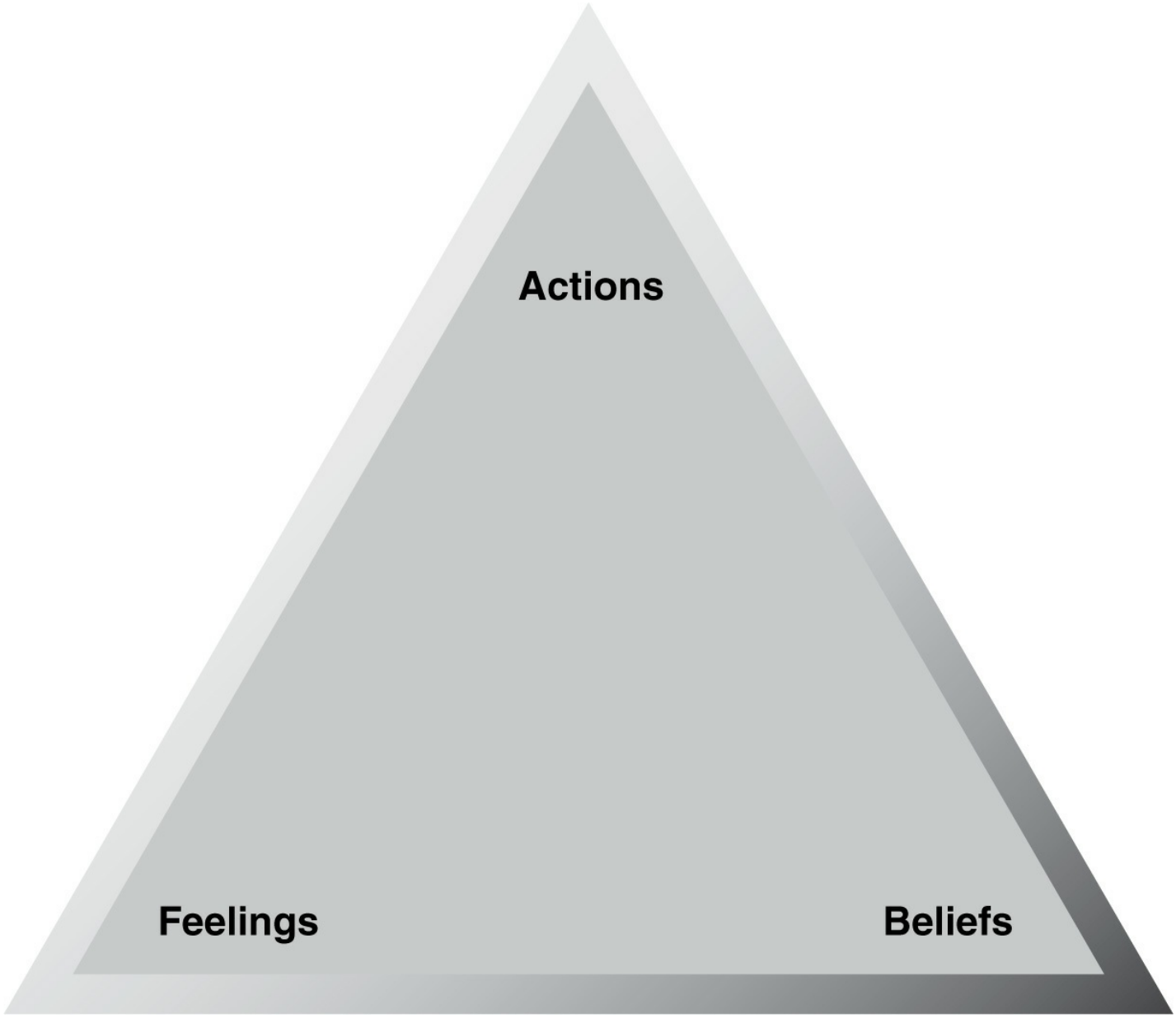

Figure 3–1 Tri-Component Model of Attitudes

Attitudes help us define how we see situations, as well as define how we behave toward the situation or object. As illustrated in the tri-component model, 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 view a person's attitude from his or her resulting behavior.

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 his or her behavior. Adler suggested that a person's thoughts, feelings, and behaviors were transactions with one'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. These interactions, however, may cause a conflict between a person's attitude and 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 one'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). As an example, Harry likes two coworkers, John and Mary, but John does not like Mary (i.e., inconsistency). Harry needs to eliminate the inconsistency. Harry may: (1) try to change John's feelings toward Mary, (2) change his feelings about either John or Mary, or (3) sever his relationship with either John or Mary (see Scott's Dilemma, **Case Study 3–1**).

Case Study 3–1 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 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 a person may use to reduce the inconsistency are:

- Eliminating his or her 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 when the hazards of smoking are 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 great an 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 drawing out 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 Harry/John/Mary example). 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 pursue a balance between their investments in and the rewards gained from their work, such that their own investment/reward ratio is the same as that of similar others. Disturbance of this balance results in behaviors to relieve the dissonance. For example, if an employee perceives that another employee is paid more for the same level of productivity, the employee will be motivated to ask for a raise, lower his or her level of productivity, or seek another job.

FORMATION OF ATTITUDES

How are attitudes formed? Attitude formation is a result of learning, modeling other individual's actions and attitudes, as well as direct experiences with people and situations. Attitudes influence our decisions, guide our behavior, and impact what we selectively remember (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.

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 3–2 Employee Attitude Survey

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." As such, employee attitude survey responses are helpful to health care managers for determining whether management is "doing the right things" for retaining and motivating employees. As an example, Lowe et al. (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.

Questions typically asked are illustrated in **Figure 3–2**. However, as Morrel-Samuels (2002) points out, organizations need to be cautious regarding the design of employee 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 3–1**).

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

Exhibit 3–1 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), pp. 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 someone's behavior by providing new information. As an example, explain to the other person how you made time in your day and how, as a result, both your cholesterol level and 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 his or her 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 illustrated by the following story:

"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 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 his or her 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 his or her related behavior. (See **Case Study 3–2**: What Changed in the Housekeeping Department?)

Case Study 3–2 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.

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 he or she 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.

Exhibit 3–2 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 identify and role-play how to handle different types of attitude challenges. Focus is to assess the impact of negative attitudes on workers, management, and patients/customers and 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. 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.

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.

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 3–2**). Attitude assessment and change is serious business. 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," may 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 4,500 respondents in over 100 hospitals that there was a strong perceived correlation between disruptive behaviors and the occurrence of medical error and compromised quality, adverse events, compromises in patient safety, and patient mortality.

Exhibit 3–3 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 versus guiding a question-and-answer session. One task of the effective facilitator is activating the group's resources to bring out the "best" of a group. For example, plan activities where people interact with one another at the start. (e.g., icebreaker type of exercise). Work with the energy of the group; use humor and laughter, and healthy competition. These interactions build trust and help people feel comfortable to share ideas and consider 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 sort out their values and priorities, explore beliefs and assumptions, and encourage

them 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 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 things that may cause them in the workplace. Ask people to expand on these. Give personal examples and ask them 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 Creative planning for the second half of life, by B. Kreitlow and D. Kreitlow, 1997, New York: Whole Person Associates. Reprinted with permission.

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 3–3**). Open communication creates environments where workers safe to dissent, and in which their opinions are respected. Everyone has attitudes, both positive and negative. To help workers realize their full potential requires ongoing efforts.

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, a person is confronted with a situation or stimuli. The person interprets the stimuli into something meaningful to him or her 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 3–3**).

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, attitude, 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 and, 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 he or she believes to be most relevant. However, perceptual defense creates an internal barrier that limits the external stimuli passing through the perception process when the stimuli is not congruent with the person's current beliefs, attitudes, motivation, and so on. This is referred to as selective perception. Selective perception occurs when an individual limits the processing of external stimuli by selectively interpreting what he or she sees on the basis of beliefs, experience, or attitudes (Sherif & Cantril, 1945).

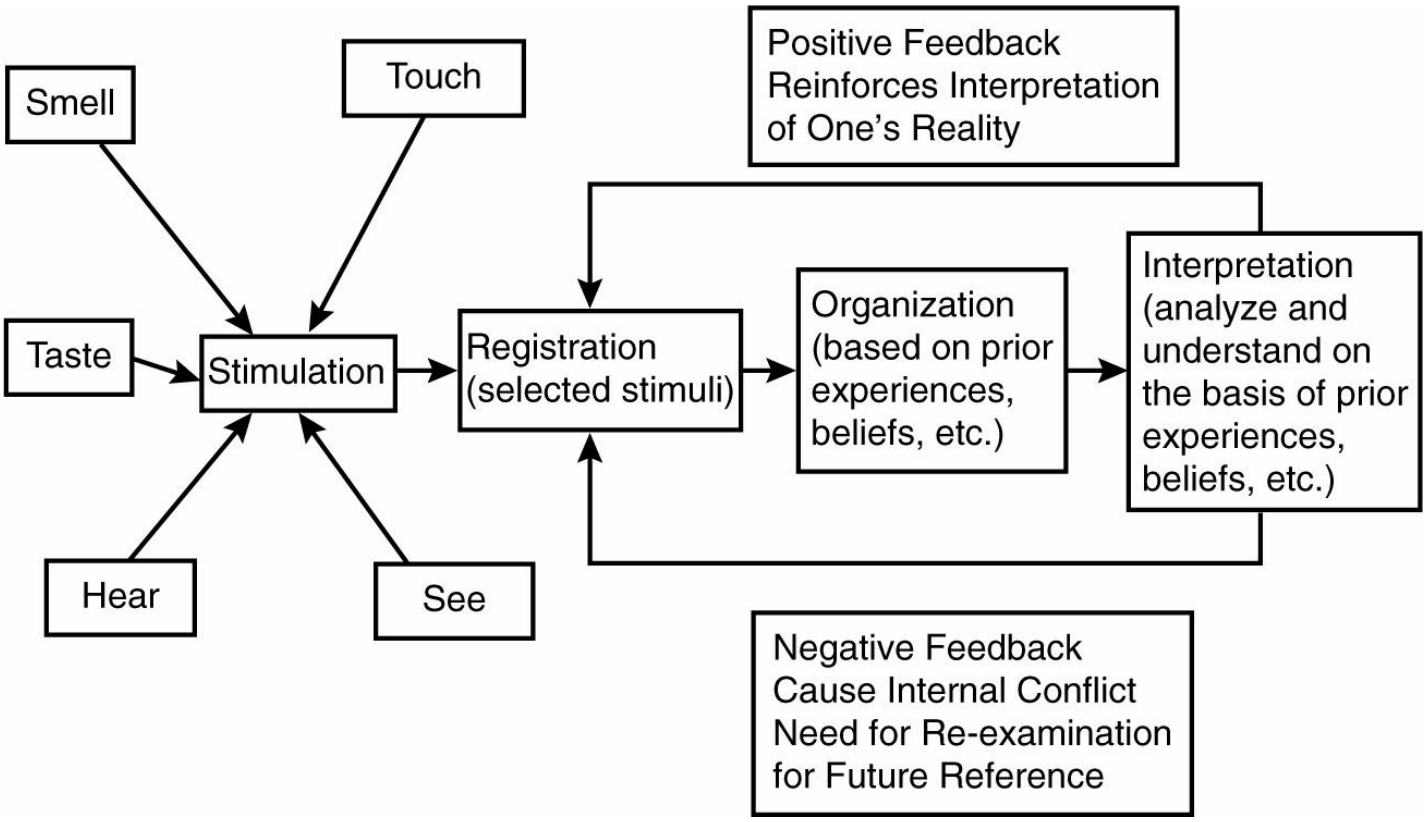

Figure 3–3 Perception Processing System

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 also driven by goal-directed actions (Allport, 1987, 1993; Neumann, 1987; Van der Heijden, 1992). The concept is that any action requires the selection of certain aspects of the environment that are action relevant and, at the same time, filtering other aspects that are action irrelevant. Therefore, when one is working toward a goal, one will skip over information that does not support one's plan. Recent studies of the brain have also led to new models, suggesting multiple channels of processing (Pashler, 1989) and selective perception 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 the 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 allows people

to offer explanations for why things happen and is more concerned with the individual's cognitive perceptions than the underlying reality of events (Daley, 1996). As such, 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 of success due to 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 he or she tends to doubt his or her ability and attributes success to luck or other factors out of his or her control. Such external persons have little drive or enthusiasm for work, because positive outcomes are not thought to be related to their direct effort.

Managers are often in a position where 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 3–4**).

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. As an example, the regional director of an international pharmaceutical company attributes her top salespersons' inabilities to reach their annual sales goals for a specific drug used to treat gastrointestinal conditions to recent negative media coverage of another, but similar drug's linkage to a high number of patients suffering strokes (e.g., adverse effects to the drug). 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.

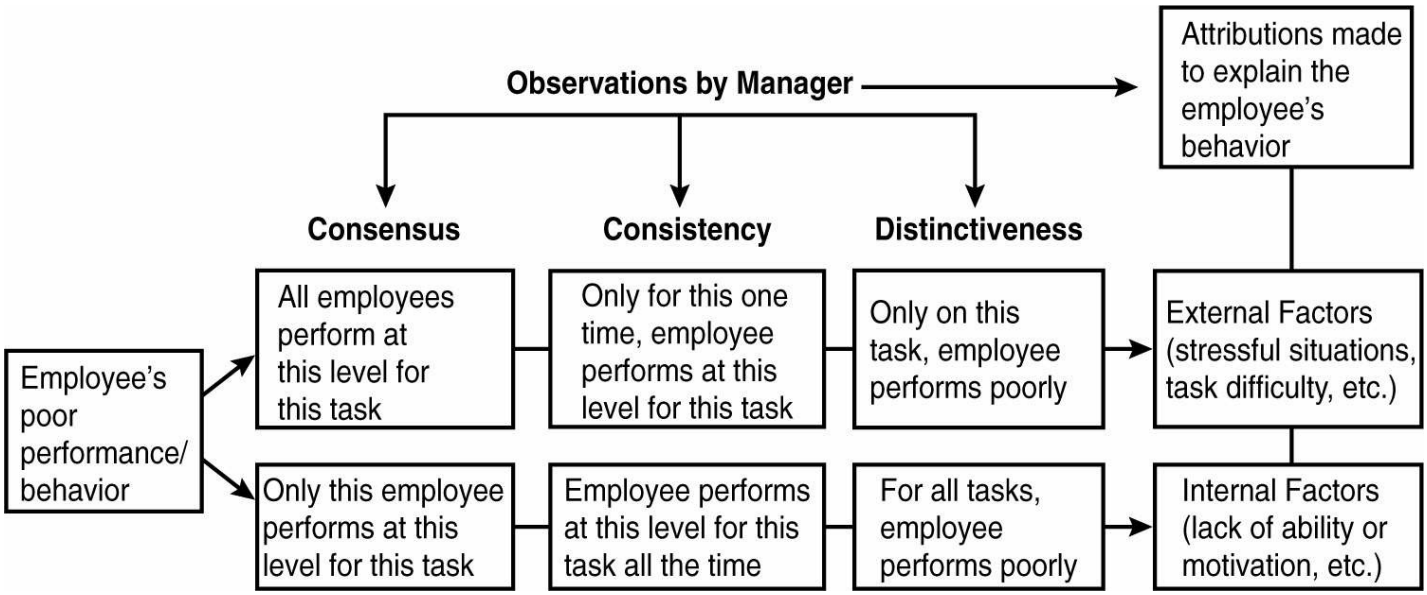

Figure 3–4 Kelley's Attribution Theory Model

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. You check back later in the day, and you find that the medication was not given. Upon 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), and (2) this nurse has had difficulty on 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 three months (low consensus). The nurse has performed poorly on this task before; he or she has performed poorly on other tasks; and no one else seems 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, intrinsic versus extrinsic motivations), and prior knowledge all impact 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 really 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 draws a general impression about another person based on a single characteristic, such as intelligence, sociability, or appearance. The perceiver may evaluate the other individual high on many traits because of his or her belief that the individual is high in one trait. For example, if an employee performs a difficult accounting task well because of the manager's belief of the employee's high intelligence, then 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 proven to be true or not.

Opposite to the halo effect is the horn effect, whereby a person evaluates another as low on many traits because of a belief that the individual is low on one trait that is assumed to be critical (Thorndike, 1920). A study on obesity conducted with health professionals and researchers reflects the horn-effect concept. 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 et al., 2003).

A challenge faced by health care managers is the halo/horn effect cognitive bias when performing workers' evaluations. Managers need to

avoid the tendency for an employee's positive or negative trait to "spill over" to other areas of their evaluation. For example, if an employee has been late to work for three days, you may conclude that this person has a poor attitude and is indifferent about his or her job. There may be other external reasons for the employee's lateness, such as his or her car broke down, the babysitter was late, or there was bad weather. As illustrated, because of one negative aspect, the manager may assume that the employee is a poor worker, and this belief therefore unfairly influences his or her overall evaluation.

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 other 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 less attractive than he or she would have been if rated on his or her own. When asked to contrast a target person with persons who were more physically attractive, ratings of attractiveness of the target were more negative, and when the target person was compared with those 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 him or her. Not only does contrast effects apply to the perception of attractiveness, but it has 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 him or her. 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 judgements. We judge an individual or object in comparison with someone else or something else. As such, by using the perceptual contrast-effects principle, one can persuade others in their judgements 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 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 "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 choose to take extreme views rather than live with uncertainty. We polarize by selectively amplifying those 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 we are all good and we can project all bad things onto the other person.

Comparing with prototypes and stereotypes—A prototype is an idealized stereotype, both of which use polarized thinking. Sometime 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. Women, of course, will do the same. In fact, we all will 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 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 if we saw them 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

look to peers and people who are "like us" to compare ourselves against. Thus rich people compare against other rich people (and often feel quite poor as a result!). People for whom being intelligent is important will compare themselves with 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 the 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 was a defensive mechanism, where we attribute our own attitudes onto someone else as a defense against our feelings of anxiety or guilt. For example, if you have a strong dislike for someone, you might instead believe that he or she does 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 may constantly accuse others of being rude. This way the person does not have to deal with the fact that he or she is rude, which would require acknowledging that there is something wrong with him or her, which is generally undesirable, thus making the individual feel better about him- or herself. 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 an individual 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, this word 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. As such, the term "stereotype" is 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 used as 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 the elderly, homeless, disabled, and those suffering from obesity. The elderly 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 or "skid row" population. There is a tendency to stereotype this group as either the elderly alcoholic male or perhaps the disheveled bag lady. However, homelessness affects families, children, and young people—groups that do not fit the typical stereotype of "homeless."

One of the most common forms of stereotyping is on the issue of gender and leadership. Women hold positions at all levels within health care organizations, but only between 10 and 13 percent hold chief executive officer positions. The influence of gender stereotypes is one possible explanation of why it is sometimes difficult for people to accept women as leaders in the workplace. Traits often attached to leadership are "masculine" qualities such as courage, persuasiveness, and assertiveness. As such, 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 a gender stereotype that women should be less authoritarian and more sensitive, gentle, and nurturing (see **Exhibit 3–4**).

We all use stereotypes because they help us simplify our world. However,

most often we 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—racism, sexism, ageism, etc. One goal of management is to assist staff in recognizing that stereotypes are illogical by challenging these faulty cognitions. The need to challenge gender 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 work toward de-stereotyping the workplace. Negative stereotypes can be problematic for any organization, and *proper* training can be effective in minimizing widely held false beliefs (see **Exhibit 3–5**). A recent study by 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 is voluntary and undertaken to advance a company's business goals (and part of the organization's culture), it was associated with increased diversity in management. According to the study, it appears that employees don't react well when "sensitivity" training is forced on them!

Exhibit 3–4 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 results in a negative label being applied to describe the person violating the expectation. This was at issue in *Price Waterhouse v. Hopkins* (1989), as cited in Lord and Maher (1991).

In the case of Ann Hopkins, she 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 et al., 1991). At the time of her eligibility/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." In addition, 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 Supreme Court and won.

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

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 consistent with the expectation. This can have negative or positive results. If a manager sets high standards for a subordinate's performance, he or she will 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 will be low. Therefore, 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, so much as the way the manager behaved. Indifferent and noncommittal treatment, more often than not, 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 in communicating high expectations.

Exhibit 3–5 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 _____

Computer Programmer _____

Medical Receptionist _____

Pharmacist _____

Nurses Aide _____

Radiology Technician _____

Nurse _____

Chief of Staff _____

Statements:

Health services administrators need to _____ be to be effective.

The hospital cafeteria is staffed by people who are _____.

Disabled people that I have worked with are _____.

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 the "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).

Therefore, managers need to understand the effects of their own self-expectations and how these expectations interact with the expectations they hold and communicate regarding 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, where people try to shape another's impression of themselves. 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. Giacalone and Rosenfeld (1989) point out that impression management is neither inherently good nor bad but rather is a fundamental part of our social and work lives, and we need to view it in the situations in which it is used. As an example, consider the concept of self-handicapping. Self-handicapping is where people place obstacles in their way, so if they do not succeed they can blame the obstacles or if successful, they can brag regarding their successful performance 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 others by controlling the information they receive. They relate that people actively carry out impression management in ways that help them achieve their objectives and goals, both individually and as part of groups and organizations. This can be done consciously and deliberately (i.e., perfecting job-interview skills), while other times it may be unconscious. At times, the impression that is managed serves to bolster or protect our own self-image (i.e., dressing for success); other times we manage impressions in hopes of pleasing significant audiences. Sometimes impression management is truthful and accurate. Other times it involves "false advertising" through the use of exaggeration, fabrication, deception, and falsehoods (Schlenker & Weigold, 1992) (see **Exhibit 3–6**).

Exhibit 3–6 The Liars Index

Twice a year, Jude M. Werra of Jude M. Werra & Associates, a headhunting firm in Brookfield, Wisconsin, reviews the hundreds of résumés he has seen in the previous six months—the elegant, triumphant CVs of CEOs and VPs—and he condenses them into a single statistic. "It's the number of people who've misrepresented their education divided by the number of people whose education we checked," Werra explained. Werra calls it the Liars Index—the percentage of people who invented a degree. The index, which has been published since 1995, was at its highest in the first half of 2000: 23.3 percent. It now stands at 11.2 percent.

If there is a case for regarding all résumés as adventures in narrative, it is one that should not be made to Mr. Werra. In his view, a lie is a lie, whether it is propagated by Ronald Zarrella, the chief executive of Bausch & Lomb, who confirmed two weeks ago that he did not, after all, have an MBA from NYU, or by Quincy Troupe, California's newly appointed poet laureate who, shortly after Zarrella's announcement, acknowledged that he had never received a degree from

Grambling College in Louisiana, despite making that claim on his résumé. (Mr. Zarrella remains at his desk, backed by the Bausch & Lomb board; Mr. Troupe's resignation has been accepted by the California senate, presumably on the ground that the last thing a state needs is a poet who makes things up.) These embellished résumés, testing our taste for the legend of the self-made man (as well as Sir Philip Sidney's claim that "the poet…never lieth") can now be filed alongside those of Kenneth Lonchar, the former chief financial officer of Veritas Software (who gave himself a Stanford MBA), Sandy Baldwin, the former president of the U.S. Olympic Committee (doctorate in American literature), George O'Leary, the former Notre Dame football coach (master's degree in education), David Geffen, Miss Virginia 1995, and John Holmes (the porn star) who invented a degree in physical therapy from UCLA.

Werra, who has been in the business of "retained executive searches" for 25 years, used to interview candidates first and then do a background check. Now he checks first and interviews later, ever since an engaging interviewee said that they had been contemporaries at Marquette University in the mid-1960s. The man claimed to remember their graduation ceremony. Werra said, "I was talking about how President Johnson's daughter had attended, and about all the security, the metal detectors, and how the place was ringed with police and Secret Service and so on, and he was saying, 'Yeah, yeah, wasn't it amazing?' And he had never been there, of course."

Werra went on, "A few years ago, I spoke with a gentleman who claimed to have a degree from Fairleigh Dickinson. Let's call him John Martin. The university had no record of him, so I dropped him a note: 'Could you clarify this?' He wrote me back six weeks later: 'You know, I've accepted a job to be director of sales and marketing of your client's No. 1 competitor—just wanted to let you know. And, by the way, the reason you couldn't find information on my degree is that my name isn't really Martin, it's Martini, and my father was rubbed out by the Mob in New York years ago, and my mother got us into the witness-protection program, and when I went to Fairleigh Dickinson I got my degree under another name. But I have a special phone number—you can call it and whoever answers the phone will tell you I have a degree.'" Werra did not make that call.

Reproduced from Department of Padding. *Dishonorable Degrees*, by I. Parker, November 4, 2002. *The New Yorker Magazine*. © Conde Nast

EMPLOYEE SELECTION

Because perceptions determine our behavior toward and can cloud our judgments of others, one area that clearly benefits from using psychological principles has been the area of employee selection. The goals of selection are: (1) identify the knowledge, skills, abilities, and qualities necessary to perform a job well, (2) design tests to measure applicants' levels on those key job requirements, (3) administer and score the tests, and (4) determine the applicants 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 (such as 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 where 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 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 responsible for hiring and promoting should look for many sources of data from which to extract the qualities essential to the job, such as personality (see **Exhibit 3–7**).

One goal in this discussion is to help managers make accurate and fair assessments of staff or potential staff for various positions within their organizations. Who should function in positions of high contact with patients? Who is better off working with computers? Who is most able to direct a unit to promote the best clinical care? Who is most suited to manage the business office? How can we help those who are not ready to assume a leadership role develop the skills while still working comfortably in their current subordinate positions? These are the questions a manager or administrator must answer in personnel decisions. To do so requires a manager to perceive the unchanging qualities of a person across situations, or their key "traits" that underlie success in a job.

Exhibit 3–7 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 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 An introduction to the five-factor model and its application, by R. R. McCrae and O. P. John, 1992, *Journal of Personality, 60*, 175–215.

Many instruments used to assess personnel and management/leadership potential, such as the Campbell Interest and Skills Inventory, 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 we carry from one job to another.

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). Based on 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 "type." Nevertheless, 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.

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, and therefore knowledge of these biases is needed 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, by understanding 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, and this includes a wide-ranging scientific literature on organizational behavior, psychology, and human resource issues in the workplace. Hopefully, 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 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 3–1 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—for example, departments negotiating over who gets to purchase a piece of new medical equipment (limited financial resources), or whether laptops or PCs are appropriate for the nursing stations, or 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 one minute, to persuade the influencee.

After you observe 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 topic 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 influencer with an adjective list. Continue until several male–female dyads have role-played as influencers and influencees. Record the descriptive adjectives. Rate overall leadership of each influencer observed. Record responses.

Discussion Questions

- Were differences in leader perceptions due to gender stereotypes or behavioral differences?
- What social invariants ("constants" or "traits") can you identify as important for leadership positions?
- Why are leadership perceptions important, and can attributions about leadership ability impact the behaviors of followers?

Debriefing

Research by Butler and Geis (1990) suggests that in role-play exercises, such as 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.

EXERCISE 3–2 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 Web site cautions, the test sometimes provides some challenging personal feedback!

EXERCISE 3–3 Jung Typology Test: Personality Assessment

A 72-item Web-based assessment is available at: www.humanmetrics.com. After completing the questionnaire you will obtain 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/assessments can be unreliable in certain situations.) This Web-based assessment is designed to stimulate your thinking about yourself.

Case Study 3–3 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, and Mary thought it had been much too short. "It's 15 weeks until Thanksgiving."

"Mary, I know you're miserable," Tom replied. "You've been increasingly unhappy in that job for the past five 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?"

"Don't you think I'd do something else if I could?" Mary replied angrily. "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," commented 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! The Lottery!" Mary answered. "That's all I can think of!"

SCENE II:

Dan, the manager of the health information department of a large health system in South Florida, sighed as he finished his coffee. … "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 she wasn't sure what was going on with Mary because they haven't been very close lately, but she said that Mary's 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?

REFERENCES

Allport, D. A. (1987). Selection for action: Some behavioral and neurophysiological considerations of attention and action. In H. Heuer & F. Sanders (Eds.), *Perspectives on perception and action*. Hillsdale, NJ: Erlbaum.

Allport, D. A. (1993). Attention and control: Have we been asking the wrong questions? A critical review of twenty-five years. In D. E. Meyer & S. Kornblum (Eds.), *Attention and performance XIV* (pp. 183–218). Cambridge, MA: MIT Press.

Allport, G. W. (1935). Attitudes. In Murchison, C. (Ed.), *Handbook of social psychology* (pp. 798–844). Worcester, MA: Clark University Press.

Assael, H. (1995). *Consumer behavior & marketing action* (5th ed.). London, UK: PWS-Kent Publishing Company.

Bargh, J. A., Chen, M., & Burrows, L. (1996). Automaticity of social behavior: Direct effects of trait construct and stereotype activation on action. *Journal of Personality and Social Psychology, 71*(2), 230.

Broadbent, D. E. (1958). *Perception and communication*. New York, NY: Pergamon Press.

Butler, D., & Geis, F. L. (1990). Nonverbal affect responses to male and female leaders: Implications for leadership evaluations. *Journal of Personality and Social Psychology, 58*, 48–59.

Daley, D. 1996. Attribution theory and the glass ceiling: Career development among federal employees. *Public Administration and Management: An Interactive Journal, 1*(1), Retrieved February 11, 2004, from www.pamij.com/

Dobbin, F., Kalev, A., & Kelly, E. (2007). Diversity management in corporate America: Do America's costly diversity management programs work? Not always. *Contexts 6*(4), 21–27.

Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.

Fiske, S. T., Bersoff, D. N., Borgida, E., Deaux, K., & Heilman, M. E. (1991). Social science research on trial: Use of sex stereotyping research in Price Waterhouse v. Hopkins. *American Psychologist, 46*, 1049–1060.

Fottler, M.D., Crawford, M., Quintana, J.B. & White, J.B. (1995). Evaluating nurse turnover: Comparing attitude surveys and exit interviews. *Hospital & Health Services Administration, 40*(2), 278–295.

Freud, A. (1967). *Ego and the mechanisms of defense: Vol. 2. The writings of Anna Freud*. New York, NY: International Universities Press. (Original work published 1936)

Freud, S. (1966). The neuro-psychoses of defense. In James Strachey (Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (3rd ed., pp. 45–61). London, UK: Hogarth Press. (Original work published 1894)

Giacalone, R. A., & Rosenfeld, P. (Eds.) (1989). *Impression management in the organization*. Hillsdale, NJ: Erlbaum.

Heidler, F. (1958). *The psychology of interpersonal relations*. New York, NY: John Wiley & Sons.

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. The National Academies Press. Retrieved April 30, 2004, from books.nap.edu/catalog/10260.html

Kassarjian, H. H., & Cohen, J. B. (1965). Cognitive dissonance and consumer behavior: Reactions to the Surgeon General's report on smoking and health. *California Management Review, 8*(1), 55–64.

Kelley, H. H. (1967). Attribution theory in social psychology. In D. Levine (Ed.), *Nebraska Symposium on Motivation* (*Vol. 15*, pp. 129–238). Lincoln, NE: University of Nebraska Press.

Kelley, H. H. (1973). The process of causal attribution. *American Psychologist, 28*, 107–128.

Kusy, M. & Holloway, E. (2009). *Toxic workplace!: Managing toxic personalities and their systems of power*. Indianapolis, IN: Jossey-Bass/Wiley.

Lindsay, P., & Norman, D. A. (1977). *Human information processing: An introduction to psychology*. New York, NY: Harcourt Brace Jovanovich.

Livingston, J. S. (1969). Pygmalion in management. *Harvard Business Review, 81*(1), 97–106.

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

Lowe, G., Schellenberg, G., & Shannon, H. (2003). Correlates of employees' perceptions of a healthy work environment. *American Journal of Health Promotion, 17*(6), 390–399.

Mitchell, T. R., Green, S. G., & Wood, R. E. (1981). An attributional model of leadership and the poor performing subordinate. *Research in Organizational Behavior, 3*, 197–234.

Moore, M. (2003). How to improve staff morale using humor, appreciation and praise—Practical strategies to help you turn your workplace into a "Thank God it's Monday" type of organization. Retrieved January 18, 2004, from www.motivationalplus.com

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

Neumann, O. (1987). Beyond capacity: A functional view of attention. In H. Heuer & A. F. Sanders (Eds.), *Perspectives on perception and action* (pp. 361–394). Hillsdale, NJ: Erlbaum.

Ott, J. S. (1996). *Classic readings in organizational behavior* (2nd ed.). Albany, NY: Wadsworth Publishing Company.

Pashler, H. (1989). Dissociations and dependencies between speed and accuracy: Evidence for a two-component theory of divided attention in simple tasks. *Cognitive Psychology, 21*, 469–514.

Price Waterhouse v. Hopkins, 109 S. Court 1775 (1989).

Rizzolatti, G., & Craighero, L. (1998). Spatial attention: Mechanisms and theories. In M. Sabourin, F. Craik, & M. Robert (Eds.), *Advances in psychological science: Vol. 2. Biological and cognitive aspects* (pp. 171–198). Hove, UK: Psychology Press.

Rosentein, A.H. (2011). The quality and economic impact of disruptive behaviors on clinical outcomes of patient care. *American Journal of*

Medical Quality, 26(5), 372–379.
Schlenker, B. R., & Weigold, M. F. (1992). Interpersonal processes involving impression regulation and management. *Annual Review of Psychology, 43*, 133–168.
Schwartz, M. B., Chambliss, H. O., Brownell, K. D., Blair, S. N., & Billington C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research, 11*(9), 1033–1039.
Sherif, M., & Cantril, H. (1945). The psychology of attitudes: I. *Psychology Review, 52*, 295–319.
Thorndike, E. L. (1920). A constant error on psychological rating. *Journal of Applied Psychology, IV*, 25–29.
Thornton, B., & Moore, S. (1993). Physical attractiveness contrast effect: Implications for self-esteem and evaluations of the social self. *Personality and Social Psychology Bulletin, 19*, 474–480.
Thurstone, L. L., & Chave, E. J. (1929). *The measurement of attitude*. Chicago: University of Chicago Press.
Van der Heijden, A. H. C. (1992). *Selective attention in vision*. London, UK: Routledge.
Wedell, D. H., Parducci, A., & Geiselman, R. E. (1987). A formal analysis of ratings of physical attractiveness: Successive contrast and simultaneous assimilation. *Journal of Experimental Social Psychology, 23*, 230–249.
Weiner, B. (1979). A theory of motivation for some classroom experiences. *Journal of Educational Psychology, 71*, 3–25.

OTHER SUGGESTED READING

Allport, G. W. (1937). *Personality: A psychological interpretation*. New York, NY: Holt Rinehart & Winston.
Brief, A. P. (1998). *Attitudes in and around organizations*. Thousand Oaks, CA: Sage.
Barnes-Farrell, J. L., & Ratz, J. M. (1997). Accommodation in the workplace. *Human Resource Management Review, 7*, 77–107.
Briggs-Myers, I., & Briggs, K. C. (1980). *Myers-Briggs Type Indicator (MBTI): Gifts differing*. Palo Alto, CA: Consulting Psychologists Press.
Briggs-Myers, I., & McCaulley, M. H. (1985). *Manual: A guide to the development and use of the Myers Briggs Type Indicator*. Palo Alto, CA: Consulting Psychologists Press.
Butler, D., & Geis, F. L. (1990). Nonverbal affect responses to male and

female leaders: Implications for leadership evaluations. *Journal of Personality and Social Psychology, 58*, 48–59.

Campbell, D. P. (1970). *Campbell Interest and Skill Survey–CISS*. Upper Saddle River, NJ: Pearson Assessments, Pearson Education. Last accessed December 28, 2003, at: www.pearsonassessments.com

Della-Giustina, J. L., & Della-Giustina, D. E. (1989). Quality of work life programs and employee motivation. *Professional Safety, 34*(5), 24.

Denton, D. K., & Boyd, C. (1990). *Employee complaint handling tested techniques for human resources managers*. Westport, CT: Quorum Books.

Eagly, A., & Chaiken, S. (1993). *Psychology of attitudes*. New York: Harcourt, Brace Jovanovich.

Feingold, A. (1998). Gender stereotyping for sociability, dominance, character, and mental health: A meta-analysis of findings from the bogus stranger paradigm. *Genetic, Social, and General Psychology Monographs, 124*(3), 253–271.

Feingold, A. (1992). Good-looking people are not what we think. *Psychological Bulletin, 111*(2), 304.

Gibson, J. J. (1966). *The senses considered as perceptual systems*. Boston, MA: Houghton Mifflin.

Hirsch, S. K. (1985). *Using the Myers-Briggs Type Indicator in organizations*. Palo Alto, CA: Consulting Psychological Press.

Kouzes, J. M., & Posner, B. (1997). *The leadership challenge: How to keep getting extraordinary things done in organizations*. San Francisco, CA: Jossey-Bass.

Kouzes, J. M., & Posner, B. (1999). *Encouraging the heart: A leader's guide to rewarding and recognizing others*. San Francisco, CA: Jossey-Bass.

McGuire, W. J. (1985). Attitudes and attitude change. In G. Lindzey & E. Aronson (Eds.), *Handbook of social psychology* (3rd ed., *Vol. 2*, pp. 136–314). Reading, MA: AddisonWesley.

Stern, M., & Karraker, K. H. (1992). Modifying the prematurity stereotype in mothers of premature and ill full-term infants. *Journal of Clinical Child Psychology, 21*(1), 76.

Sternberg, R. J., & Lubart, T. I. (1995). *Defying the crowd: Cultivating creativity in a culture of conformity*. New York, NY: Free Press.

Stone, E. F., Stone, D. L., & Dipboye, R. L. (1992). Stigmas in organizations: Race, handicaps, and physical unattractiveness. In K. Kelly (Ed.), *Issues, theory, and research in industrial and organizational psychology* (pp. 385–457). New York, NY: Elsevier Science.

Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Sciences Medicine, 50*(6), 813–828.

Walsh, V., & Kulikowski, J. J. (1998). *Perceptual constancy: Why things look as they do*. Cambridge, UK: Cambridge University Press.

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* 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.

Workplace Communication

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. As previously noted, communication is a major challenge for managers because they are responsible for providing information, which results in efficient and effective performance in organizations. Every managerial function and activity involves some form of communication. For a manager to plan, organize, direct, or lead, he or she must communicate with and through others. Managerial decisions are effective only if they are communicated and understood by those responsible for enacting them. Furthermore, employee motivation and satisfaction are dependent 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 within 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 memorandum, letter, fax, or e-mail 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 sender and the intended receiver. For example, a receiver may hear a sender but may not have comprehended the sender's actual meaning. Effective communication occurs when the message received is the same as the one intended. Communication enables one 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 4–1** illustrates the S-M-C-R model of the communication process. Information originates from the sender (S), which is encoded into 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 which 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 it back 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.

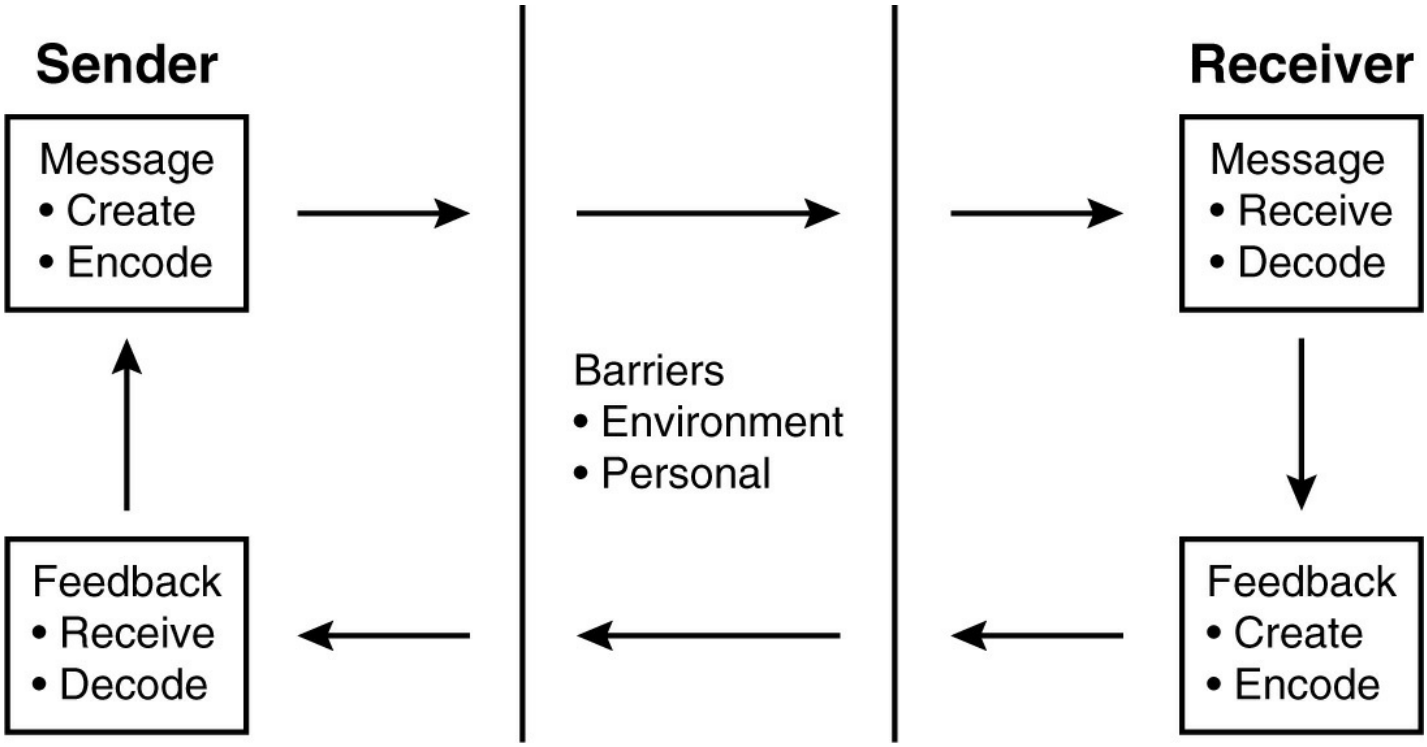


Figure 4–1 The Communication Process

Reproduced from Organizational behavior: Emerging realities for the workplace revolution (2nd ed., 324), by S. L. McShane and M. A. Von Glinow, 2003, Boston, MA: McGraw-Hill Book Company.

FEEDBACK

Effective communication takes place when a sender's message is fully understood by the receiver. As such, feedback is a response (i.e., signal) from the receiver indicating 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 eybrows, 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 if a corrective action is needed to clarify the intended message. For instance, a manager needs feedback to determine staff acceptance of his or her new policy requiring employees to call and verbally confirm all patients' appointments 48 hours in advance. Through the feedback process, both senders and receivers may need to adjust their outputs as related to the transmitted information. In the absence of feedback, or in a case where the communication process does not allow for sufficient feedback to develop or feedback is ignored, a certain

amount of feedback will occur spontaneously and tends to take a negative form.

In one-way communication, a person sends a one-directional message without interaction. For example, after reviewing a patient's lab results, a physician orders a medical test for the patient. He 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 and fellow Manager B to attend her staff meeting and comment on her form of communication. After the meeting, B told 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 provided descriptive feedback of A's communication with her staff.
- *Evaluative Feedback*: Feedback that provides an assessment of the person who communicates. In the preceding case, if Manager B evaluates Manager A's form of communication and concludes that she was instructive and helpful, which enabled her 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 how she could have made changes to better communicate her message

to her staff. B suggests for A to be friendlier and more cooperative by giving the staff specific times that 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 he or she have the skills helpful to this group? What attitudes does he or she have toward the group as they 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. Like the questions raised at the individual feedback level, similar questions are asked of the group. Do team members within the group have adequate knowledge to complete a task? Have they developed a communication network to facilitate their objectives?

Feedback can be in the form of questionnaires, surveys, and 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 making group members 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. As such, managers should use feedback as a strategy to enhance goals, awareness, and learning.

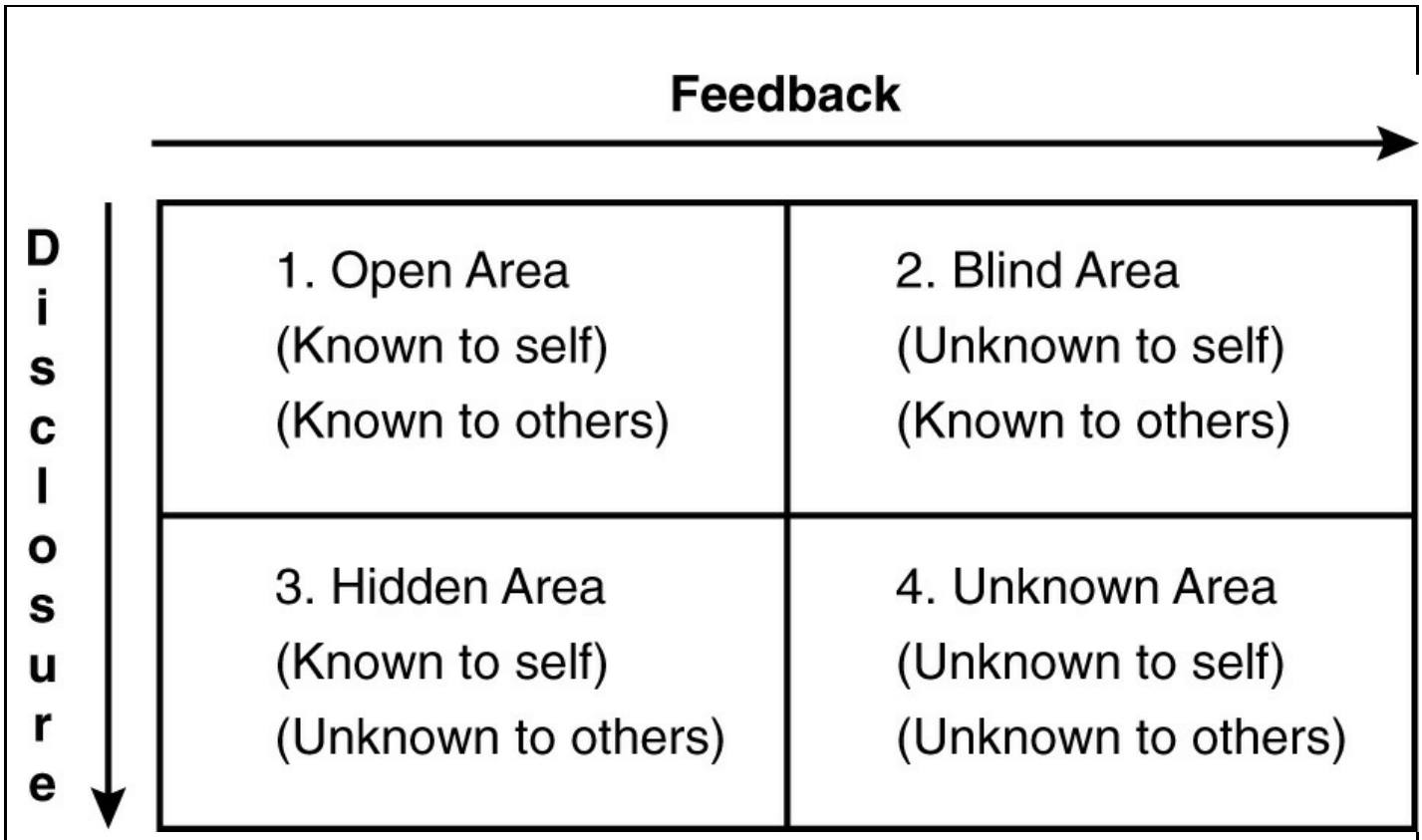
Feedback, as a managerial tool, enables managers to anticipate and respond to changes. Structured feedback enhances managerial planning and controlling functions. Because of the value of feedback, managers should encourage feedback and evaluate it systematically.

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 4–1**, 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 as the general cocktail party conversation in which an individual willingly shares personal information with others. For instance, at an office picnic, you reveal to your coworkers that you are a vegetarian to support your desire for a healthier lifestyle. Windowpane 2 refers to a blind area in which others know information about you that you are either unaware of or that you do unknowingly. As an example, your colleagues know that although you are a nice and caring person, you chronically interrupt and talk over others in conversation.

Exhibit 4–1 The Johari Window



Modified from *Group processes: An introduction to group dynamics* (3rd ed.), by J. Luft, 1984, Palo Alto, CA: Mayfield.

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 last windowpane is the unknown—things that are unknown by you, and are 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 an individual to increase the open area and reduce the blind, hidden, and unknown areas of oneself (McShane & Von Glinow, 2003). In the Johari Window, Luft (1984) argues for increasing the open area 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 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 openly discuss organization-related issues such as goals and conflicts. Nevertheless, Luft (1984) is cautious on 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. 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 noted by Mazurenko and Hearld (2014, p. 2), "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 4–2**.

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. It is a process by which participants are exposed to new information. The process involves a series of meetings of organizational members that represent different views on issues of mutual interest. According to Edgley and Robinson (1991), in order for dialogue to be successful, there are several fundamental principles: engage motivated people; use a facilitator and 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.

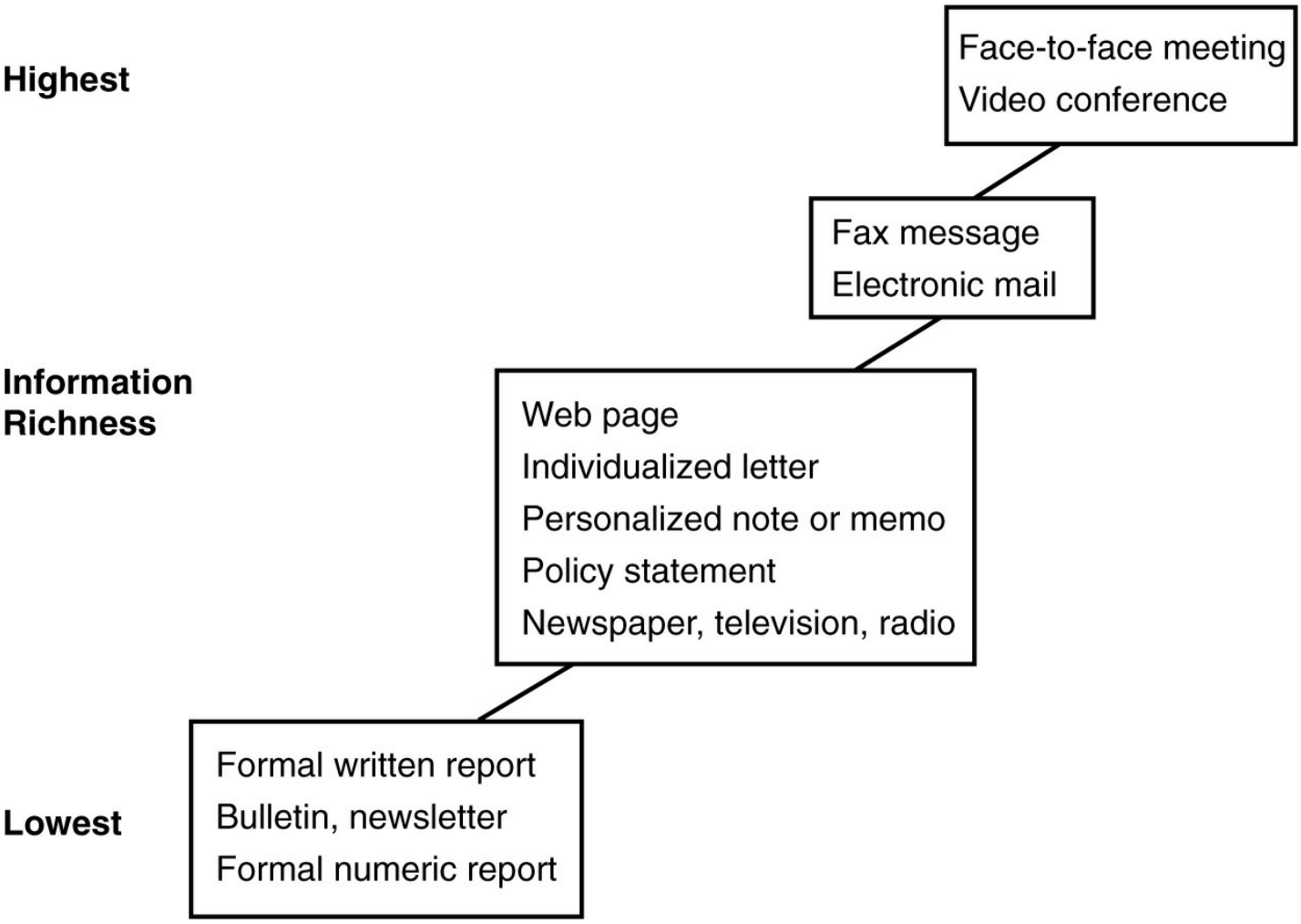


Figure 4–2 Communication Channels

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, since they allow for emotions to be transmitted and immediate feedback to take place. Written communication is more appropriate for describing details, especially of a technical nature, as in the example of monitoring a patient's complex medical condition. Although traditional written communication had been considered slow, with the development of electronic mail and computer-aided communication, written communication through these channels has now dramatically improved efficiency (see **Case Study 4–1**: Are We Getting the Message Across?).

Case Study 4–1 Are We Getting the Message Across?

James Warick, director of physical plant at Southern Hospital, e-mailed Diane Curtis, director of nursing, informing her of a leak in Operating Room 1, which would need to be shut down for repairs early 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 in the day shift to switch the 8:00 a.m. operation from Room 1 to Room 8 and taped it on 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 future policies should be put in place to prevent this from occurring again?

Computer-Aided Communication

The use of computers and information technology is dramatically affecting the way 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, e-mails, 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. These systems can enhance communication if properly set up and managed effectively. On the other hand, ineffective management can hinder communication and result in decreased productivity.

Electronic mail uses the Internet or intranet to send computer-generated text and documents. E-mail has revolutionized the communication process. E-mail allows messages to be rapidly created, changed, saved, and sent to many people at the same time. One can select any part of the message to read and skip to important parts of the message. E-mail is a preferred channel for coordinating work and schedules. Messages can be clearly defined through concrete and specific instructions rather than abstract words or generalization. For example, an e-mail can be sent to all physicians to inform them that a meeting starts promptly at 10:00 a.m.

Electronic mail has several problems and limitations. The most obvious is information overload. E-mail users are overwhelmed by the number of messages received on a daily basis, of which many are unnecessary to the receiver. Moreover, e-mail messages frequently carry computer viruses, which have caused major damage to computers and interruptions in work flow. Another problem with e-mail is its ineffectiveness to communicate emotion. Tones of messages are easily misinterpreted, causing misunderstandings between sender and receiver. Therefore, icons have been developed to represent emotions (emoticons) in e-mail messages. For instance, the symbol :-) or :) means happy (Peck, 1997). E-mail also reduces 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 over e-mail, whereas a traditional letter provides time for one to cool down and develop second thoughts. To reduce these communication problems, some have recommended training for communication on the Internet, called netiquette (Extejt, 1998). Netiquette rules include keeping e-mail messages to fewer than 25 lines and not sending sensitive issues through e-mail.

There are also key benefits to using e-mail. E-mail reduces time and cost of distributing information to employees. Furthermore, e-mail has increased the potential for more employee collaboration and teamwork. Rather than using the telephone, letters, or memos, employees can use e-mail to rapidly send and receive messages. For instance, if a hospital ethics committee is composed of physicians, nurses, and administrators, staff who are

responsible for setting up monthly meetings find that the most efficient and effective way to confirm a meeting date and time is through e-mail. Another advantage of e-mail is its flexibility. This is especially so for employees with mobile devices like smartphones and tablets. These technologies are multifunctional—that is, they can accomplish many tasks, including managing appointments, sending and receiving e-mail, and watching video clips. These handheld devices have contributed to the increased demand for access to information.

Other Computer-Aided Communication

In addition to e-mail technology, other forms of technology have entered health care organizations and directly enhanced and impacted the communication process. Coile (2002) describes several such technological advancements that can be used to bridge the communications gap between clinicians and administrators. Computer-aided drug discovery is expected to double the number of new medications. High-speed, high-definition images are created for rapid access via telemedicine. Wireless, handheld digital electronic medical records are capable of voice recognition. Telepresence surgery with minimally invasive, remotely guided instruments extends beyond the precision of humans. Medical applications of artificial intelligence are designed for diagnosis, treatment planning, and continuous monitoring of the chronically ill (Coile, 2002).

Nonverbal Communication

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

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 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 degree 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

of the hands and rubbing 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 serve as negative factors in 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 4–2, 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 creates a waste of time and leads to more misunderstanding. When communication is nonroutine or unclear, information-rich channels are required for more effective communication. As an example, a gunshot victim is brought into a trauma center. Coordinating 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 to say, 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 e-mail 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 shown in **Table 4–1**, 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 the messages when sent and received.

Table 4–1 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/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	1. Consciously engage in efforts to be cognizant of other's frame of reference and beliefs
2. Beliefs	2. Recognize that others will engage in selective perception, jealousy, fear, and prejudices to help diminish the barriers
3. Values	3. Engage in empathy
4. Prejudices	
5. Selective perception	
6. Jealousy	
7. Fear	
8. Evaluate the source (sender)	
9. Status quo	
10. Lack of empathy	

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

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. The receiver hears the message, but does not understand it. As a result of inadequate attention paid to the message, the receiver 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 listening, the receiver fails to comprehend the message. Time is another barrier. Lack of time prevents the sender from carefully thinking through and thoroughly structuring messages accordingly, and 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 intra-organizational communication upward or disseminate information downward will create procedural and organizational blockages. By requiring that all communication follow the chain of command, lack of attention and concern toward employees is a sign of a managerial philosophy that restricts communication flow. Furthermore, when subordinates encounter managers who fail to act, they are unwilling to communicate upward in the future, because communications are not taken seriously.

Managerial philosophy not only affects communication within the organization, but also impacts the organization's communications with external stakeholders. For instance, when the chief executive officer (CEO) of one hospital becomes aware that patients might have been exposed to a dangerous infection while hospitalized, he immediately decides to cover up the incident and communicates that message down to his managers. However, another hospital CEO deals with this incident in a very different manner. She uses 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 up or down, 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. As an example, the CEO asked department administrators to relay

his message of sincere congratulations and appreciation to the staff for their hard work to obtain their institutional re-accreditation from The Joint Commission. This message was transmitted through several layers in the organization and was received in a more nonchalant manner than 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 ago. 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 as a result. For instance, a poor supervisor–subordinate relationship inhibits the subordinate from reporting that the project is not working as planned. A subordinate who is fearful of the power and status of the manager prevents effective communication from taking place. Another environmental barrier that may lead to miscommunication is the use of specific terminology unfamiliar to the receiver or when messages are especially complex. Managers and clinical staff in health care organizations use medical terminology, which may be unfamiliar to external stakeholders. Communication between people 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 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, Rakich, & Darr, 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 may be difficult to completely understand the sender's message. In addition to frame of reference, one's

beliefs, values, and prejudices also can alter and block messages. Preconceived opinions and prejudices are formed on the basis of varying personalities and backgrounds. Selective perception is a tendency for retaining positive parts of the message and filtering out negative portions.

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 refuses to 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. In the case where 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 over three hours. At the same time, the physician should also empathize with his assistants because they are 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 4–1).

Longest, Rakich, and Darr (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/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/status levels.
5. Using multiple channels to reinforce complex messages decreases the likelihood of misunderstanding.

Personal barriers to effective communication are reduced by conscious efforts of senders and receivers to understand each other's values and beliefs. One must recognize that people engage in selective perception and are prone to jealousy and fear. Sharing empathy with those to whom messages are directed is the best way to increase effective communication.

Communicating effectively among 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 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 administration to improve their communication abilities to disseminate knowledge within the organization. The following 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 to provide information, elicit a response or reaction, or 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 4–3**).

A formula to evaluate an individual's effectiveness in communicating to others can be calculated as shown in **Exhibit 4–2**.

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 4–2**: What Should We Do Now?).

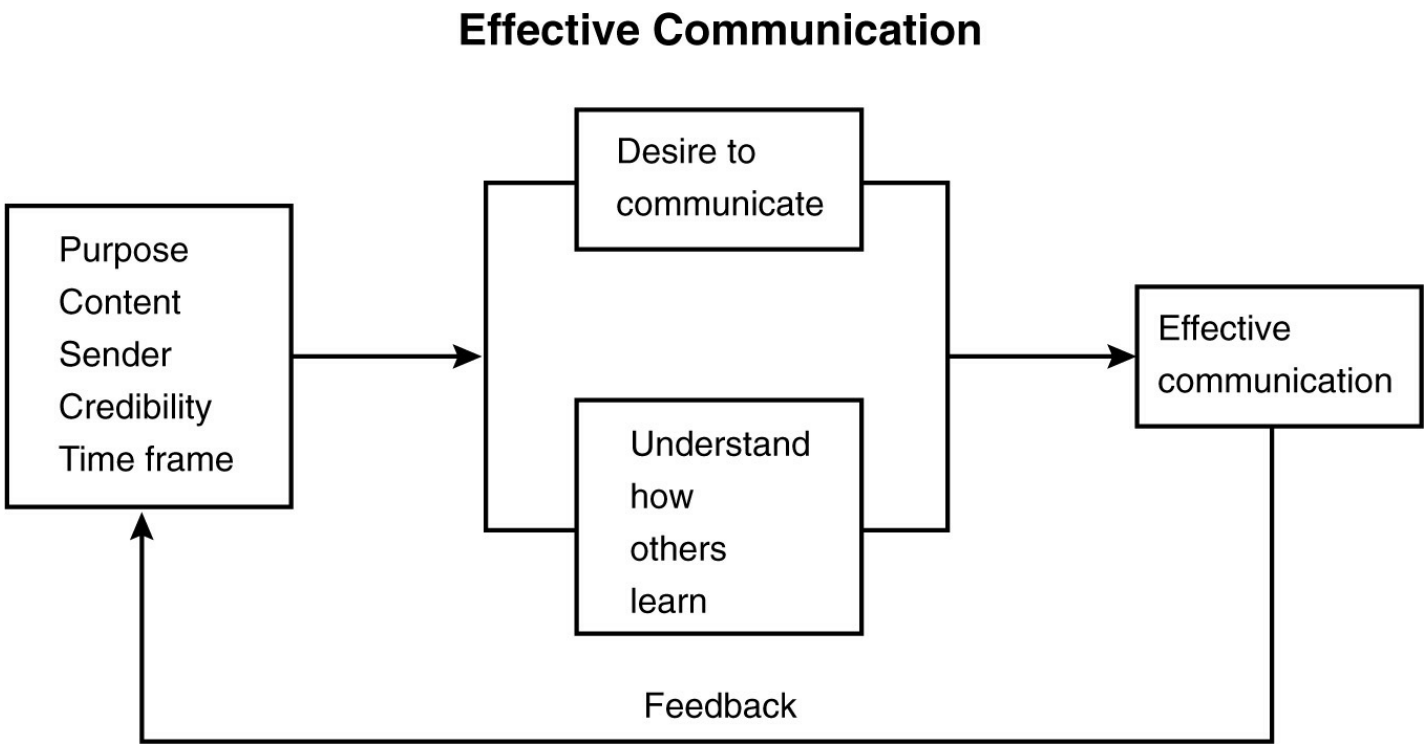


Figure 4–3 Interrelationships of Effective Knowledge-Management Communication

Reproduced from Effective hospital-physician relationship (p. 87), by S. M. Shortell, 1991, Ann Arbor, MI: Health Administration Press.

Exhibit 4–2 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.), by S. C. Certo, 1992, Boston, MA: Allyn and Bacon.

Case Study 4–2 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 three months she had forgotten to order supplies. Jenny had been borrowing supplies from the pediatrics office next door. Now, they were unwilling to lend her more. Jenny confessed that she had called the supply center once and faxed a list of supplies over, but had not followed through. This morning, Jenny called the supply center again and found out 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 with 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, which consists of five components.

1. *Outcome*: The specific result that an individual wants to achieve.
2. *Context*: The organizational importance of the communication.
3. *Messages*: The key information that staff 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, Rakich, and Darr (2000) provides us with several forms of intraorganizational communication for health care organizations, which are 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 employee thoughts and feelings about the organization. Upward flow becomes especially important with increased organizational complexity. For example, as noted by Adelman (2012, p. 133), 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 with higher authority. As a result, they 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, 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. Since 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 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 communications on a one-to-one basis. 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, Mino, & Rowles, 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. While diagonal flow does not follow the typical hierarchical chain of command, diagonal flow 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 4–3**: Communication Flows).

Case Study 4–3 Communication Flows

Sara Lang is a charge nurse at Sunny Nursing Home and has worked under the same president, Lisa Davis, for five 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 three 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 eight-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 and complained that Anna was getting preferential treatment and she 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 her 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 e-mailed 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. Yet, 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?
2. What changes should have been implemented?
3. What should be done now?

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 4–4**).

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 too complex communication may occur (Keyton, 2002). 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 where 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 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.

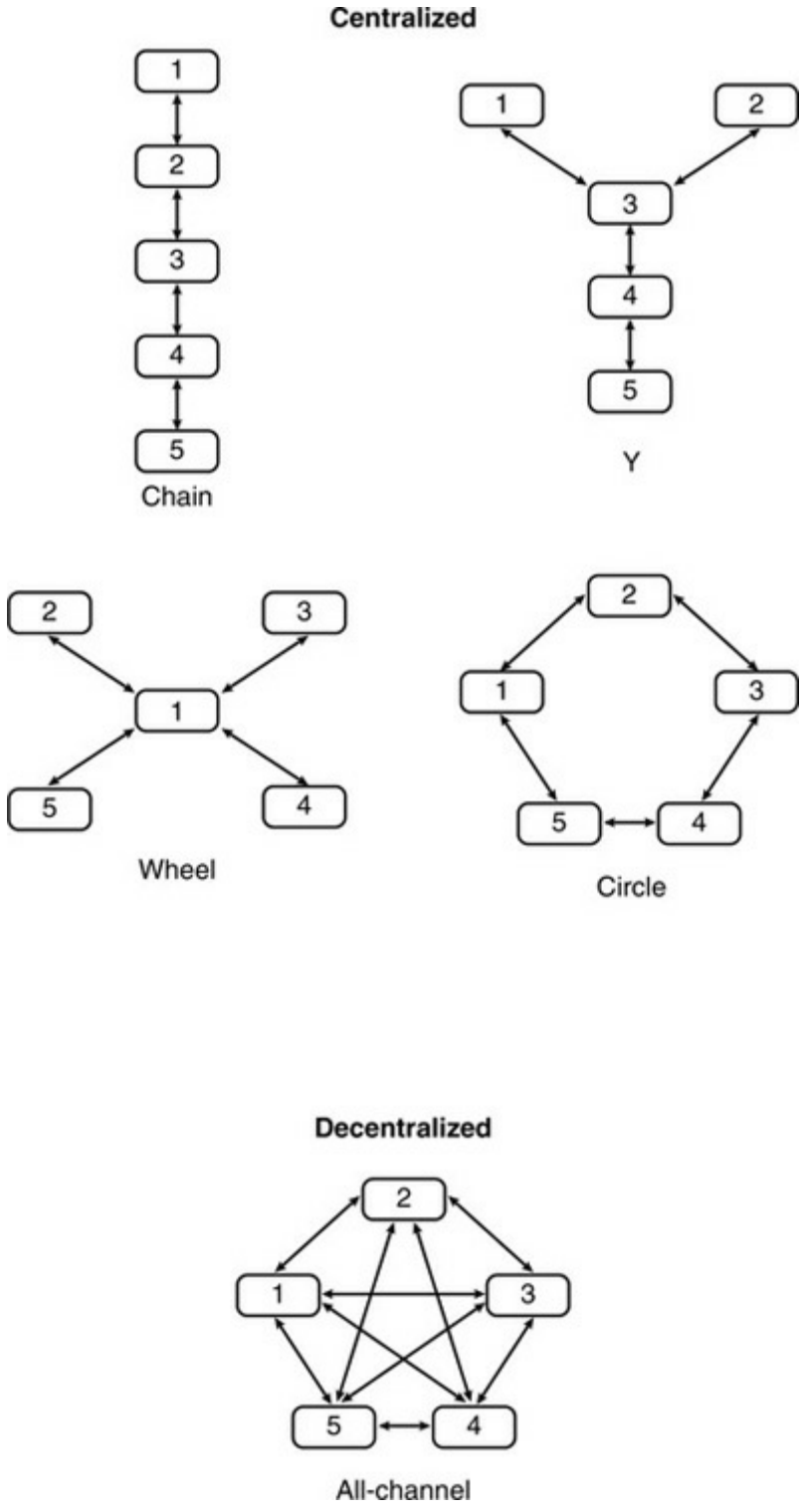


Figure 4–4 Two Types of Communication Networks: Centralized and Decentralized

Reproduced from Managing health services organizations (6th ed., p. 684), by B. B. Longest, and K. Darr, 2014, Baltimore, MD: Health Professionals Press.

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 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.

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 where four vice presidents report to a president if the vice presidents have little interaction. 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, then the president may 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. Since each 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 also slow down the communication process to enable everyone access to information.

Although there are different communication networks, there is not one that works for all situations. Different forms can be applied under varying circumstances. To be effective, health care managers must be able to select appropriate flows of communication for specific situations. Identifying an ideal communication network is critical to successful communication. Since health problems range from simple to complex, simple problems can be easily resolved using simple networks. As an 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 4–5** shows the specific criteria when making a selection among the different types of networks.

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. However, the allchannel 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- and wheel patterns, 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 compared with other networks, since the most centrally positioned person plays the most crucial roles and leaves less important decision-making responsibilities for those around the wheel.
4. *Range of Individual Member Satisfaction*: The range of an individual's satisfaction within the communication network shows 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 since there is greater participation by all members of the communication network; yet, individual satisfaction tends to be low.

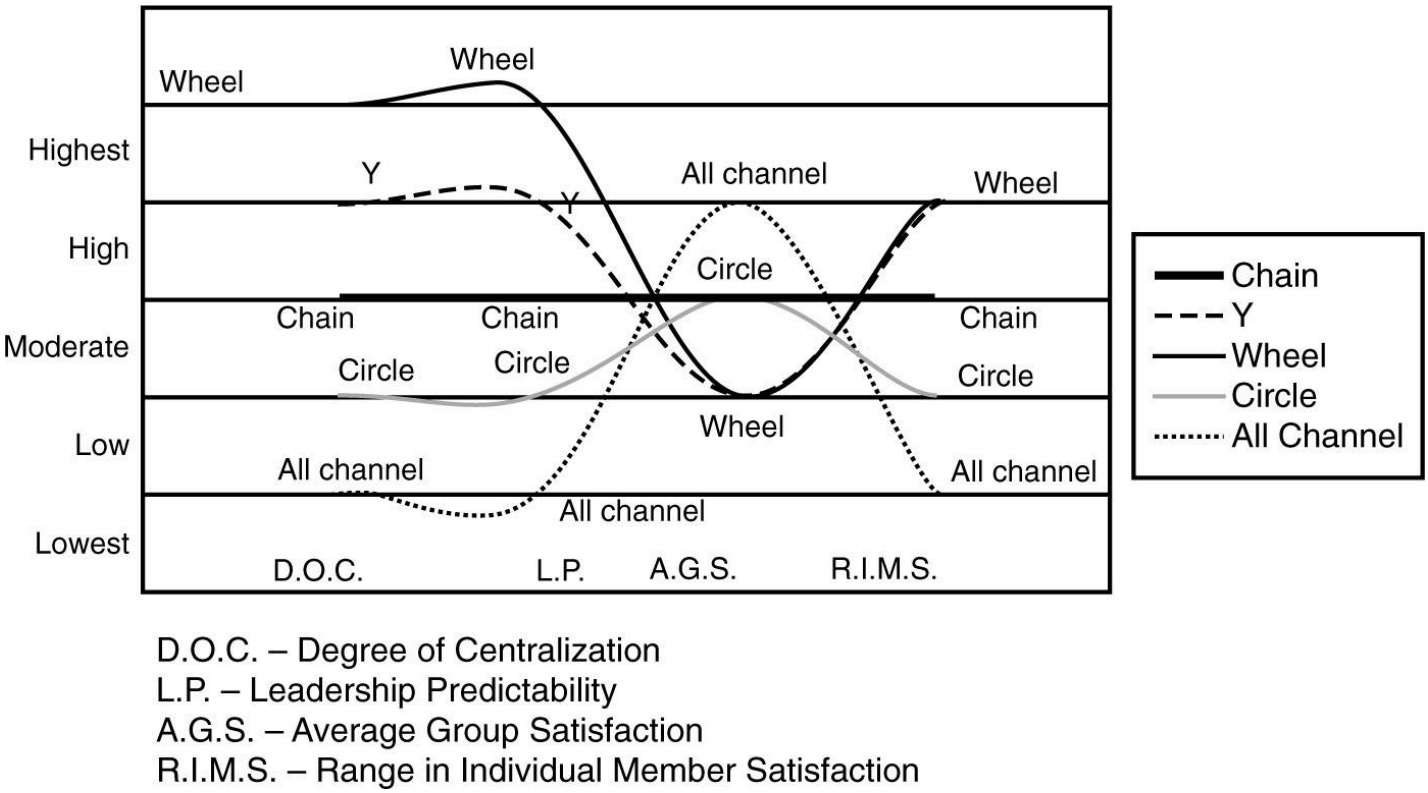


Figure 4–5 Effects of Five Communication Networks

Reproduced from Organizational behavior (10th ed., p. 301), by D. Hellriegel and J. W. Slocum, 2004, Mason, OH: South-Western.

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 corporate grapevine. The grapevine is an unstructured and informal network founded on social relationships rather than organizational charts or job descriptions. According to some estimates, 75 percent 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. It transmits information rapidly in all directions (Newstrom & Davis, 1993). **Figure 4–6** illustrates four common patterns that the grapevine can take.

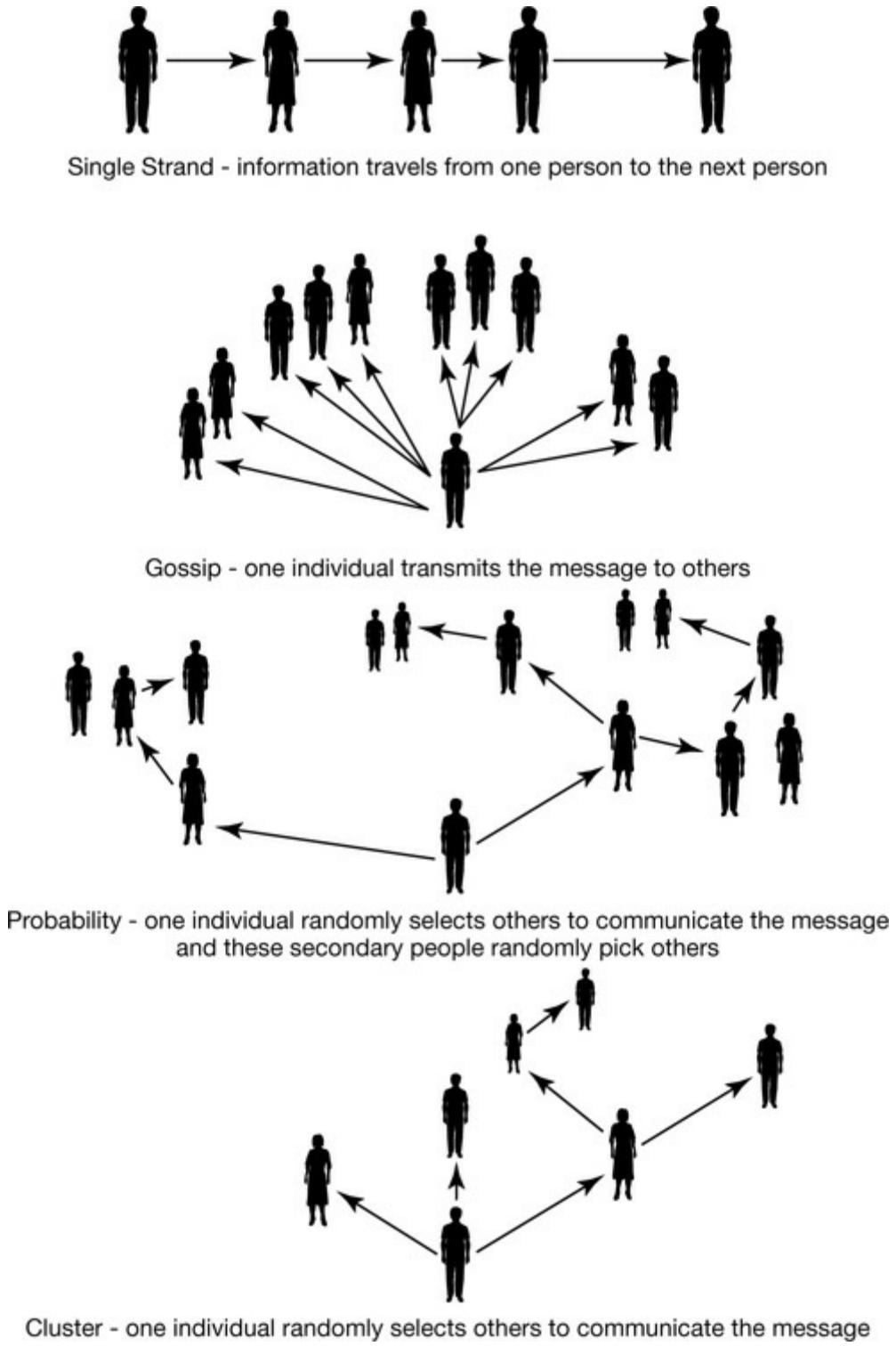


Figure 4–6 Grapevine Networks

The typical pattern 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 key points of the message.

In this era of information technology, e-mail and instant messaging 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 Web sites 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 4–4**: Did You Hear the Latest?).

Case Study 4–4 Did You Hear the Latest?

Sally Reeds, a medical secretary for the department of neurology at Western Heights Hospital in Colorado, turned on her computer and found an e-mail 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. The hospital security allegedly reported that Dr. Sites was completely intoxicated, and he was rushed home. Sally spiced up the tale and immediately e-mailed 10 of her friends. This morning, Sally looked up and saw 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 copy of Zeels's e-mail was thrust into Dr. Sites's hands 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, ran to her computer to e-mail the latest 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?

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 and impede efficient

and 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 as many as 20 languages may be encountered among staff and patients. In the United States, more than 25 percent of the population is foreign-born, and 15 percent speak a language at home other than English (Thiederman, 1996). Since 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 there is a foreign accent involved in the communication.
- 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 other cultures have increased dramatically. As U.S. industries branch into world markets through the interconnectedness of the Internet, e-mail, fax machines, voice messaging, electronic bulletin boards, and smart phones, organizations are able to conduct business without ever meeting face to face. To be effective in cross-cultural communication, several guidelines are important.

- Understand one's 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 or pursue are affected by racial, cultural, gender, and social class factors.

- Enhance personal and social interactions. With globalization, we have increased opportunities to associate and develop close interactions with individuals who are different from us. The conscious decisions we make to become more accommodating, flexible, and tolerant of others broaden our views of the world and enrich our perspectives. Our relationships with those of different cultures help us to learn more about the world and to break typical 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 preferred in a particular situation. Moreover, competent communicators use this knowledge to communicate in ways to achieve personal, team, and organizational objectives. A manager with high communication competence would be better than others at determining whether an e-mail, telephone call, or personal visit would be the best approach 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 4–3** shows steps for analyzing stakeholders to increase the acquisition of useful information.

First, scanning the macro- and microenvironments results in information about stakeholders. In the case of one state's department of health, shown in **Figure 4–7**, the diversity of stakeholders is illustrated (Ginter, Swayne, & Duncan, 1998).

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 external environment. The size and variety of external stakeholders make communication complex, especially since stakeholders attempt to influence the decision making of organizations. Fottler et al. (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 negative relationships.

Exhibit 4–3 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)

Reproduced from *Managing health services organizations* (6th ed., p. 687–688), B. B. Longest, and K. Darr, 2014, Baltimore, MD: Health Professions Press.

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, and take the information gathered and transmit it to those who need the information.

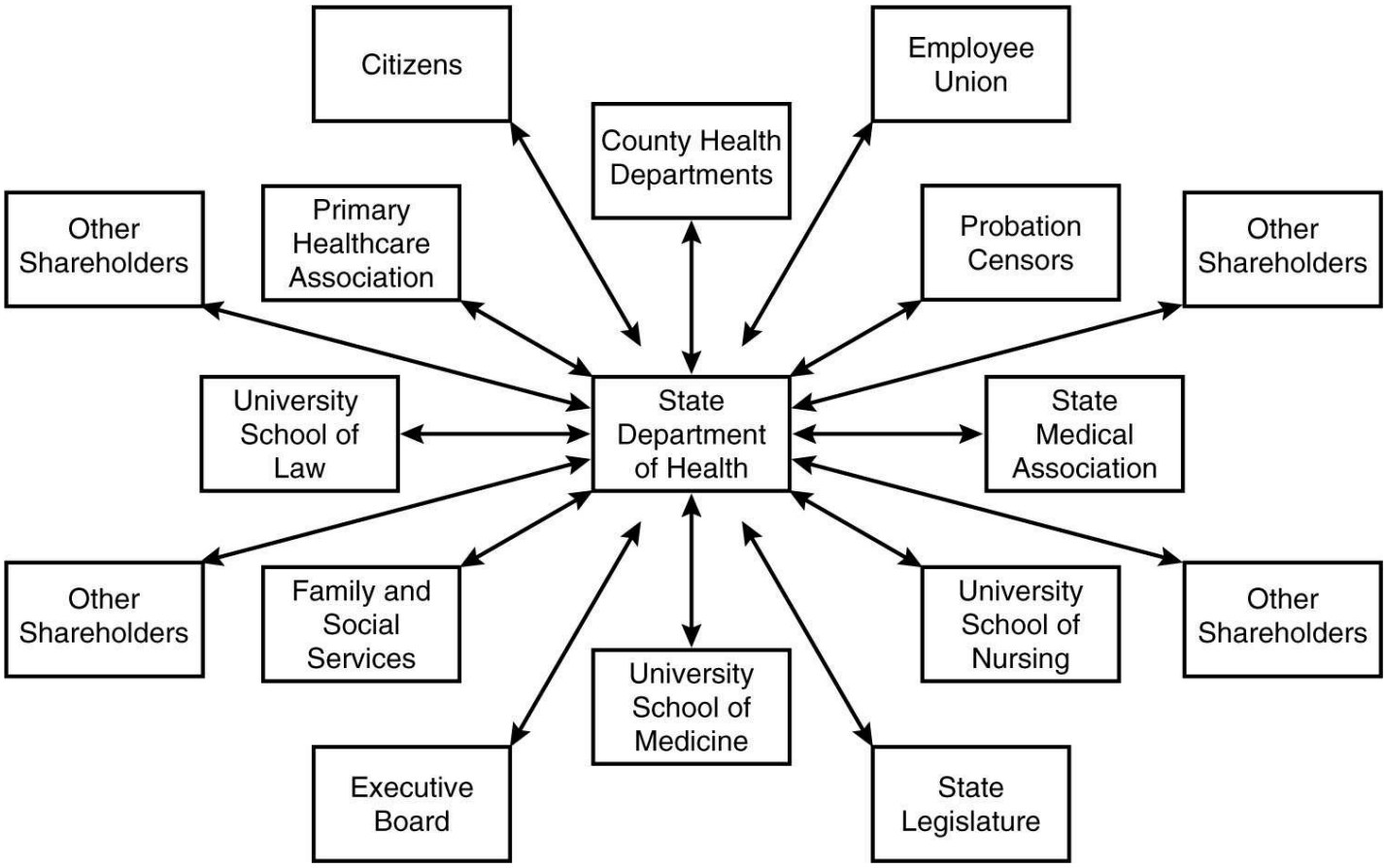


Figure 4–7 Grapevine Networks

Reproduced from Ginter, P. M., Swayne, L. M., & Duncan, W. J. (1998). Strategic Management of Health Care Organizations, 3rd ed. Malden, MA, Blackwell, p. 458.

Another way to describe communication with external stakeholders is called 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 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 as 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. Thus, 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 holds 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, realistic expectations must be formed by both parties. There are six areas of responsibility toward their communities for health care organizations (Longest, Rakich, & Darr, 2000). They include:

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 to establishing and maintaining 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 electronic mail, 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, wheel, circle, and all-channel. Certain networks work better than others in varying situations. 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 made up of 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 4–5 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 six months. She holds monthly staff meetings, as well as additional individual meetings with staff 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 her staff who were constantly tardy or absent. She also told Jamie about the things the staff 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 with, "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 she should use a different form of communication with Catherine?

Case Study 4–6 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 administrator are located in a separate building of the medical center. The administrator, Dan Jules, spends three hours a day in the clinic, from 9:00 to 10:30 every morning, and 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 this was followed by a third line ringing. The nursing assistant was in room 1 with the physician, and the medical assistant was in room 3 with another patient. The only available staff member 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. Nurse 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'm too 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?
3. Because Dan works in a different building, who should have communicated this ongoing problem to Dan?

REFERENCES

Adelman, K. (2012). Promoting employee voice and upward communication in healthcare: The CEO's influence. *Journal of Healthcare Management, 57*(2), 133–148.

Agarwal, R., Sands, D. Z., & Schneider, J. D. (2010). Quantifying the economic impact of communication inefficiencies in U.S. hospitals. *Journal of Healthcare Management, 55*(4), 265–282.

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

Coile, R. C., Jr. (2002). Physician executives explore "New Science" frontier: Bridging the communications gap between medical staff and administration. *Physician Executive, 28*(1), 81–83.

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

Dunn, R. (2006). *Haimann's healthcare management* (8th ed.). Chicago, IL: Health Administration Press.

Dutton, G. (1998). One workforce, many languages. *Management Review,*

87, 42–47.
Edgley, G., & Robinson, J. (1991). The dialogue process. *Association Management, 43*(10), 37–40.
Extejt, M. M. (1998). Teaching students to correspond effectively electronically: Tips for using electronic mail properly. *Business Communication Quarterly, 61*, 57.
Fottler, M. D., Blair, J. D., Whitehead, C. J., Laus, M. D., & Savage, G. T. (1989). Assessing key stakeholders: Who matters to hospitals and why? *Hospital & Health Services Administration, 34*, 530.
Ginter, P. M., Swayne, L. M., & Duncan, W. J. (1998). *Strategic management of healthcare organizations* (3rd ed.). Malden, MA: Blackwell.
Guo, K. L. (2003). A study of the skills and roles of senior level healthcare managers. *Healthcare Manager, 22*(2), 152–158.
Hellriegel, D., & Slocum, J. W. (2004). *Organizational behavior* (10th ed.). Mason, OH: South-Western.
Heraty, P. (2014). Transparency: How leaders create a culture of candor. In J. L. Pierce & J. W. Newstrom (Eds.), *The manager's bookshelf: A mosaic of contemporary views* (10th ed., pp. 111–115). Upper Saddle River, NJ: Pearson Education.
Hicks, J. M. (2011). Leader communication styles and organizational health. *Health Care Manager, 30*(1), 86–91.
Hybels, S., & Weaver II, R. L. (2007). *Communicating effectively* (8th ed.). Boston, MA: McGraw-Hill Book Company.
Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: National Academies Press.
Johnson, J. D., & Chang, H. J. (2000). Internal and external communication, boundary spanning and innovation adoption: An over-time comparison of three explanations of internal and external innovation communication in a new organizational form. *Journal of Business Communication, 37*(3), 238.
Keyton, J. (2002). *Communicating in groups: Building relationships for effective decision making* (2nd ed.). Boston, MA: McGraw-Hill Book Company.
Liebler, J. G., & McConnell, C. R. (2008). *Management principles for health professionals* (5th ed.). Sudbury, MA: Jones and Bartlett Publishers.
Longest, B. B., Rakich, J. S., & Darr, K. (2000). *Managing health services organizations* (4th ed.). Baltimore, MD: Health Professions Press.

Luft, J. (1984). *Group processes: An introduction to group dynamics* (3rd ed.). Palo Alto, CA: Mayfield.

Luthans, F. (1984). *Organizational behavior* (5th ed.). New York, NY: McGraw-Hill Book Company.

Luthans, F., Welsh, D. H. B., & Taylor, L. A., III (1988). A descriptive model of management effectiveness. *Group & Organization Studies, 13*(2). ABI/INFORM Global 148.

Mazurenko, O., & Hearld, L. R. (2014). Environmental factors associated with physicians' engagement in communication activities. *Health Care Management Review, 39*(3), e-print.

McShane, S. L., & Von Glinow, M. A. (2003). *Organizational behavior: Emerging realities for the workplace revolution* (2nd ed.). Boston, MA: McGraw-Hill Book Company.

Mead, R. (1993). Cross-cultural management communication. In J. V. Thill & C. L. Bovee (Eds.), *Excellence in business communication* (2nd ed., pp. 161–162). New York, NY: McGraw-Hill Book Company.

Mehrabian, A. (1980). *Silent messages*. Boston, MA: Wadsworth Publishing Company/Cengage Learning.

Nelson, D. L., & Quick, J. C. (2003). *Organizational behavior: Foundations, realities and challenges* (4th ed.). Mason, OH: South-Western.

Newstrom, J. W., & Davis, K. (1993). *Organizational behavior: Human behavior at work* (9th ed.). New York, NY: McGraw-Hill Book Company.

O'Hair, D., Stewart, R. & Rubsentein, H. (2006). *Speaker's guidebook: Text and reference* (3rd ed.). Boston, MA: Bedford/St. Martin's Publishing.

Peck, R. (1997, June 5). Learning to speak computer lingo. *(New Orleans) Times-Picayune*, p. E1.

Porter, M. (1985). *Competitive advantage: Creating and sustaining superior performance*. New York, NY: The Free Press.

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

Sobo, E. J., & Sadler, B. L. (2002). Improving organizational communication and cohesion in a healthcare setting through employee-leadership exchange. *Human Organization, 61*(3), 277–287.

Sperry, L., with Whiteman, A. (2003). Communicating effectively and strategically. In L. Sperry (Ed.), *Becoming an effective healthcare manager: The essential skills of leadership* (pp. 75–98). Baltimore, MD: Health Professions Press.

Spillan, J. E., Mino, M., & Rowles, M. S. (2002). Sharing organizational

messages through effective lateral communication. *Communication Quarterly, 50*(2): Research Library Core, Q96.
Thiederman, S. (1996). Improving communication in a diverse healthcare environment. *Healthcare Financial Management, 50*(11), 72–74.
Tubbs, S. L. (2001). *A systems approach to small group interaction* (7th ed.). Boston, MA: McGraw-Hill Book Company.

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Understanding Individual Behaviors

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

In Chapter 5, 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. Each of these theories contains some parts of the others, as they attempt to explain what motivates employees.

In Chapter 6, 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 7, we examine attribution theory. The discussion of attribution theory and its relevancy in the workplace provides managers with a better understanding of the highly cognitive and psychological mechanisms that influence individuals' motivation levels.

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 its criticisms.
- 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 and process. 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 (see **Figure 5–1**). In other words, motivation is the psychological process through which unsatisfied needs or wants lead to drives that are aimed at goals or incentives. The purpose of an individual's behavior is to satisfy needs or wants. 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: (1) content and (2) 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 behavior?" Content theories help managers understand what arouses, energizes, or initiates employee behavior.

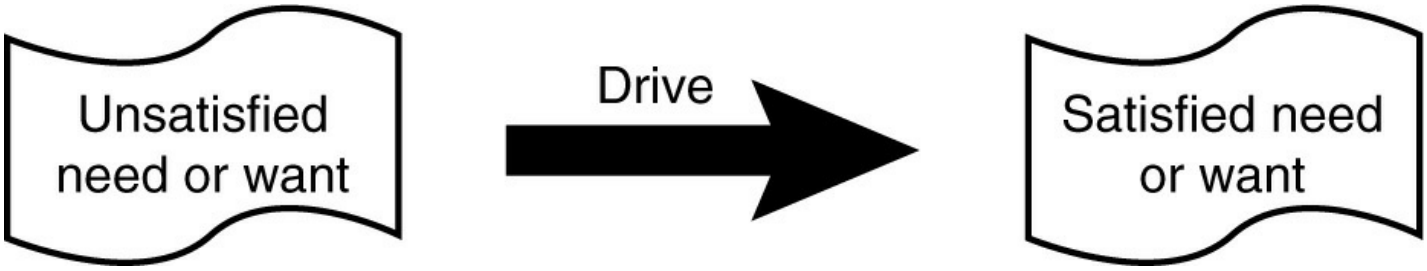


Figure 5–1 Process of Motivation

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 analysis of how behavior is energized, directed, sustained, and stopped. Process theories help explain how an employee's behavior is initiated, redirected, and halted.

Employee motivation has a direct impact on a health service organization's performance; therefore, managers need to understand what motivates employees. By understanding what motivates employees, managers can assist them in reaching their fullest potential. There are some factors the manager can control (e.g., extrinsic factors such as 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. As a brief background, humanistic psychology incorporates aspects of both

behavioral 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 not controlled only by internal or external factors (e.g., needs), but by both, and that some factors have precedence over others. From this concept, Maslow created his five-tier Hierarchy of Needs (see **Figure 5–2**).

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 are 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 or "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. Within the workplace, employees seek a sense of community and belonging. As such, 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 others, 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 grows when one receives attention and recognition from others for one's accomplishments. Therefore, careful use of praise and of positive feedback to staff is an important means of motivating employees. A pat on the back 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. 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.

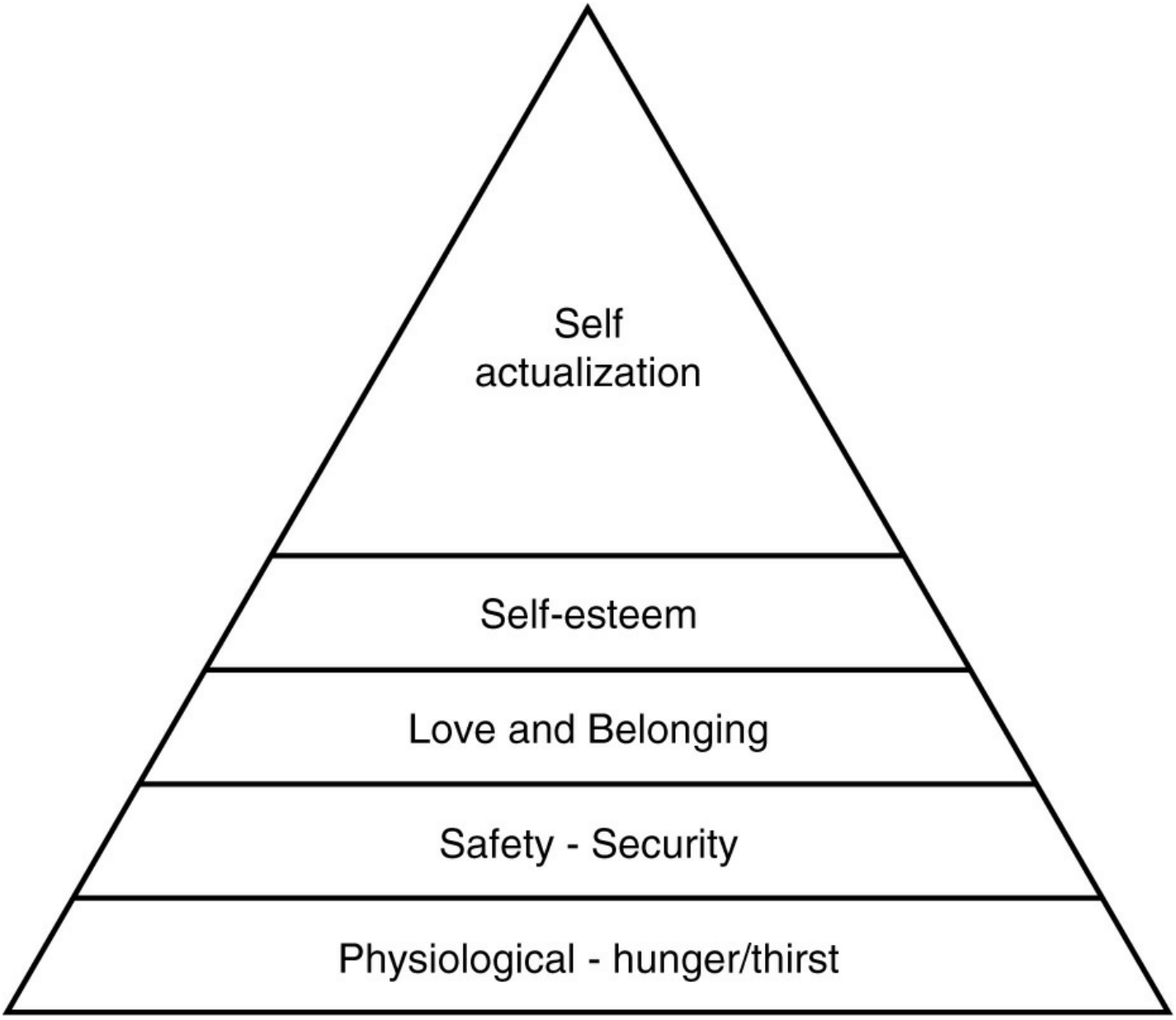


Figure 5–2 Maslow's Hierarchy of Needs

Reproduced from Motivation and personality, by A. H. Maslow, 1954, New York: Harper & Row.

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, they create an inner tension within the

individual that must be relieved (see **Case Study 5–1**: Poor Cindy, What Should She Do?). However, if an individual has satisfied his or her needs, those needs cease to motivate the individual, and the person moves to the next level in the hierarchy. 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.

Case Study 5–1 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 health system as a medical coder after obtaining her bachelor's degree. After 10 years, Cindy returned to school to earn an MHSA degree so 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 talking with Harry last week.

Harry and Cindy went to school together and have kept in touch over the years since Harry moved to another state to work for a larger health system. Harry told Cindy that he was laid off three months earlier and has not been able to even secure an interview with other provider organizations because of the uncertainty in the marketplace due to the reform changes. Harry's current experience further stressed Cindy as she thought about how this could be her situation soon. She tried to get reassurance from her boss about her job security, but he just seemed to give her the runaround. Due to 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 four weeks due to stomach cramps and headaches.

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

The highest level of need is an individual's desire to become all that he or she 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 we are, and to become everything that one is capable of becoming. It is referred to as a "being need" (B-need) because it is motivating without deficiency, as with the D-needs. In Maslow's view, self-actualization is not an endpoint, but rather 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 due to things such as illness (lack of physiological well-being), loss of 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 all employees are not driven by the same needs, nor is any employee driven by the same need at the same time. For example, right now as you read this book, you may have several needs operating simultaneously—curiosity, 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 in Maslow's Hierarchy of Needs (see **Figure 5–3**).

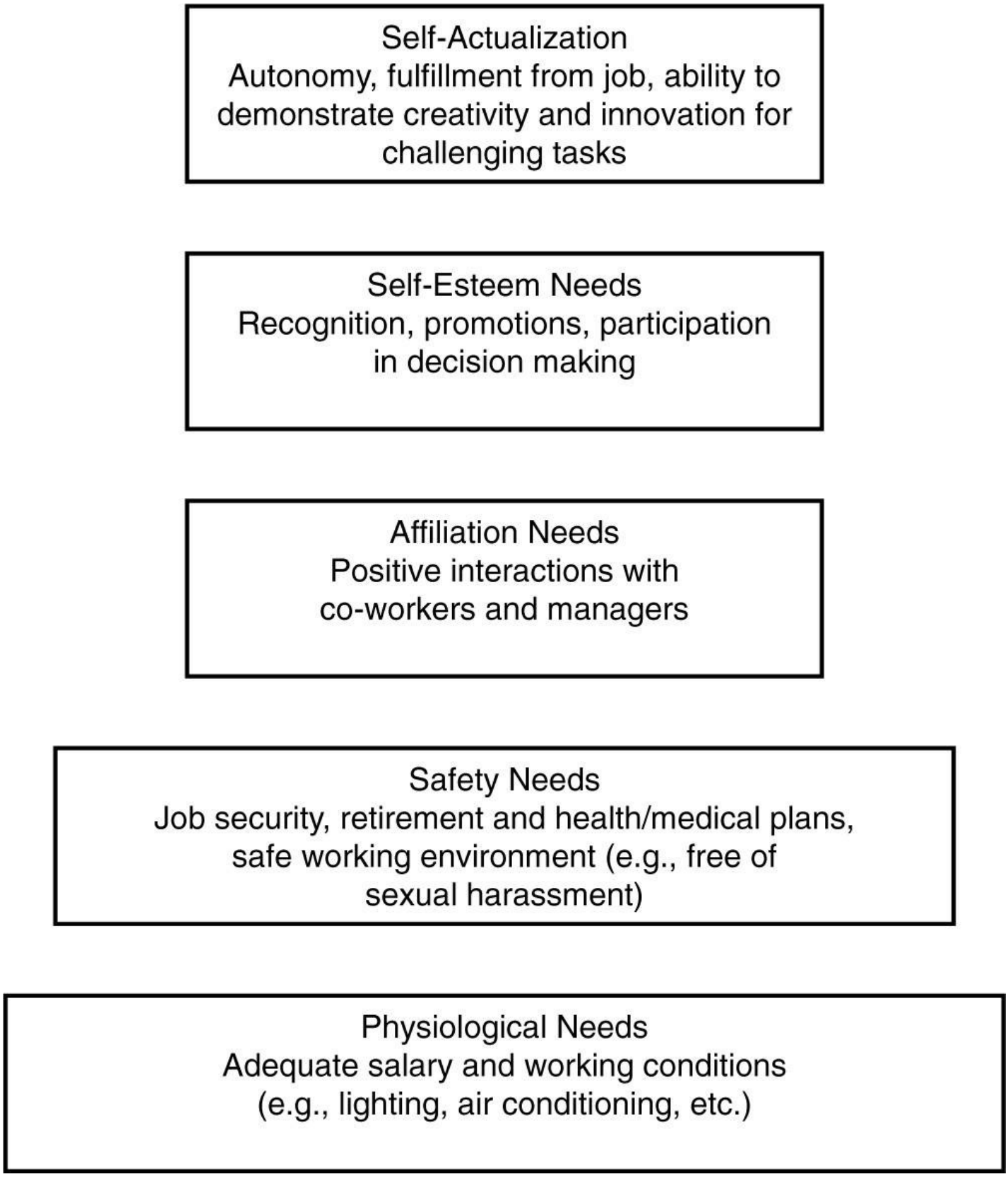


Figure 5–3 How Managers Can Satisfy Employees' Needs at Different Levels of Maslow's Hierarchy of Needs

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 published have reported mixed findings (Alderfer, 1972). In fact, some research contradicts Maslow's specific "ordering" of needs. For example, Huizinga, as cited in 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. He 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, 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).

In addition, 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. X).

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 5–1**).

- *Existence* refers to an individual's concern with basic material and physiological existence requirements, such as food, water, pay, fringe benefits, and working conditions.
- *Relatedness* refers to the need for developing and sustaining interpersonal relationships such as relations 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 are satisfied. In other words, the ERG Theory does not require an individual 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 compared to Maslow.

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 5–1 Alderfer's ERG Theory

Level of Need	*Definition*	*Properties*
Growth	Impel a person to make creative or productive effects on himself or herself and the environment.	Satisfied through a person using his or her 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 their 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 divided among people, one person's gain is another's loss when resources are limited.

Third, which may be 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 obtaining a higher-level need, a person may "regress" to a lower-level need (or vice versa) to achieve satisfaction. For example, a person wants existence-related objects when his or her 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; focusing exclusively on one need will not effectively

motivate an employee. In addition, the frustration–regression principle impacts workplace motivation. For example, if growth opportunities are not provided to employees, they may regress to relatedness needs and socialize more with coworkers, or even 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, an increased desire for more money or better working conditions may occur. 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 5–2**: I Get by with a Little Help from My Friends.)

Case Study 5–2 I Get by with a Little Help from My Friends

Jennifer Smith, RN, has worked at St. Joe's Medical Center for the past five 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 her coworkers. Almost every day, they eat lunch together. They have monthly dinner parties at one another's homes and 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 felt her nursing career was at a stalemate, and that she was getting bored with "doing the same thing every day." Jennifer questioned why she went back to school to earn her MSN degree, when Helen never gave her an opportunity to apply what she had learned. Jennifer started to think about looking for a new position at a different hospital that would give her the opportunity to grow professionally. Jennifer's coworkers empathized 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 Jennifer was informed by Helen that another staff member with more "management" experience was 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 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 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.

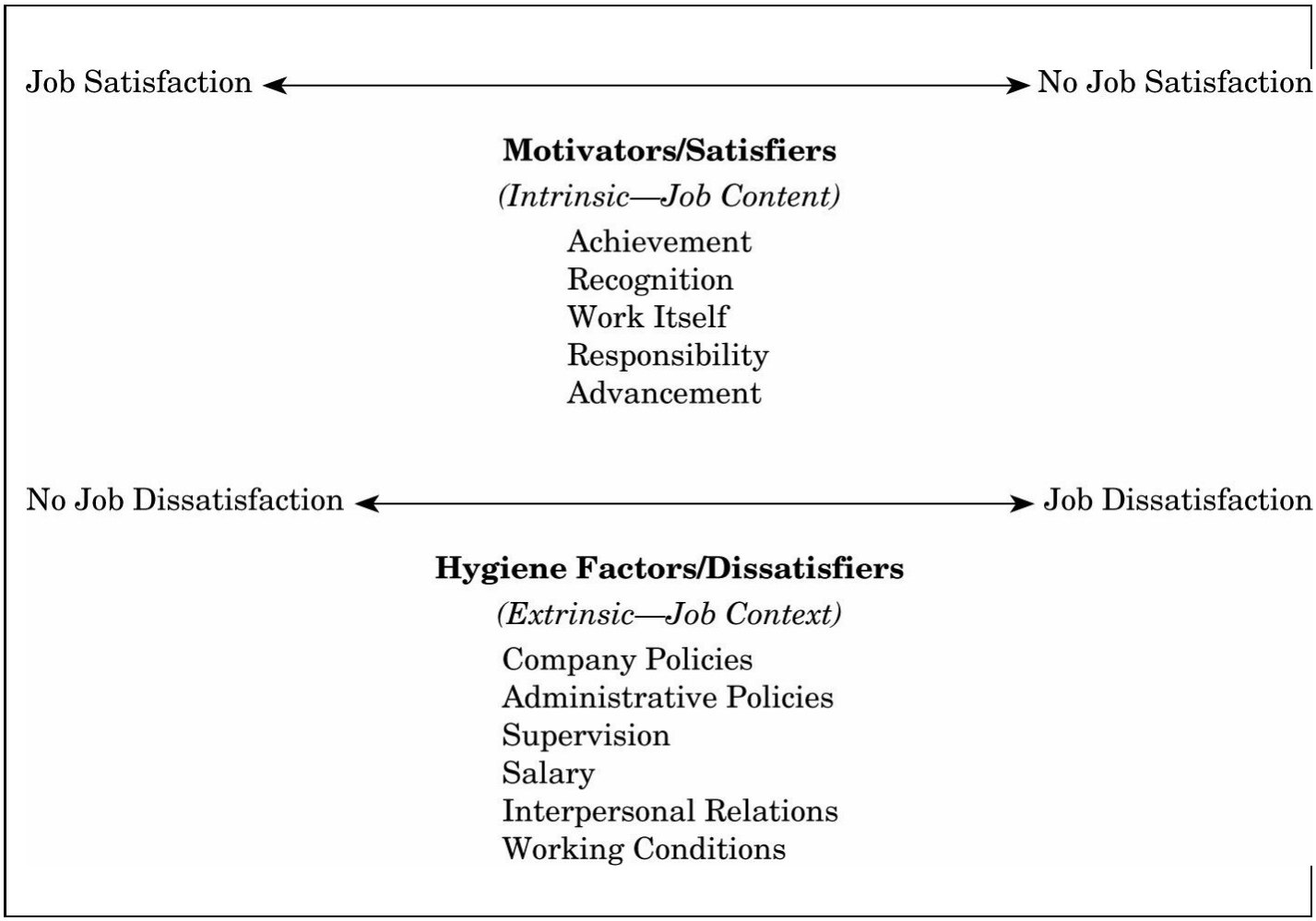
HERZBERG'S TWO-FACTOR THEORY

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, which 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 5–1**).

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 illustrated in Exhibit 5–1, 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 the satisfiers, referred to as motivators, assist employees with increasing their motivation to do their work (job content). Unfortunately, Timmreck's (2001) study of 99 health service midmanagers found that only a minority actually believed in and used motivators to stimulate subordinates' behavior.

Exhibit 5–1 Job Satisfaction



One of the criticisms of Herzberg's Two-Factor Theory is that a single factor may be a motivator for one person, but cause job dissatisfaction for another. As an example, increased responsibility may be welcomed by one employee, but avoided by another. Another criticism has been Herzberg's placement of salary/pay in the dissatisfier category, which has caused some to 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 reititerated in Daniel Pink's (2011) book *Drive: The Surprising Truth About What Motivates Us*. He 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 5–2**).

Exhibit 5–2 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 percent of employees said that in the past 12 months, their managers had done things that made them want to quit. And 89 percent 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 eight 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.

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 percent 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 percent 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, available at: 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 doesn't the level of an employee's productivity equate to the compensation received by their workers?"

In the late 1950s, the U.S. economy was in a tremendous economic 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 amounts of performance. Herzberg's work validated what the employers were feeling. Herzberg suggested that higher performance levels would come not from higher salaries but by giving employees the opportunity to create and impact their 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 5–3**: Why Don't I Just Quit!).

Case Study 5–3 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 to herself, "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 an MSW and has been a social worker for the Alpine Medical Center for the past four years. Although she loves her interaction with her clients, with the ability and freedom to help them through the "system" satisfying all 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 graduate with an AS/Nursing are earning. In addition, Robin believes 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 hasn't been able to find the money in the department budget to purchase a new computer that she desperately needs to help her clients. To make matters worse, her coworkers, who "live in their own worlds," never extend 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 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 tell her that without her assistance, he would not have known all the community services available to him so 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.

Building 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 (fulfiling 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 they ask their employees to do. Herzberg's approach can be summarized by "if you want people to do a good job for you, then you must give them a good job to do." Managers need to be concerned with job-design characteristics, including job enrichment. Job enrichment is the vertical expansion of the job as opposed to a horizontal expansion (job enlargement) (see **Table 5–2**).

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 5–4**).

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.

Table 5–2 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 his or her activity; job freedom	Responsibility, achievement, and recognition
Making periodic reports directly available to the worker himself or herself 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: One more time: How do you motivate employees? by F. Herzberg, *Harvard Business Review, 81*(1), p. 93, 1983.

- *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 5–4, 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, where 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 and 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.

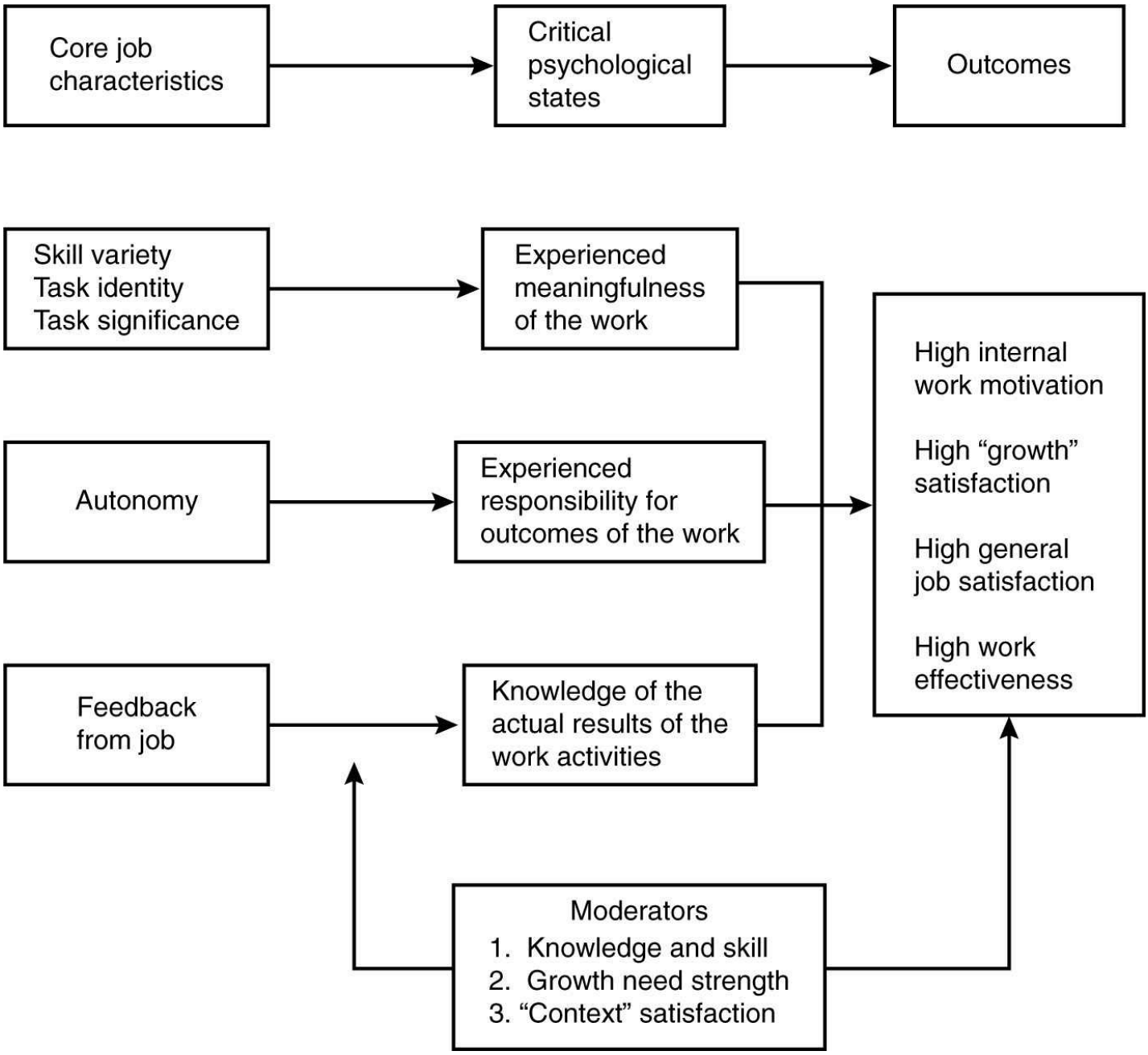


Figure 5–4 The Job Characteristics Model of Work Motivation

Source: Work redesign (p. 90), by J. R. Hackman and G. R. Oldham, 1980, Reading, MA: Addison-Wesley.

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." Others have less strong needs for growth or personal accomplishment. Therefore, individuals with strong growth needs respond positively to the opportunities provided by enriched work. However, individuals with low growth needs may not recognize the existence of

enriching opportunities, or may not value them, or may 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 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, challenging task, and 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 would 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 and Oldham, 1975). The 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 and divided by three, 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 meaningfulness of the work. 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 four years. Grant and his colleagues' work supports that careful job redesign that increases performance and satisfaction is an important factor not only for employees but for organizations as well. 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 six months later, it showed that not only were the tellers more satisfied with their roles, but they were also more committed to the organization (Grant, Fried, & Juillerat, 2010).

MCCLELLAND'S THREE-NEEDS THEORY

David McClelland (1985) experimented with individuals' responses to pictures of various groups of persons 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 persons 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 need to be liked by his or her subordinates, colleagues, and supervisors. Although persons with high power needs are attracted to leadership roles, they may not have the required flexibility and human relations skills necessary to be effective. McClelland argues that persons 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 persons do not possess a strong n-Ach motivation, those who do 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 where 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 they would never miss. Another group stood so far away that if they actually did place the ring on the peg, it was due to chance, not ability. The third group calculated their distance from the peg. They didn't stand too far away to make the task impossible, nor did they stand too close 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 persons have various attributes. First, n-Ach persons 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 goals 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 persons view goal achievement as their reward and require feedback that is quantifiable and factual. As such, they equate 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 persons 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. Those with a high need for personalized power have tendencies to display impulsive aggressive actions, abuse alcohol, and 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 versus loyalty to the organization. Yukl (2001) points out that when a high personalized power leader leaves an organization, it usually results in 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 versus their own personal gain. As McClelland (1985) and Yukl (2001) relate, they are more interested in seeking power because it is through power that they can influence others 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 persons in n-Aff. They prefer friends over experts when working in groups (n-Ach 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. As such, individuals with a high need for affiliation do not make good managers (see **Case Study 5–4**: The Office Manager's Dilemma).

Case Study 5–4 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 six years and considered it 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 's birthdays and anniversaries were recognized and celebrated. She was very concerned that everyone was happy and 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 's 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 also over the years she had assumed the responsibilities for ordering supplies and scheduling surgeries.

Karen thought making the transition to office manager would be easy. 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 the staff's lunch periods. In addition, she was overscheduling, causing patients to wait for hours. Karen told the office staff 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 and I love working in such a warm and friendly office."

A week later, the staff approached Karen again and asked if she had spoken with Suzie because the problems were getting worse. Karen lied and said that last week was so busy, 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 caused their workload to increase 20 percent.

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 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 if Dr. Green made the right decision promoting Karen Lewis to office manager. Why?

SUMMARY

When a comparison is made of the content theories of motivation, there are noted similarities (see **Table 5–3**). Each theory describes 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 after 60 years (Latham & Pinder, 2005).

Table 5–3 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 Self-esteem	Growth	Achievement
Hygiene factors	Love	Relatedness	Power (influencing others) Affiliation (exchange of warm feelings)
	Safety Physiological	Existence	

DISCUSSION QUESTIONS

1. Define motivation.
2. Explain the connection of 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.

CASE STUDIES AND EXERCISE

Case Study 5–5 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 six 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 certainly 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.

Reproduced from Pidge Diehl, EdD.

Case Study 5–6 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 three years ago after relocating from the northeast. She is 30 years old and has been a staff nurse since graduating from a two-year college nursing program 10 years ago. She is married to a lawyer, and they have two children, ages 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 been running pretty high because of time 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 percent pay increase. With this increase, the hospital staff is now the highest paid as compared with other hospitals within the region. Jane believes 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 her willingness to work hard and had made very few, if any, patient-care errors. However, over the past three months, Jane has noticed that Susan is not performing at her same productivity level and appears to argue frequently with the treating physicians and other nurses about the patients' treatment plans. Jane frequently 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 her prior "self"?

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

Case Study 5–7 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 percent of respondents described improving communications and personal relationships.
- 9 percent mentioned improving leadership quality.
- Only 3 percent 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 5–8 We Only Wanted to "Scare" Management into Making Changes!

A small group of nurses, employed at a large community hospital, were unhappy about their work environment and would meet daily during lunch to discuss the situation. There had been a recent change in the hospital's senior management, which caused 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 two years; and the cost of living in their community had increased by 10 percent 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, with no appreciation or recognition of their efforts. Due to recent layoffs of support staff, each day the nurses lost precious time caring for their patients due to hunting for needed medications and supplies. They felt that these "hunting and gathering" activities threatened patient

safety because it kept the nurses away from the bedside. They also had enough of the physicians' verbal abuse and disruptive behaviors. Whenever the nurses approached management with their concerns, they perceived them as falling on deaf ears since no changes were made.

Feeling like they had no other choice, the nurses contacted a labor union. The labor union began an organizing effort in the hospital shortly thereafter, holding an aggressive campaign over a six-week period. There was tremendous peer pressure, as some of the well-respected nursing staff became active leaders for unionization, although they were not part of the initial group of nurses 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 5–1 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 (1)	Slightly Disagree (2)	Disagree (3)	Undecided (4)	Slightly Agree (5)	Agree (6)	Strongly Agree (7)

My job:

1. Provides much variety. _____
2. Allows me the opportunity to complete the work I start. _____
3. Is one that may affect a lot of other people by how well the work is performed. _____
4. Lets me be left on my own to do my own work. _____
5. Provides feedback on how well I am performing as I am working. _____
6. Provides me with a variety of work. _____
7. Is arranged so that I have a chance to do the job from beginning to end. _____

8. Is relatively significant in the organization. _____
9. Provides the opportunity for independent thought and action. _____
10. Provides me with the opportunity to find out how well I am doing. _____
11. Gives me the opportunity to do a number of different things. _____
12. Is arranged so that I may see projects through to their completion. _____
13. Is very significant in the broader scheme of things. _____
14. Gives me considerable opportunity for independence and freedom in how I do my work. _____
15. 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.

© Donald Clark, created March 18, 2000, last update August 28, 2010. Available at: www.nwlink.com/~donclark/leader/jobsurvey.html.

REFERENCES

Alderfer, C. (1972). *Existence, relatedness, and growth*. New York, NY: Free Press.

Dent, E. B. (2002). The messy history of OB&D: How three strands came to be seen as one rope. *Management Decision, 40*(3), 266–280.

Dolea, C., & Adams, O. (2005). Motivation of health care workers: Review of

theories and empirical evidence. *Cahiers de Sociologie et de Démographie Médicales, 45*(1), 135–161.
Grant, A. M., Fried, Y., & Juillerat, T. (2010). Work matters: Job design in classic and contemporary perspectives. In S. Zedeck (Ed.), *APA handbook of industrial and organizational psychology* (*Vol. 1*, pp. 417–453). Washington, DC: American Psychological Association.
Griffin, E. (1991). *A first look at communication theory*. New York, NY: McGraw-Hill Book Company.
Hackman, J. R., & Oldham, G. R. (1975). Development of the job diagnostic survey. *Journal of Applied Psychology, 60*(2), 159–170.
Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational Behavior and Human Performance, 16*, 250–279.
Hackman, J. R., & Oldham, G. R. (1980). *Work redesign*. Reading, MA: Addison-Wesley.
Herzberg, F. (1966). *Work and the nature of man*. New York, NY: The World Publishing Company.
Herzberg, F., Mausner, B., & Snyderman, B. (1959). *The motivation to work*. New York, NY: John Wiley & Sons.
Latham, G. P., & Pinder, C. C. (2005). Work motivation theory and research at the dawn of the twenty-first century. *Annual Review of Psychology, 56*(4), 85–516.
Lunenburg, F. C. (2011). Motivating by enriching jobs to make them more interesting and challenging. *International Journal of Management, Business, and Administration, 15*(1), 1–11.
Maslow, A. H. (1954). *Motivation and personality*. New York, NY: Harper & Row.
Maslow, A. H. (1970). *Motivation and personality* (2nd ed.). New York, NY: Harper & Row.
McClelland, D. C. (1961). *The achieving society*. New York, NY: The Free Press.
McClelland, D. C. (1985). *Human motivation*. Glenwood, IL: Scott-Foresman. O'Connor, D., & Yballe, L. (2007). Maslow revisited: Constructing a road map of human nature. *Journal of Management Education, 31*(6), 738–756.
Pink, D. H. (2011). *Drive: The surprising truth about what motivates us*. New York, NY: Riverhead Books/Penguin Group.
Sashkin, M. (1996). *The MbM questionnaire: Managing by motivation* (3rd

ed.). Amherst, MA: Human Resource Development Press.
Timmreck, T. C. (2001). Managing motivation and developing job satisfaction in the health care work environment. *Health Care Manager, 20*(1), 42–58.
Yukl, G. A. (2001). *Leadership in organizations* (5th ed.). Upper Saddle River, NJ: Pearson Education.

OTHER SUGGESTED READING

Campbell, J. P., Dunnette, M. D., Lawler, E. E., & Weick, K. E. (1970). *Managerial behavior, performance and effectiveness*. New York, NY: McGraw-Hill Book Company.
Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*, 370–396.

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 impact 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 varying levels of education. On a daily basis, we need to manage not only secretarial staff with minimal educational requirements, but also highly skilled individuals such as nurses, physicians, and other licensed health care professionals. As such, process theories assist us in predicting employees' behavior so 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 is dependent upon (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 × I × E (see **Figure 6–1**).

Vroom (1964) explains that the force that drives a person to perform is dependent upon three factors: valence, instrumentality, and expectancy (pp. 15–19).

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 it to not attaining it, a valence of zero when the person is indifferent to attaining or not attaining it, and a negative valence when the person prefers not attaining it to attaining it. As such, 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. As such, one outcome, advancement, is positively related to or instrumental with respect to achieving another outcome—achievement. Others may not want the promotion because it would require additional time commitment and, therefore, less time for family or friends. Therefore, one outcome, advancement, is negatively related to or instrumental with respect to another outcome—need for affiliation.

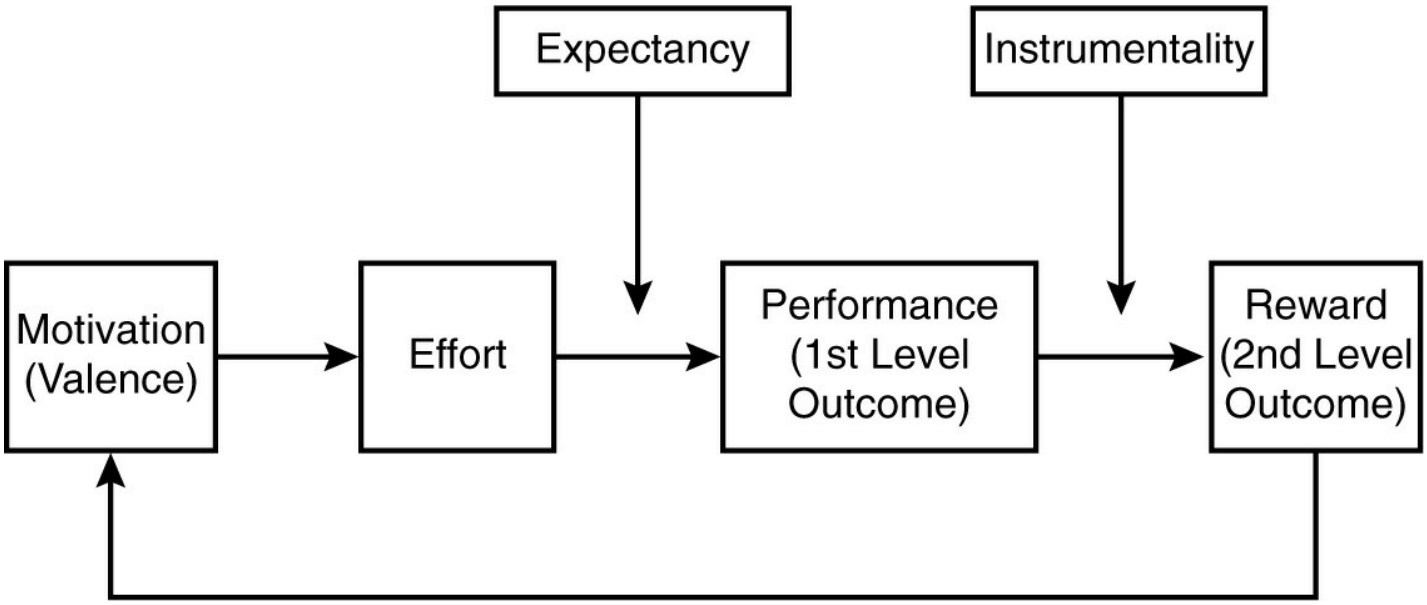


Figure 6–1 Vroom's Expectancy Theory (VIE)

Instrumentality is an individual's perception that his or her 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 he or she believes that behavior will be rewarded with something that has value to the individual. For example, a person believes that by producing both high-quality and high-quantity work, it will result in recognition (e.g., praise) or a promotion from his or her supervisor.

Expectancy is an individual's perception that his or her effort will positively influence his or her 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 perceives that if he or she works 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 it routine and unchallenging? Does the job incorporate Herzberg's Two-Factor Theory motivators?
2. *Criteria*: Does he or she 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 an employee is aware of what he or she is 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 avoid future growth opportunities.
5. *Confidence*: Does the individual believe he or she can perform the job well? Employees need to believe that they can perform a task well. Although an employee may have the knowledge and skill, he or she may not see himself or herself with 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 6–2**.)

For managers, Expectancy Theory is very useful because it helps to understand a worker's behavior. If employees lack motivation, it may be caused by their 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 the organization will not promote from within, then the employee has low *instrumentality*, and the employee will not be motivated to perform his or her job at a high level. So the important question for managers to ask is, "What rewards (outcomes) do my employees value?" (See **Case Study 6–1**: Jane Wants to Be an RN.)

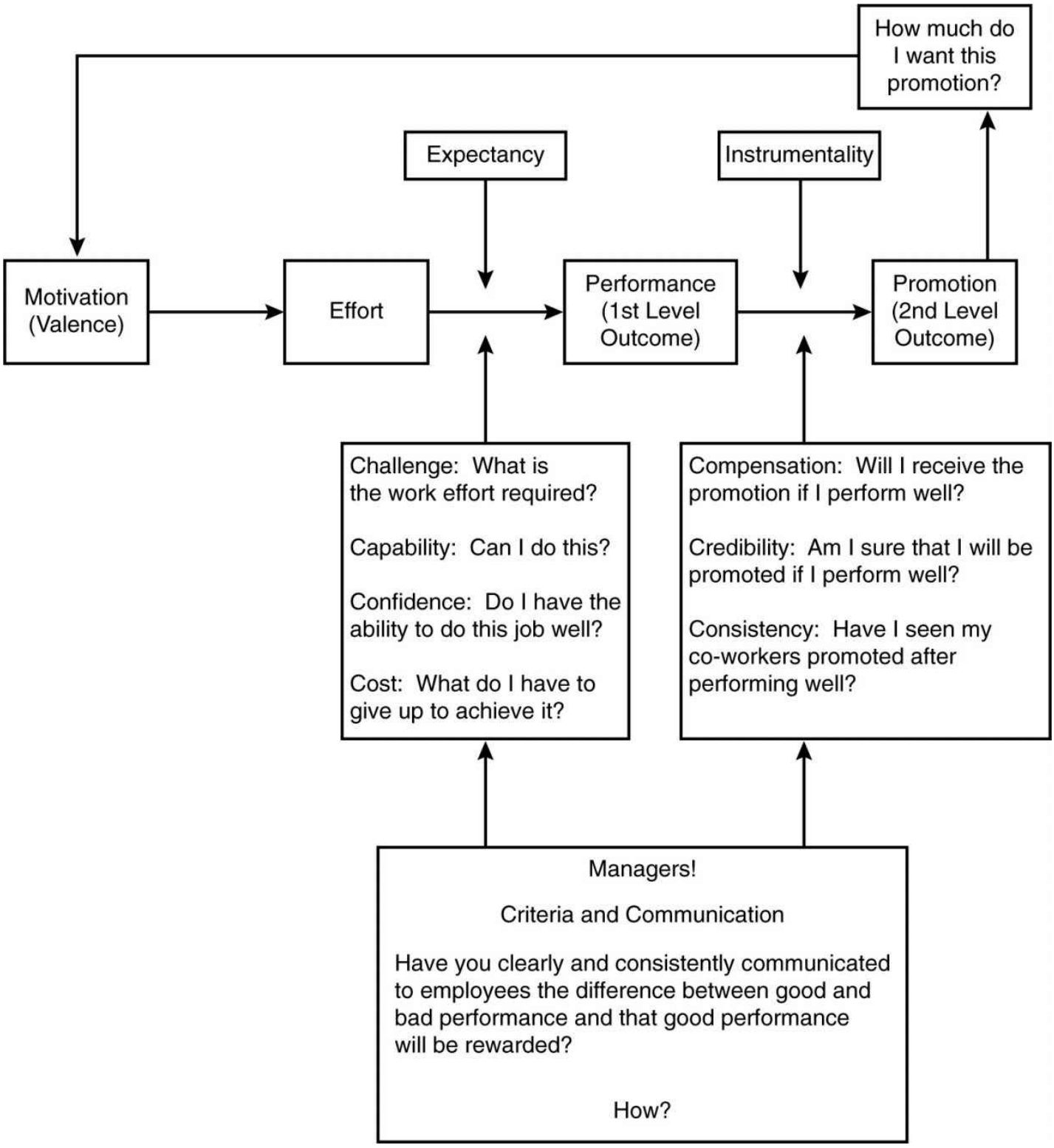


Figure 6–2 Application of Expectancy Theory Using Newsom's Nine Cs

Case Study 6–1 Jane Wants to Be an RN

Jane Smith is a 21-year-old single mother of two children, ages 3 and 4 years old. 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, which is located across the street from her mother's house and two blocks from the nursing home that she works at as a LPN. Jane 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 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 to take advantage of this opportunity. 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), p. 507. Reprinted with permission.

EQUITY THEORY

J. Stacy Adams (1963, 1965) proposed his Equity Theory, stating that a person evaluates his or her 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. First, 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 and contributions of both parties to an exchange, satisfaction is likely to result from the interaction (Mowday, 1983). If an inequality is perceived, then dissatisfaction occurs, which triggers an internal tension within one or more of the individuals. For example, a hardworking, dedicated employee believes that she is paid a fair salary given her experience and education until she becomes aware that other departmental staff with the same level of seniority and education are paid higher salaries. This new information may cause the employee to become unmotivated, thus lowering her level of productivity.

The two major components in Equity Theory are inputs and outcomes. Inputs are defined as those things a person contributes to an exchange. In the workplace, an employee's inputs would be 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 others' outcomes and inputs (see **Figure 6–3**).

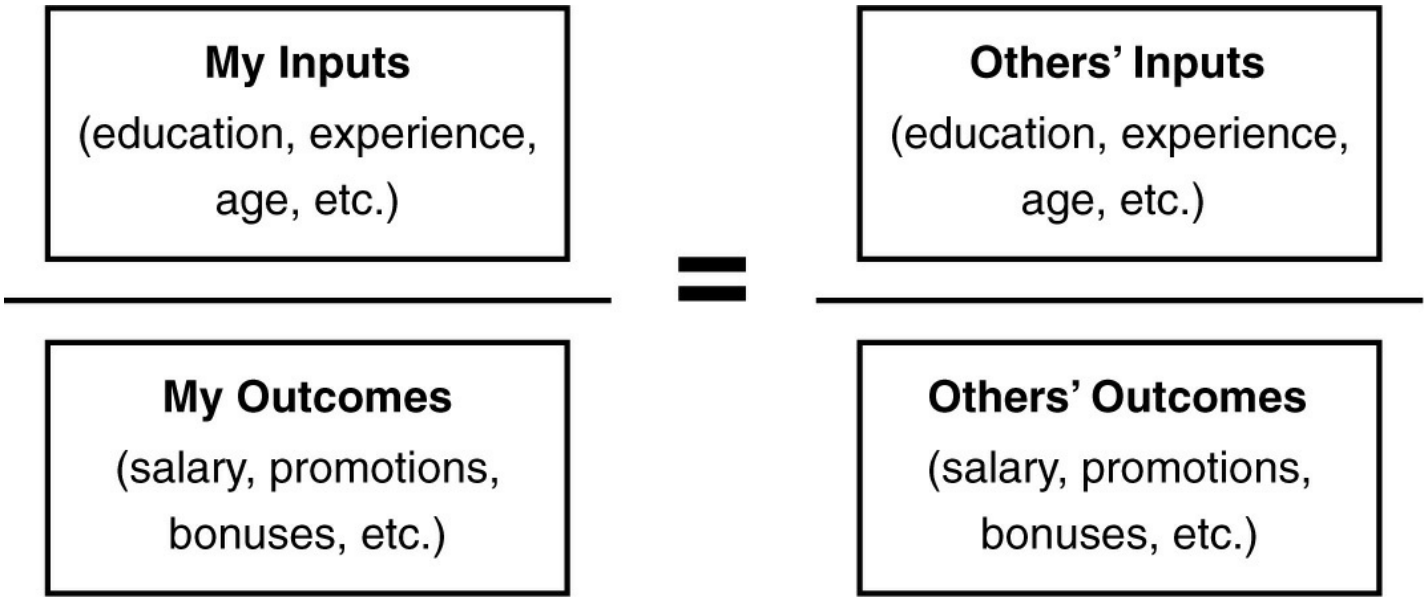


Figure 6–3 Adams's Equity Theory

Several important aspects of Adams's theory are noted. 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 the similar ratio. Third, inequity exists when a person is either underpaid or overpaid. For example, if employees perceive they are overcompensated, they may increase their level of productivity. If employees perceive they are undercompensated, they may either decrease their level of productivity or attempt to obtain additional compensation.

Adams (1965) proposed that when an inequity is perceived by an individual, (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 him or her to relieve it, and (4) the strength of the motivation to reduce the tension is proportional to the perceived inequity. Adams states that there are several cognitive and behavioral mechanisms 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:

1. *Altering Inputs*: Reduce productivity, take longer break times, and use sick days for personal activities.
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 will be selected by the individual. The behavior chosen by the individual depends on the situation with the goal of maximum utility (see **Case Study 6–2**: I Don't Know What to Do). 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. Another group may lower their level of productivity and become disruptive in the workplace, expressing negative attitudes toward management and/or their peers. Other individuals 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 6–2 I Don't Know What to Do

Katie was disgusted with the situation she was in. 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 the past 10 years. She originally started in the housekeeping department, but she knew she wanted more. So Katie 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 at the time she returned to school and that it took her three long years to earn her associate of science degree. It was worth the time and effort, although sometimes she had to admit it was stressful working full time during the day in the housekeeping department, with three small children at home. But her husband Mike supported her, taking care of the children and household chores at night and on weekends so she could attend class or study in 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 four years since she became an RN, and Katie has enjoyed working in the hospital's intensive care unit (ICU)—that was, until Beth joined the ICU nursing staff last year.

When Katie returned home one evening, Mike could see that Katie was very upset. When Mike asked her what was bothering her, she related,

"Beth has been working at Good Point Hospital for two years and in the ICU for the past year. I am now convinced that Beth has absolutely no work ethics. Maybe it's part of her being in the Millennial generation a Millennial; her 21st birthday is next month. She spends half of her shift either on the phone or emailing 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 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 Beth 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 Beth's 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 Beth 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 had my share of non-holiday time off, and everyone has to work his or her way up the ladder. I've spoken to Terry, our manager, about Beth on numerous occasions, but I feel I'm wasting my time. Terry 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!

Discuss Katie's motivation to quit the ICU using Adams's Equity Theory.

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. As such, 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 a great concern to organizations because turnover and absenteeism have a direct influence on an entity's effectiveness (Lawler, 1983). 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 to improved performance.

The Porter and Lawler model reflects that satisfaction results from performance itself, the rewards for performance, and the perceived equitability of those rewards (see **Figure 6–4**).

Porter and Lawler (1968a) stated that job satisfaction is generated when an employee receives rewards for his or her 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 he or she believes he or she is receiving.

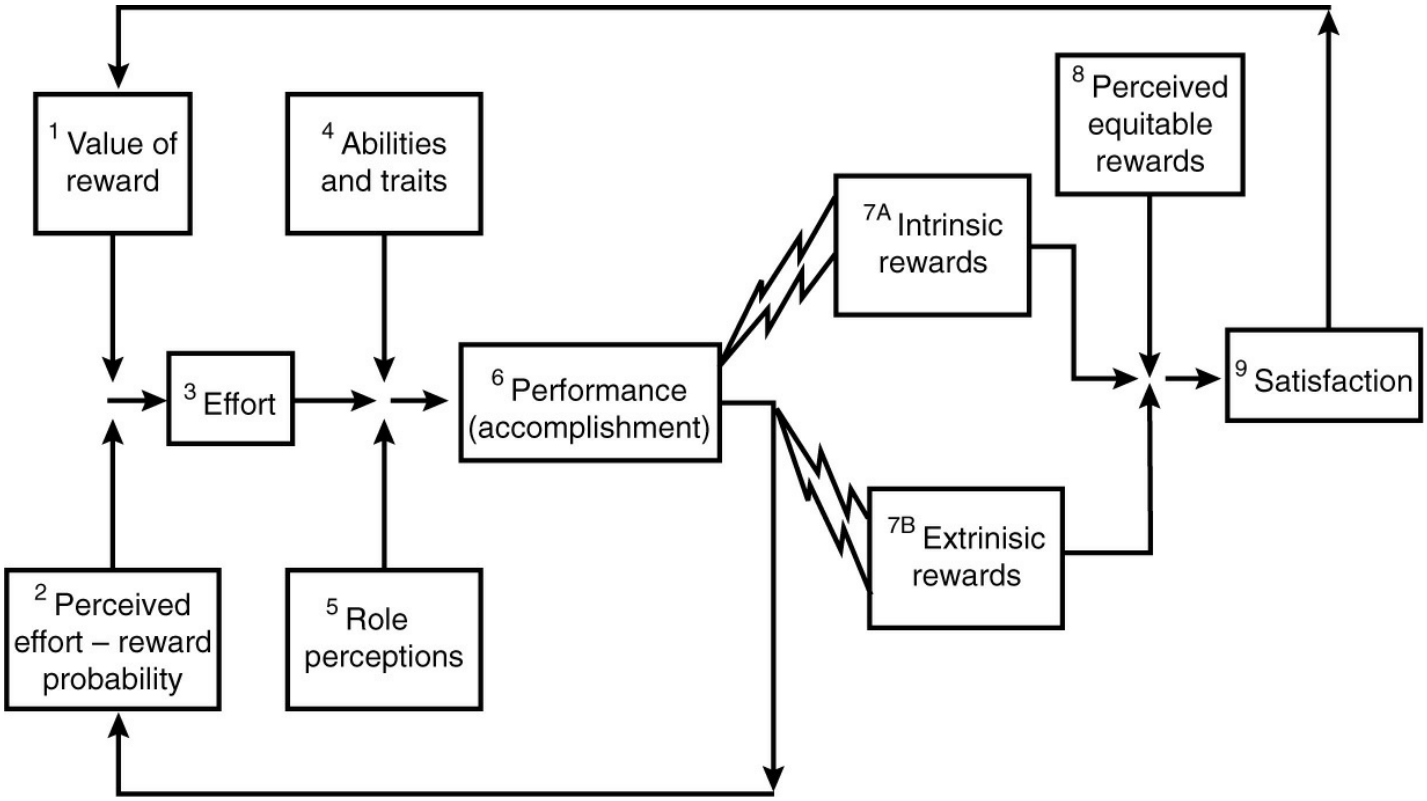


Figure 6–4 Porter–Lawler Satisfaction–Performance Model

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 he or she has performed (e.g., pay increases based on seniority or labor union agreements). As such, 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) where rewards are received on the basis of the quality and quantity of his or her performance, there would be a correlation between satisfaction and performance. Porter and Lawler's (1968a, 1968b) 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 he or she perceives that a higher degree of effort on his or her 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 1974–75 study, Latham found that unionized truck drivers increased the number of logs loaded onto their trucks from 60 percent to 90 percent of the legal allowable weight as a result of setting goals. They saved the company $250,000 in nine 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 6–5**). 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.

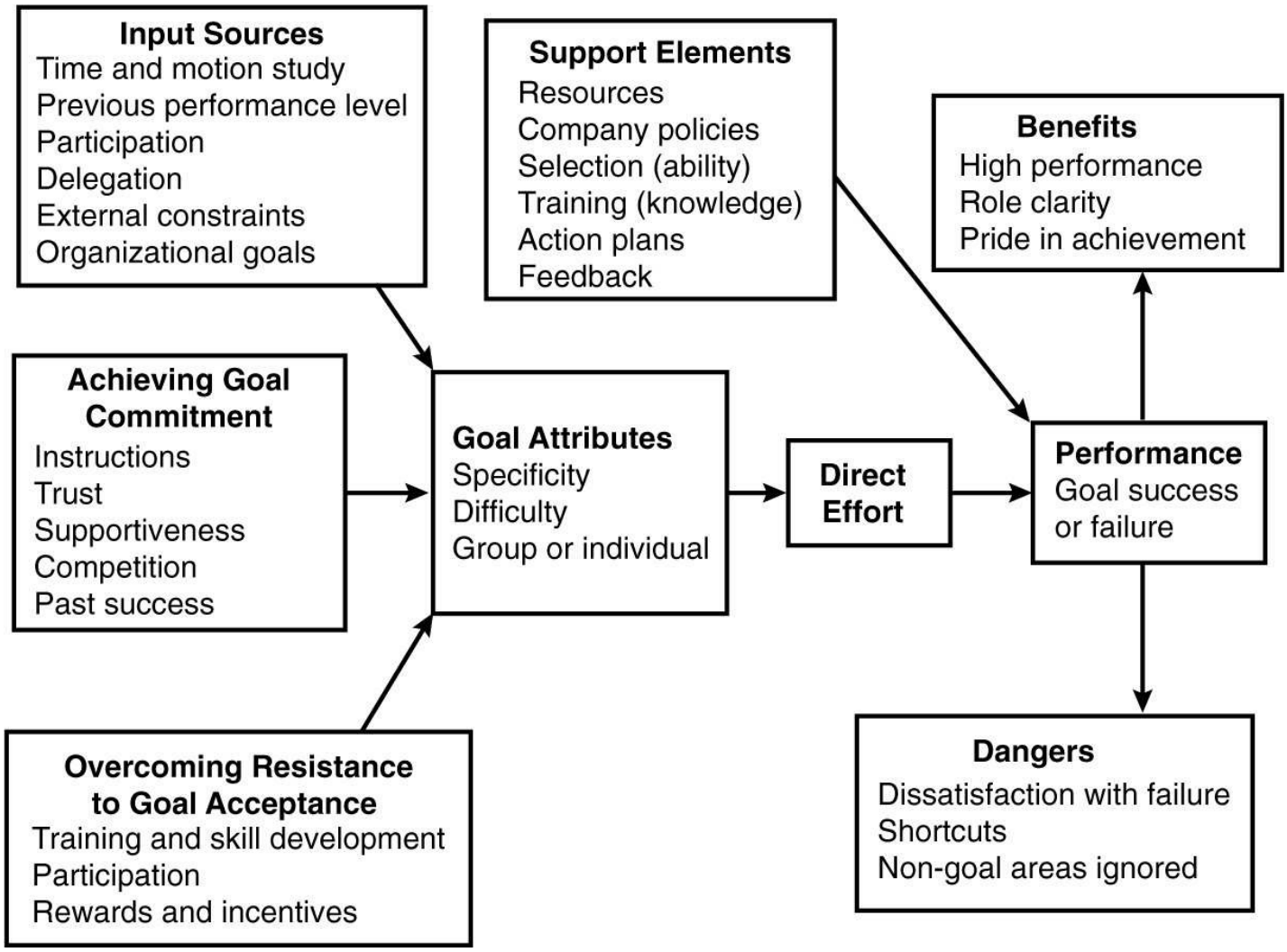


Figure 6–5 Latham and Locke's Goal-Setting Model

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: (1) setting the goal, (2) obtaining goal commitment, and (3) providing support elements.

1. *Setting the Goal*: The goal 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 percent within the next six 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 employee will experience dissatisfaction and frustration. Managers need to be conscious that seeking 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, for managers to 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 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 Goal Commitment*: 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 may perceive themselves as being incapable of reaching the goals. To overcome this resistance, managers need to provide training to increase employees' skills and knowledge, therefore increasing their self-confidence that the goal can be achieved. Second, employees may not see any relationship between their personal benefits (i.e., feeling of accomplishment or external rewards) and obtaining 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 obtaining the agreed-upon goals.

3. *Providing Support Elements*: Managers must ensure that employees have adequate resources (e.g., financial, equipment, time, assistance, etc.) 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 may 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 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 poor management or the low or undercompensation 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 understand and influence, when necessary, behavioral change by the reinforcements used. 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 6–6**) (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 staff, the daily turnover time decreased by 15 percent within a six-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.

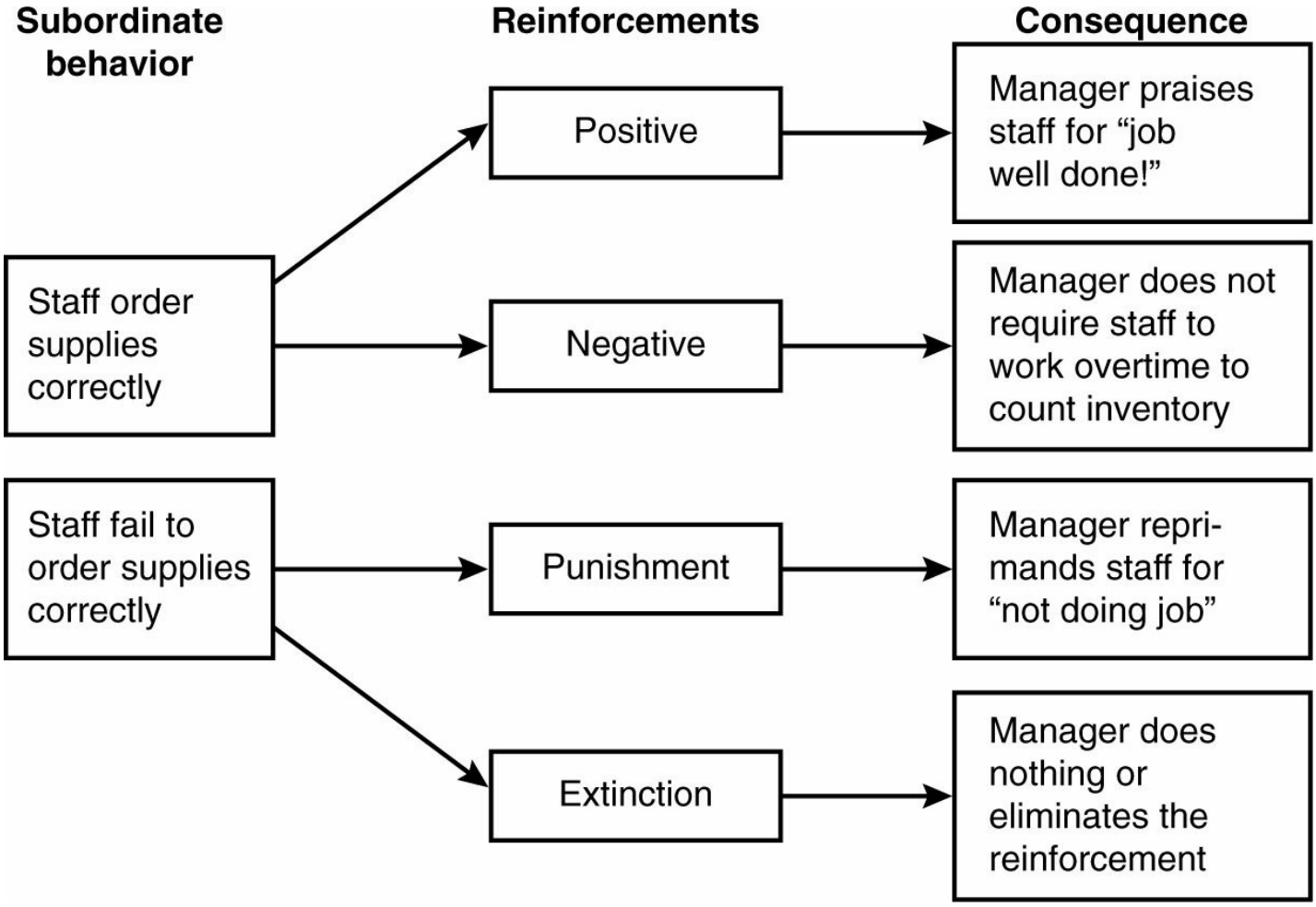


Figure 6–6 Reinforcement Theory and Types of Reinforcements

Negative reinforcement occurs when an unpleasant effect is eliminated or avoided, which, like positive reinforcement, encourages repeated positive behavior. We return to 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) 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 in the attempt 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. (Because of this reprimand, the OR nurse was "motivated" to design an inventory system so 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 her to update the inventory supply list within 24 hours, which required her to work on her scheduled day off and cancel her 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), he or she 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 with the following message: "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 regarding the administrating of punishment reinforcements. Unless done carefully and appropriately, the effects can cause long-term consequences for the organization. It 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). Variableratio 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?

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SUMMARY

In this chapter, we discussed various process theories of motivation. These motivation theories help health care managers 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 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 6–3 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 felt 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 employees worked best at what they wanted to work at. But his problem still remained: There was no money in the training budget and no other employees as skilled with the system as Betty was. Was there an approach to convincing her to help that he hadn't thought of?

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 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, since 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 6–4 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 three years. Until recently, she had enjoyed her job responsibilities and coworkers, and although she would like to earn more money, she believes 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 as well as 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 eight months of the year to clients' facilities throughout the United States. During this period, Alice works 12-hour days, six 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 working this schedule because she enjoys what she does and she feels in the end it all balances out. Plus, although she has never requested time off during the traveling months, her director had said she would cover for Alice if the need arose.

Alice's traveling period just began, and she found out that her mother will need surgery the following month, which will require a two-day hospitalization stay and complete bed rest for a week. Alice's dad is available to help with the situation, but Alice and her mother are very close and she 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 due to being short staffed there is no one to cover her clients' training requirements during that week period. 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 this affects her reputation with the 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 three 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 giving up her weekends for eight months of the year, her director's delays that cause her to loss bonus money, and the lack of growth opportunities. She doesn't know how much longer she can continue working for MGM Healthcare Consulting Group.

Discuss Alice's job dissatisfaction and lack of motivation using Porter–Lawler's Satisfaction-Performance Theory.

Case Study 6–5 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 hospitals were ordered on a timely basis. This would cause the departmental staff who were performing their job 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 spent more time doing "other things" than their assigned jobs in the purchasing department.

Jack and Chris started becoming less motivated to work as hard because they felt they were picking up the slack of their coworkers. The overperformance levels for the department began to fall. Backlogs started to rise as well as complaints from the other functional units of the hospital when requested supplies were not received in a timely fashion. In fact, surgical cases had to be canceled and rescheduled because the proper supplies were not available for the surgeons. Something had to be done!

Using 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 6–6 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 no, why? Develop recommendations as to how to motivate physicians to improve 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 6–7 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 6–8 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 (all with graduate degrees in health administration). The staff is evenly divided

between males and females, single and married individuals between 25 and 35 years old. Of the 10 married, two spouses work outside the home. All the married individuals have families of at least two children, and all 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 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 his or her 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 are required to work approximately 55 to 60 hours per week. Staff receive two weeks' vacation annually, in addition to one week for continuing professional education and one week personal time, which is utilized by 100 percent of the staff.

Roger Harris is concerned because, although partners' billable hours (i.e., hourly rates charged to clients for services rendered) have increased 12 percent over the past two years, the staff's billable hours have decreased by 14 percent. In addition, Roger Harris noted that the turnover rate (i.e., percentage of the newly hired graduates that stay with the firm for approximately three to four years before taking a position in one of their client's hospitals) has increased to 50 percent (from 10 percent five years earlier).

In order to increase the firm's productivity and retention rate, Roger Harris initiated a bonus program as follows: If a staff member bills out 2,000 hours annually, he or she receives a bonus equal to 5 percent of his or her annual salary. For every hour billed over the minimum 2,000 hours, the employee is paid twice the hourly rate.

All employees earned their 5 percent bonus, but no one's productivity increased over the minimum 2,000-hour base.

Roger Harris was concerned by this lowering productivity and increasing 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 the staff displayed their willingness to do so, as long as the time required to develop the articles would be applied toward their minimum 2,000 hours' bonus calculation.

Roger Harris related to 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 eight to ten years of continuous employment with the firm). However, the most recent promotion to partner was made to an individual hired from the outside after only three years of employment with the firm.

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

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

REFERENCES

Adams, J. S. (1963). Toward an understanding of inequity. *Journal of Abnormal and Social Psychology, 67*, 422–436.

Adams, J. S. (1965). Inequity in social exchange. In L. Berkowitz (Ed.), Advances in experimental social psychology (*Vol. 2*, pp. 267–300). New York, NY: Academic Press.

Fusion, J. (n.d.). Motivation & goal setting theory. Available at: smallbusiness.chron.com/motivation-goal-setting-theory-1187.html

Latham, G. P., & Locke, E. A. (1983). Goal setting—A motivational technique that works. In J. R. Hackman, E. E. Lawler, & L. W. Porter (Eds.), *Perspectives on behavior in organizations* (pp. 296–304). New York, NY: McGraw-Hill Book Company.

Lawler, E. E. (1983). Satisfaction and behavior. In J. R. Hackman, E. E. Lawler, & L. W. Porter (Eds.), *Perspectives on behavior in organizations* (pp. 78–87). New York, NY: McGraw-Hill Book Company.

Locke, E. A. & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation. A 35-year odyssey. *American Psychologist, 57*(9), 705–717.

Locke, E. A., & Latham, G. P. (2006). New directions in goal-setting theory. *Current Directions in Psychological Science, 15*(5), 265–268.

Luthans, F. (2002). *Organizational behavior* (9th ed.). New York, NY: McGraw-Hill Book Company.

Mowday, R. T. (1983). Equity theory predictions of behavior in organizations. In J. S. Ott (Ed.), *Classic readings in organizational behavior* (pp. 94–102). Albany, NY: Wadsworth Publishing Company.

Nadler, D. A., & Lawler, E. E. (1983). Motivation: A diagnostic approach. In J. R. Hackman, E. E. Lawler, & L. W. Porter (Eds.), *Perspectives on behavior in organizations* (pp. 67–78). New York, NY: McGraw-Hill Book Company.

Newsom, W. B. (1990, February). Motivate, now! *Personnel Journal*, 51–55.

Porter, L. W., & Lawler, E. E. (1968a). *Managerial attitudes and performance*. Homewood, IL: Irwin.

Porter, L. W., & Lawler, E. E. (1968b). What job attitudes tell about motivation. *Harvard Business Review, 46*(1), 118–126.

Robbins, S. P. (2003). *Organizational behavior* (10th ed.). Upper Saddle River, NJ: Prentice Hall.

Skinner, B. F. (1953). *Science and human behavior*. New York, NY: Macmillan.

Tosi, H. R., & Mero, N. P. (2003). *The fundamentals of organizational behavior: What managers need to know*. London, UK: Blackwell Publishing.

Vroom, V. H. (1964). *Work and motivation*. New York, NY: John Wiley & Sons.

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 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 health care managers can use to promote motivational attributions among employees.

ATTRIBUTION THEORY

Before describing 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. To illustrate, 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, meaning that 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 her success in diagnosing a patient's rare disease to her intelligence and training, or to good luck.

As these examples might suggest, the attribution process is something that people typically engage in many 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 we are confronted with in our daily lives. When we experience desirable outcomes, attributions help us understand what caused those events so we can experience them again. When we experience unpleasant outcomes, attributions help us identify and avoid the behaviors and other factors that caused them to occur.

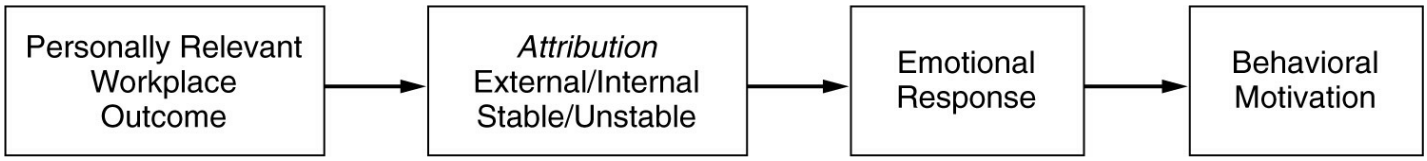

Figure 7–1 Attribution–Emotion–Behavior Process

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 7–1**. 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 his own carelessness (i.e., overlooked the patient's symptoms) is making an internal attribution. If the same outcome 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 toward 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 his or her 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 aforementioned dimensions of locus of causality 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 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 where someone failed at a task because of his or her own actions, but erroneously blamed the failure on other people or circumstances. In fact, if we are totally honest with ourselves, we can each probably recall one or two instances where we made such false attributions ourselves.

Astute observers may also notice that some people make these

attributional errors more frequently than others. 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 aforementioned 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 suggests, people who exhibit this tendency often lack confidence in themselves and are pessimistic concerning their chances for success (Abramson, Seligman, & Teasdale, 1978). This tendency can also promote depression and a tendency toward learned helplessness.

A third attributional tendency, known as a *hostile attribution style*, also warrants discussion. This style is similar to the optimistic style just described in that it denotes a tendency toward external attributions for negative outcomes. 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. As such, we can conclude that hostile attribution styles in the workplace are not only unproductive but can also be dangerous as well.

Table 7–1 Summary of Attribution Styles

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

Before discussing the implications of these attribution styles (see **Table 7–1**), and attributions in general, on 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 her attribution style. Thus, 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 7–1** at end of 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. Two desirable motivational states, empowerment and resilience, are then discussed.

Learned Helplessness

After repeated punishments and failures, people often become passive and unmotivated and stay that way even after the environment changes so that personal or professional success is possible (Abramson, Seligman, & Teasdale, 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 placed in a shuttle box 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 administering an unpleasant, but nonlethal, shock, a light flashed. The dogs quickly learned to associate the flash of light with the impending electrical shock, because of classic conditioning. After the conditioning was complete, the experimenters removed the tethers that had previously made escaping to the nonelectrified side of the chamber impossible. Instead of leaping to safety when the light flashed, however, most of the dogs froze, whimpered, and braced themselves for the shock. It was concluded that the dogs had "learned" helplessness, 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 in the same way the experiments induced it in dogs (Martinko & Gardner, 1987). Specifically, organizational policies/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 her subordinates' successes while blaming them for their failures may find herself 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, like the aforementioned dogs, it 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 that employee motivation and performance would immediately improve. The reality, however, 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 change.

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 is removed if proper steps to restore employees' confidence are not taken. This example also illustrates one of the downsides of the aforementioned 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

Another undesirable motivational state discussed here differs from learned helplessness in several ways. Perhaps the most significant is that, 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 he is underpaid and steals from his employer is performing instrumental aggression. Hostile aggression refers to behaviors aimed primarily at harming another person or entity. An employee who physically attacks a manager, for example, 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, et al., 2005). Whereas instrumental aggression is primarily motivated 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 7–1**, 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 others (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 a hostile attribution style can truly be a double-edged sword for managers. In addition to having a heightened tendency toward aggressive behaviors, employees with hostile attribution styles also 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, et al., 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 nonetheless 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 if any aggression will occur at all, appears to be the perceived intent of the responsible party. In cases where 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). There is some evidence, however, that some individuals will remain motivated to engage in acts of instrumental aggression in these situations (see Martinko, Douglas, et al., 2005). When it is perceived 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). That is, 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 are either internally controllable or that are external, unstable, and uncontrollable. Thus, a physician who misdiagnoses a patient's disease, but believes the error was under her 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 a physician who attributes the error to his 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 her 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 those with an optimistic attribution style may become disillusioned with themselves and feel empowered even when their skills and abilities are lacking. Thus, 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 is 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 non-resilient 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 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 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 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 7–2 Summary of Attributions Associated with Motivational States

Motivational State	*Associated Attributional Tendency*
Learned Helplessness	Tend to favor internal and stable attributions for failures; external attributions for successes
Aggression	Tend to favor external and stable attributions for failures
Empowerment	Tend to favor internal and stable attributions for successes; external and unstable attributions for failures
Resilience	Tend 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 can be used by managers 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. Unlike most of the suggestions in this section, however, our advice concerning resilience does not focus on increasing it among existing employees. This is because individuals' 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 grown adults who break down in response to relatively minor problems. This suggests that resilience levels are formed early in life and are unlikely to change dramatically in the course of normal life events (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 organizations require a high level of resilience in their employees. 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, then, will probably benefit from a resilient workforce. A less stressful organization, on the other hand, might not require such resilience among employees.

Organizations such as hospitals that require high levels of resilience should, then, try to attract and hire individuals that demonstrate high levels of resilience. Although it is unlikely that managers can increase the resilience levels of employees, they can try to form a workforce that has high preexisting levels. This can be accomplished through the use of standardized measures of resilience (see Huey & Weisz, 1997, for an example) during the employee screening process, or through simple interview questions. Asking potential candidates to describe past hardships, and their responses to these hardships, is likely to shed light both on 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 (see Kent & Martinko, 1995; Lefcourt, 1991; Lefcourt et al., 1979; Peterson, Bettes, & Seligman, 1985; Peterson, Semmel, et al., 1982; and Russell, 1982, for examples of these instruments) 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 understand both the internal and external factors involved with workplace outcomes, by helping them to understand the "big picture" in terms of the multiple personal and situational factors likely to contribute to positive and negative events. This promotes a more thorough causal search process and can help employees 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 she is assigned in a new position may quickly decide that she lacks the ability to succeed at the job (an internal and somewhat stable attribution). If she is allowed to tackle a number of more surmountable assignments before engaging in more difficult tasks, however, she is likely to see that she has 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 also 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 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 their 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 regarding their situation. Research has shown that managers who have direct experience with the work their employees perform are relatively 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 among 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-degree 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 7–1 at end of chapter.)

SUMMARY

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. We have seen repeatedly, however, 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 steer employees down 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 7–1 Managing Employees' Attributions

David was just promoted to manage a small medical transcription department and has inherited a problem. His predecessor recently completed annual performance evaluations of the staff, and it is now time to distribute annual raises based, in large part, on these evaluations. Of the seven employees David now manages, all received fairly strong evaluations, mostly in the "above average" range, although no one 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 higher performance levels, he 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, he has decided to allocate the raises equally among them. These raises will probably be disappointingly small, however. 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, based on 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 least demotivational for the staff? Why?

Case Study 7–2 "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 bend the rules just a bit to make the whole thing go away. For example, imagine a situation where 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 her 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 then took an extended lunch break on the day the work was due, you might feel a degree of 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—namely, insufficient effort. This guilt might, depending on other factors, such as your values and the consequences of your manager learning of the missed deadline, reduce your willingness to lie about finishing the work on time.

Your response might change, however, if you feel 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 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, and anger 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, but procedural, mistake had been made in diagnosing a patient. Each physician was given the same hypothetical scenario with one difference—the cause for the mistake (i.e., the attribution) was varied so that in some cases the mistake was due to internal and stable or unstable factors (i.e., the physician has poor attention to detail or was distracted), or to external and stable or unstable factors (i.e., 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, on the basis of the preceding discussion, physicians were more likely to say they would alter the paperwork when the cause of the mistake was beyond their control and was stable (i.e., likely to occur again) in nature. Before taking an overly dim view of these physicians, however, 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 we might not normally consider.

This justification process is an almost unavoidable part of life. There are always going to be times where 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 7–1 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 holding 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

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).

Modified from Kent, R. L., & Martinko, M. J. (1995). The measurement of attributions in organizational research. In Martinko, M. J. (Ed.) Attribution theory: An organizational perspective (pp. 53–75). Delray Beach, FL: St. Lucie Press. Reprinted with permission.

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 this attribution style, how would you help him or her stay motivated when negative events occur?

REFERENCES

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49–74.

Campbell, C. R., fe Martinko, M. J. (1998). An integrative attributional perspective of empowerment and learned helplessness: A multi-method field study. *Journal of Management, 24*, 173–200.

Conger, J. A., & Kanungo, R. N. (1994). Charismatic leadership in organizations: Perceived behavioral attributes and their measurement. *Journal of Organizational Behavior, 15*, 439–452.

Coutu, D. L. (2002). How resilience works. *Harvard Business Review, 80*, 46–55.

Douglas, S. C., & Martinko, M. J. (2001). Exploring the role of individual differences in the prediction of workplace aggression. *Journal of Applied Psychology, 86*, 547–559.

Fedor, D. B., & Rowland, K. M. (1989). Manager attributions for subordinate performance. *Journal of Management, 15*, 37–48.

Gundlach, M. J., Douglas, S. C., & Martinko, M. J. (2003). The decision to blow the whistle: A social information processing framework. *Academy of Management Review, 28*, 107–123.

Harvey, P., & Martinko, M.J. (2009). An empirical examination of the role of attributions in psychological entitlement and its outcomes. *Journal of Organizational Behavior, 30*(4), 459–416.

Harvey, P., Harris, K. J., Gillis, W. E., & Martinko, M. J. (2014). Abusive supervision and the entitled employee. *Leadership Quarterly, 25*(2), 204–

217.
Harvey, P., Martinko, M. J., & Borkowski, N. (2007). Unethical behavior among physicians and students: Testing an attributional and emotional framework. Presented at the 2007 Academy of Management Conference, Philadelphia, PA.
Heider, F. (1958). *The psychology of interpersonal relations*. New York, NY: John Wiley & Sons.
Huey, S. J., & Weisz, J. R. (1997). Ego control, ego resiliency, and the five-factor model as predictors of behavioral and emotional problems in clinic-referred children and adolescents. *Journal of Abnormal Psychology, 106*, 404–415.
Jones, E. E., & Nisbett, R. E. (1971). The actor and the observer: Divergent perceptions of the causes of behavior. In E. E. Jones, D. E. Kanouse, H. H. Kelley, R. E. Nisbett, S. Valins, & B. Weiner. (Eds.), *Attribution: Perceiving the causes of behavior* (pp. 79–94). Morristown, NJ: General Learning Press.
Kent, R., & Martinko, M. J. (1995). The development and evaluation of a scale to measure organizational attribution style. In M. Martinko (Ed.), *Attribution theory: An organizational perspective* (pp. 53–75). Delray Beach, FL: St. Lucie Press.
Kovenklioglu, G., & Greenhaus, J. H. (1978). Causal attributions, expectations, and task performance. *Journal of Applied Psychology, 63*, 698–705.
Lefcourt, H. M. (1991). The multidimensional-multiattributional causality scale. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (Vol. *1*, pp. 454–457). San Diego, CA: Academic Press.
Lefcourt, H. M., Von Baeyer, C. L., Ware, E. E., & Cox, D. J. (1979). The multidimensional-multiattributional causality scale: The development of a goal specific locus of control scale. *Canadian Journal of Behavioural Science, 11*, 286–304.
Martinko, M. J. (1995). The nature and function of attribution theory within the organizational sciences. In M. J. Martinko (Ed.), *Attribution theory: An organizational perspective* (pp. 7–16). Delray Beach, FL: St. Lucie Press.
Martinko, M. J. (2002). *Thinking like a winner: A guide to high performance leadership*. Tallahassee, FL: Gulf Coast Publishing.
Martinko, M. J., Douglas, S. C., Harvey, P., & Joseph, C. (2005). Managing organizational aggression. In R. Kidwell & C. Martin (Eds.), *Managing*

organizational deviance: Readings and cases (pp. 237–260). Thousand Oaks, CA: Sage.

Martinko, M. J., & Gardner, W. L. (1987). The leader-member attribution process. *Academy of Management Review, 12*, 23–249.

Martinko, M. J., Harvey, P., & Sikora, D., & Douglas, S. C. (2011). Perceptions of abusive supervision: The role of attribution style. *Leadership Quarterly, 22*, 751–164.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*, 227–238.

Overmier, J. B., & Seligman, M. E. P. (1967). Effects of inescapable shock upon subsequent escape and avoidance learning. *Journal of Comparative and Physiological Psychology, 63*, 23–33.

Peterson, C., Bettes, B. A., & Seligman, M. E. P. (1985). Depressive symptoms and unprompted casual attributions: Content analysis. *Behavior Research and Therapy, 23*, 379–382.

Peterson, C., Semmel, A., Von Baeyer, C., Abramson, L., Metalsky, G., & Seligman, E. (1982). The attributional style questionnaire. *Cognitive Therapy and Research, 6*, 287–300.

Russell, D. (1982). The causal dimension scale: A measure of how individuals perceive causes. *Journal of Personality and Social Psychology, 42*, 1137–1145.

Spreitzer, G. M. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of Management Review, 38*, 1442–1465.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review, 97*, 548–573.

Weiner, B. (1995). *Judgments of responsibility: A foundation for a theory of social conduct*. New York, NY: Guilford Press.

OTHER SUGGESTED READING

Schermerhorn, J. R. (1987). Improving health care productivity through high-performance. *Health Care Management Review, 12*(4), 49–55.

Leadership

"Power is America's last dirty word. It is easier to talk about money—and much easier to talk about sex—than it is to talk about power. People who have it deny it; people who want it do not want to appear hungry for it; and people who engage in its machinations do so secretly" (Kantner, 1979, p. 65).

Power is the ability to influence others' 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?" We begin our discussion in Chapter 8, in which we provide an overview of the definition of power and the types, sources, and uses of power. Chapter 9 discusses the early theories of leaderships, such as the Great Man and trait theory. In Chapter 10, 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 11 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 answer the question, "What does it take to be an effective leader?"

Power, Politics, and Influence

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 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 first asked to nominate and then 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). So, then, it would be no surprise to learn that for the 2014 list, 16 percent of the top 100 powerful people are elected or appointed federal employees (President Obama taking the number-one position) who hold the purse strings on an annual budget in excess of $770 billion or hold 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. Mechanic (1962) defined it 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 where 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 are dependent on the federal government, specifically the Medicare and Medicaid programs, for reimbursements. Any change in the levels of reimbursement can have either 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, Stark I and Stark II regulations, Health Insurance Portability and Accountability Act of 1996, Sarbanes–Oxley Act of 2002).

Potential power exists when an individual has the ability to influence but does not use it (e.g., a supervisor sitting at her desk completing paperwork, but without staff interaction). 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.

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 have been diminished.

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.

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 aged 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 title someone holds within 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 only holds legitimate power if P accepts O as holding a legitimate power position.

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.

Expert power exists when P awards power to O on the basis of P's perception of O's knowledge within a given area. P evaluates O's expertness in relation to his or her 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.

In recent years, 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. Both of these sources of power are discussed further in the following sections.

OTHER SOURCES OF POWER WITHIN 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:

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 anyone outside the organization upon 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 dependent upon 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 largely due to the ward physicians' dependency on the attendants. The dependency resulted from the physicians' short tenure, lack of interest in administration, and the large amount of administrative responsibilities the physicians 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 concerning patients. Failure of the ward physician to honor his or her 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 officially assigned to the physician.

Another example is new physician residents' dependency on the floor nurses in a large teaching hospital. These new physicians are dependent on the nurses for providing information regarding how to 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 his or her insurance company? The new residents are dependent on the nurses' goodwill toward them. If the nurses withhold their cooperation, the physicians would have little or no alternative but to attempt to decipher the hospital's policies and procedures, which would be a very time-consuming process.

Increasing complexity within organizations has made the expert or staff person more powerful as a result of the organization's dependency on his or her specialization, knowledge, and skills. Experts have tremendous potentialities for power by withholding information or providing incorrect information. For example, Mechanic (1962) discusses the situation of a lay hospital administrator (as opposed 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 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. As such, 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 they themselves do not want to do, but which are accompanied with a certain amount of power. For example, a physician usually delegates the responsibility of scheduling his or her appointments to a secretary. The secretary schedules both patient and nonpatient appointments and, as such, wields enormous power as to who will or will not see the physician this week. 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 of selecting what specialists the physician's patients will be referred to within the managed care network. A specialist could experience a decrease in his or her patient referrals by not cooperating with the PCP's administrative staff's requests (e.g., seeing referred patients in a timely fashion).

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 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 so that others will defer to them on those matters. This can be accomplished through visible achievement (i.e., professional reputation and track record).
- *Identification*: Managers will try to foster others' unconscious identification with them or ideas they stand for. 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 others believe that they are dependent on the manager, for either help or not being hurt. The manager can accomplish this by securing resources that another person requires to perform his or her job. At the same time, the

manager makes it known that he or she 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, in reality, he or she possesses. 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 et al. (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. They are as follows:

- *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 his or her 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, to bury or obscure important (but potentially damaging) details that the employee hopes go unnoticed.
- *Creating and Maintaining a Favorable Image*: Creating and maintaining a favorable image includes 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 others 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 includes 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 25 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. These categories are as follows:

- *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 a growing knowledge of how various employee tactics used to influence behaviors of those in higher positions within the organization work or do not work under certain circumstances and within different cultures (Farmer & Maslyn, 1999; Ralston, Vollmer, et al., 2001; Ralston, Hallinger, et al., 2005).

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.

In other words, Carney, Cuddy, and Yap (2010) showed that an individual's nonverbal displays can govern how he or she thinks and feels about themselves and that a person's body movements can change his or her mind. The technique study is referred to as the "power pose."

SUMMARY

In this chapter, we discussed what is meant by power and how individuals can use it to influence others. As noted, 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 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 8–1 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 felt 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 employees worked best at what they

wanted to work at. But his problem still remained: There was no money in the training budget and no other employees as skilled with the system as Betty was. Was there an approach to convincing her to help that he hadn't thought of?

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 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 since it requires a person with a lot of technology knowledge and experience."

Describe French and Raven's five sources of power. In the above case, who has power(s) and why?

Case Study 8–2 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 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—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 "Case Discussion: Workplace Bully," by J. Pinto, M. Vecchione, & L. Howard, October 2004. Presented at the 12th Annual International Conference of the Association on Employment Practices and Principles, Ft. Lauderdale, FL.

REFERENCES

Allen, R. W., Madison, D. L., Porter, L. W., Renwick, P. A., & Mayes, B. T. (1979). Organizational politics: Tactics and characteristics of its actors. *California Management Review, 22*, 77–83.

Burda, D. (2003, August 25). Command and control: To make powerful list, you need to hold the purse strings or hire the workers. *Modern Healthcare*, p. 36.

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.

Emerson, R. M. (1962). Power-dependence relations. *American Sociological Review, 27*, 40–40.

Falbe, C. M., & Yukl, G. (1992). Consequences for managers of using single influence tactics and combinations of tactics. *Academy of Management Journal, 35*, 652–652.

Farmer, S. M., & Maslyn, J. M. (1999). Why are styles of upward influence neglected? Making the case for a configurational approach to influence. *Journal of Management, 25*(5), 653–682.

French, J., & Raven, B. (1959). The bases of social power. In D. Cartwright (Ed.). *Studies in social power* (pp. 150–167). Ann Arbor, MI: University of Michigan Press.

Hersey, P., & Blanchard, K. (1982). Management of organizational behavior: Utilizing human resources (4th ed.). Englewood Cliffs, NJ: Prentice Hall.

Kantner, R. M. (1979, July/August). Power failure in management circuits. *Harvard Business Review, 57*(4), 65–75.

Kipnis, D., & Schmidt, S. M. (1988). Upward influence styles: Relationship

with performance evaluations, salary, and stress. *Administrative Science Quarterly, 33*, 542–542.

Kipnis, D., Schmidt, S. M., & Wilkinson, I. (1980). Intraorganizational influence tactics: Explorations in getting one's way. *Journal of Applied Psychology, 65*, 452–452.

Kotter, J. P. (1977, July/August). Power, dependence, and effective management. *Harvard Business Review, 55*(4), 125–136.

Mechanic, D. (1962, December). Sources of power of lower participants in complex organizations. *Administrative Science Quarterly, 7*(3), 349–365.

Pfeffer, J. (1992). *Managing with power: Politics and influence in organizations*. Boston, MA: Harvard Business School Press.

Ralston, D. A., Hallinger, P., Egri, C. P., & Naothinsuhk, S. (2005). The effects of culture and life stage on workplace strategies of upward influence: A comparison of Thailand and the United States. *Journal of World Business, 40*(3), 321–337.

Ralston, D. A., Vollmer, G. R., Srinvasan, N., Nicholson, J. D., Tang, M., & Wan, P. (2001). Strategies of upward influence: A study of six cultures from Europe, Asia, and America. *Journal of Cross-Cultural Psychology, 32*(2001), 748–755.

Scheff, T. J. (1961). Control over policy by attendants in a mental hospital. *Journal of Health and Human Behavior, 2*, 105–105.

Siu, R. G. H. (1979). *The craft of power*. New York, NY: John Wiley & Sons.

Thibaut, J., & Kelley, H. H. (1959). *The social psychology of groups*. New York, NY: John Wiley & Sons.

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.

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 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 others 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, and 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 when 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 distinctive 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 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 Druker and Warren Bennis, "Management is doing things right; leadership is doing the right things." Khan (2010) emphasizes that organizations need both strong leadership and strong management for optimum effectiveness. Robbins relates (as cited in 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 its achievement. 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.

Table 9–1 Leaders vs. 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 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 their 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

As noted, management and leadership are two separate behaviors that occur within an organization, but both are necessary for an organization to achieve its goals (see **Table 9–1**). Note that the distinctions in the table are based on behaviors—that is, what an individual does—and are not based 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, and at the time, many 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 the 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 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 midlevel 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 others and realize that to accomplish tasks they must be considerate of others' needs and values (Stogdill, 1974).

As study in 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 were common to four or more of the investigations. Thus, no clear set of traits upon which we can distinguish great leaders emerged. Despite the difficulties in linking traits to successful leaders, evidence does reveal that many successful leaders share some basic traits based on observed characteristics of both successful and unsuccessful leaders (see **Exhibit 9–1**). 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 noted by Robbins (2005), 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).

Exhibit 9–1 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 *On Leadership*, by J. Gardner, 1989. New York: Free Press.

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. How did the typical leader appear during that period? Leaders in the 1930s would have been male, Caucasian, authoritarian, and educated. Absent these traits, it would have been difficult to find 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 the question "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 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 matched on personal characteristics (for example, IQ and popularity), and all groups worked on the same project (produced 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 a clear impact on group productivity as well as the behaviors and interpersonal relationships among group members. With 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 behavior: 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. When groups experienced 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. Under the laissez-faire style, the group produced the least number of items, and the items were of low quality.

Overall, the democratic leadership style appeared the most successful. However, some of the children reported that they preferred the authoritarian style. Thus, this study provided us with not only our initial examination of leadership behavior but also alerted us to the possibility that followers may exhibit a preference for specific leadership styles. In concert with the latter, 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 they perceived as right or natural judging from 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. As we discuss here, 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.

Consideration for people 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 9–1**).

Leaders who ranked high on both dimensions were more likely to influence the workforce to higher levels of satisfaction and performance. A weakness 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 may not require initiating structure from their manager.

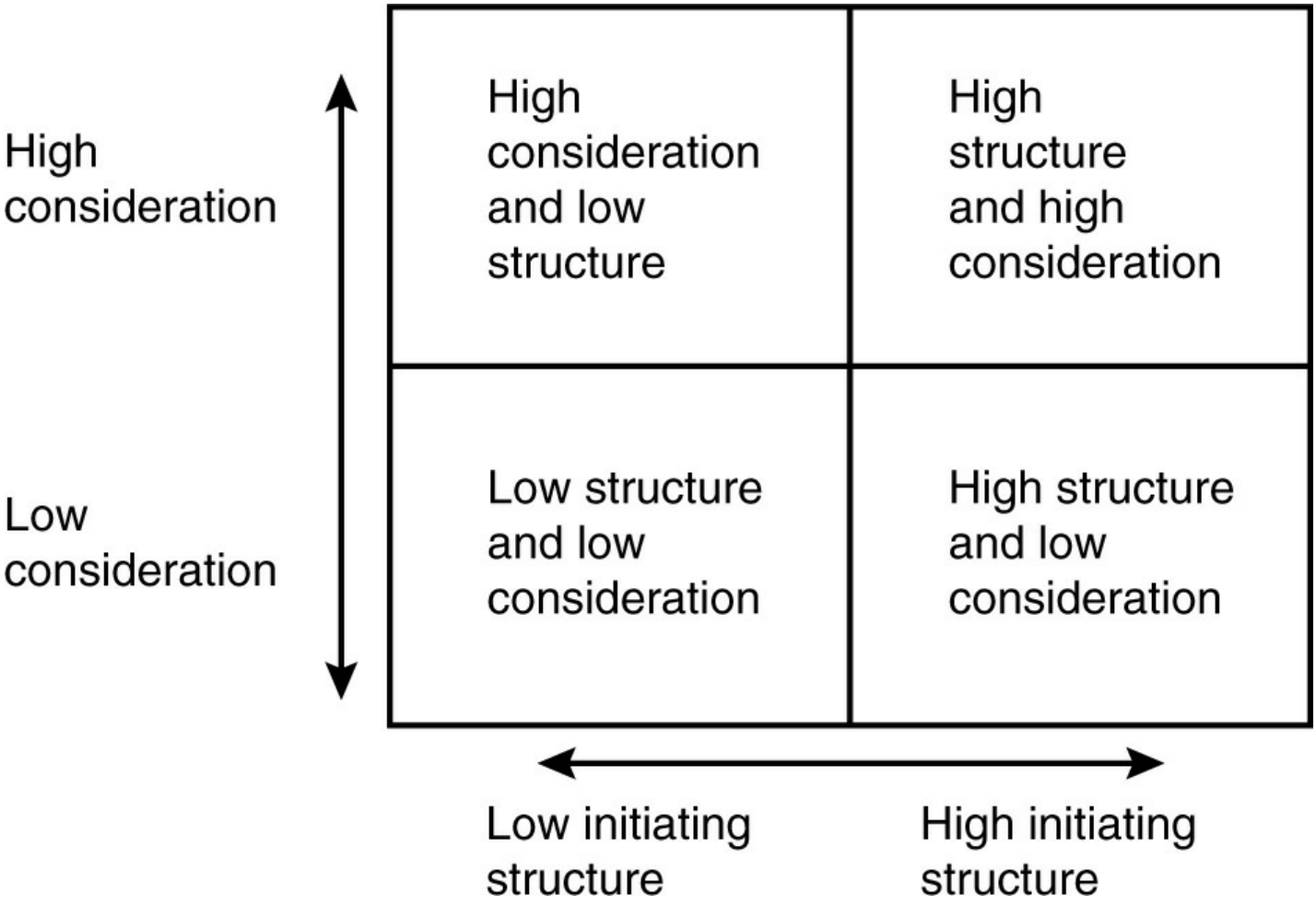

Figure 9–1 Ohio State Studies

UNIVERSITY OF MICHIGAN STUDIES

During the same period of time as the Ohio State studies, researchers at the University of Michigan were also 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 note 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).

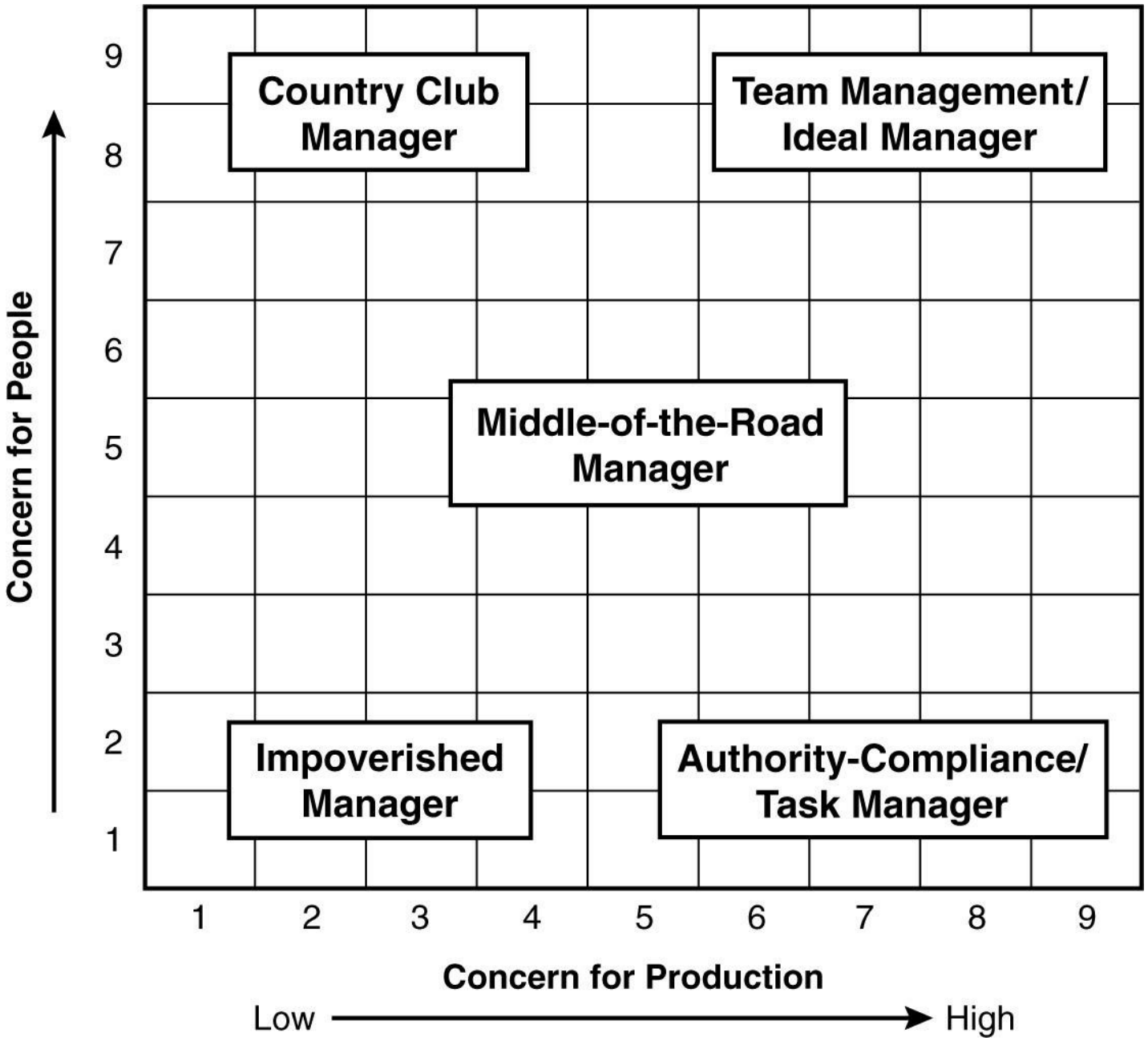

Figure 9–2 Blake and Mouton's Leadership Grid

Blake and Mouton's Leadership (Formerly Managerial) Grid

During the 1960s, Blake and Mouton reexamined the two dimensions of leaders that were identified in the Ohio State studies: consideration for people and initiating structure. Their work developed a two-factor framework (Razik & Swanson, 1995, p. 53). The Managerial Grid (renamed the Leadership 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 his or her 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 9–2**) 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/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).

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 leadership) exercises minimal effort on getting the task accomplished, doing only that amount of work that is required to sustain his or her position within the organization. Additionally, the impoverished manager is much more focused on his or her own well-being than on the subordinates he or she supervises. This manager possesses 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 as a means of production. The task manager is unconcerned by the potential negative impact his or her 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, in contradictory fashion, tell someone else exactly what they want to

hear despite their earlier stance. 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.

On 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 concern for 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, but it is a theoretically perfect infusion 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.

In 1991 when Blake and McCanse renamed the Managerial Grid as the Leadership Grid, they added two more styles: the opportunistic management style and the paternalistic management style. The opportunistic management style refers to a manager that uses any combination of the five basic styles for personal reward and advancement (see **Figure 9–3**). The purpose of his or her performance and effort is to realize personal gain.

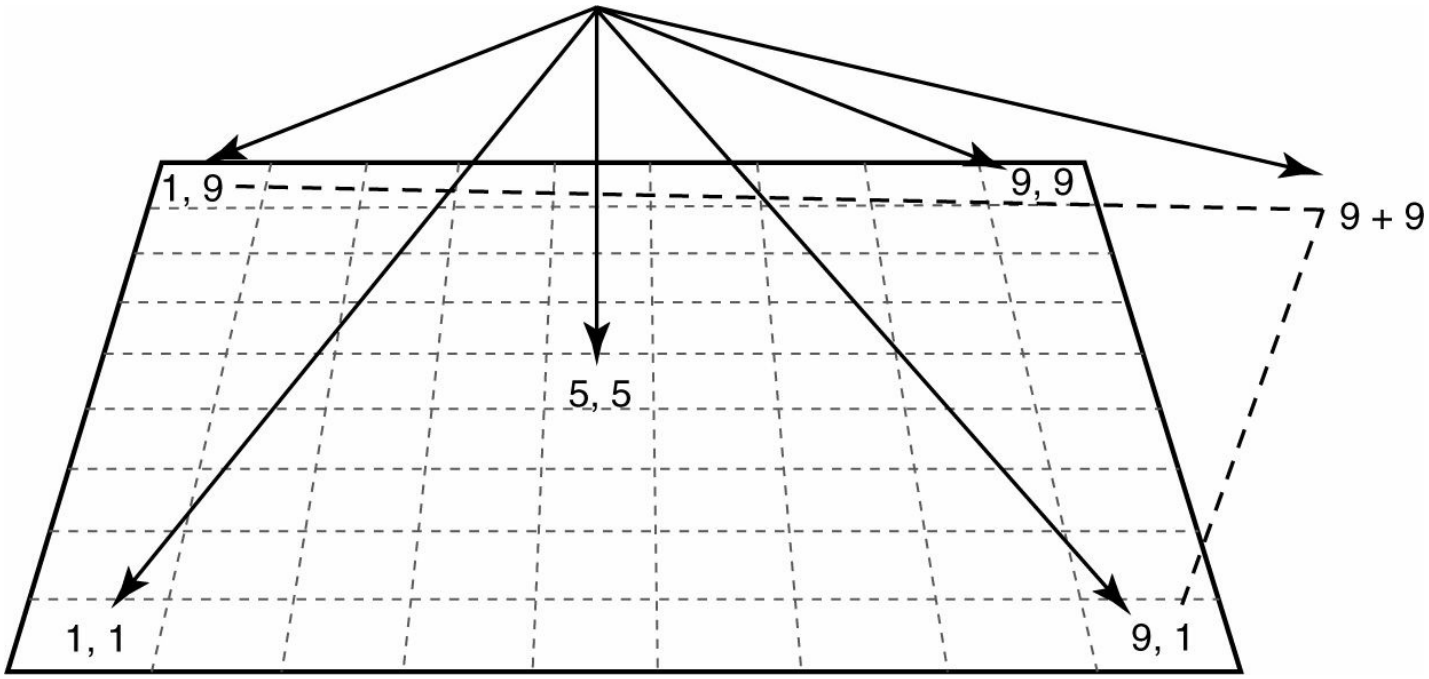

Figure 9–3 Opportunistic Management Style

SOURCE Robert R. Blake, R.R. & McCanse, A.A. (1991). Leadership Dilemmas—Grid Solutions, p. 31. Used with permission from Grid International, Inc.

The paternalistic management style refers to a manager who uses both 1,9 and 9,1 styles but does not integrate the two (see **Figure 9-4**). In other words, the person acts "fatherly or motherly" toward his or her subordinates but is the key decision maker, and this manager rewards loyalty but punishes noncompliance.

The grid is a useful tool in 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.

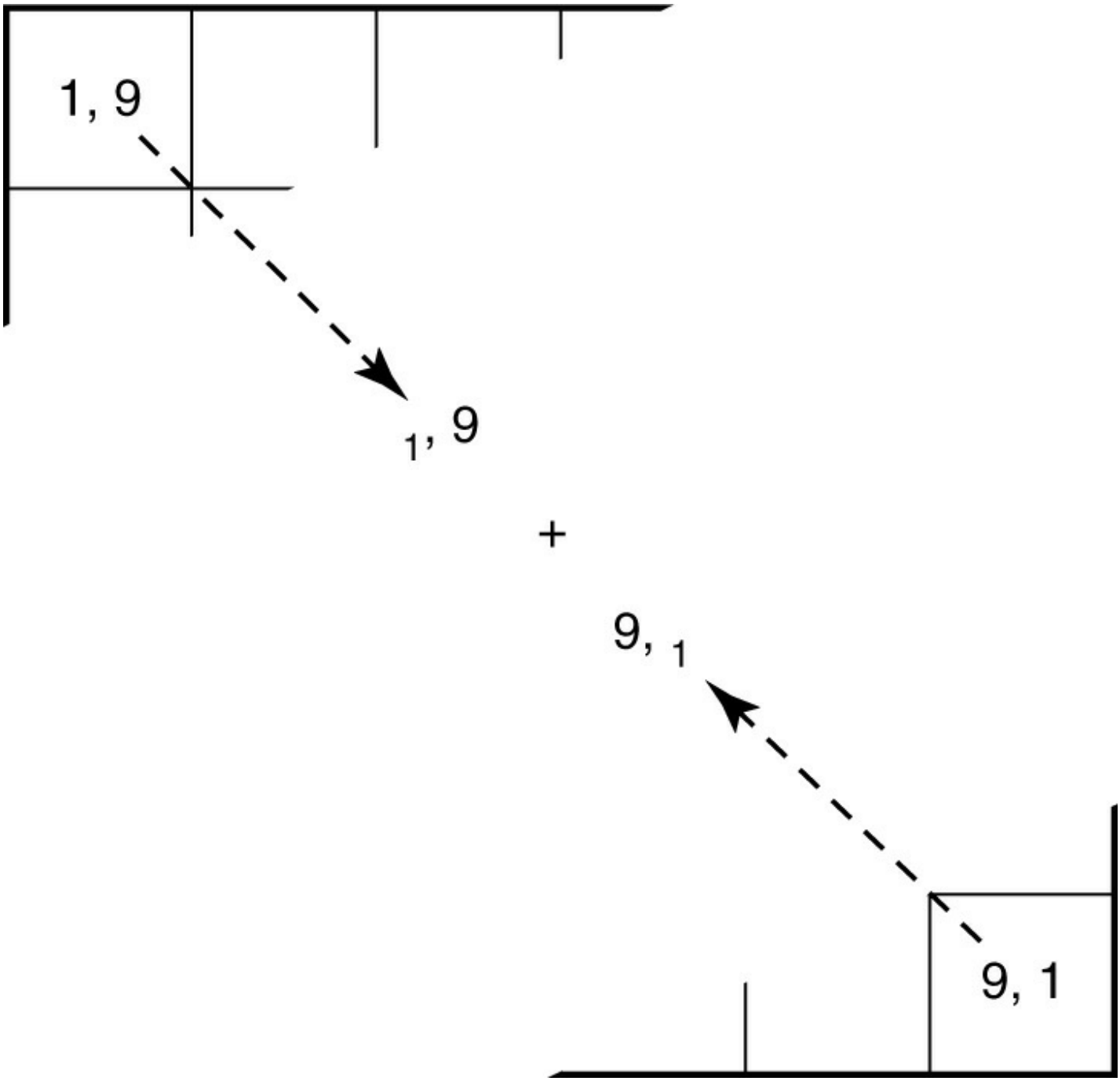

Figure 9–4 Paternalistic Management Style

SOURCE Robert R. Blake, R.R. & McCanse, A.A. (1991). Leadership Dilemmas – Grid Solutions, p. 30. Used with permission from Grid International, Inc.

SUMMARY

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 upon which to definitely distinguish leaders? No. Examining the findings across numerous studies, we uncover a lack of consistency and modest relationships. One, however, would not want 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 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. 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 may 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—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 regarding leadership styles and behaviors.
3. Discuss the contributions and the weaknesses of trait theory.
4. Discuss the results of the Ohio State studies in regard to 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 Managerial (Leadership) Grid in relationship to previous leadership research.

CASE STUDY AND EXERCISES

Case Study 9–1 Leadership Style

A small group of nurses, employed at a large community hospital, were unhappy about their work environment and would meet daily during lunch to discuss the situation. There had been a recent change in the hospital's senior management, which caused 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 two years. The nurses saw the situation as management requiring them to do more work with fewer resources, with no appreciation or recognition of their efforts. Whenever the nurses approached management with their concerns, they perceived them as falling on deaf ears since no changes were made.

Feeling like they had no other choice, the nurses contacted a labor union. The labor union began an organizing effort in the hospital shortly thereafter, holding an aggressive campaign over a six-week period. There was tremendous peer pressure, as some of the well-respected nursing staff became active leaders for unionization, although they were not part of 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 9–1

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 these concepts in the chapter influence your word choices? Are you comfortable distinguishing the roles? To what degree, if at all, do you believe a manager should also be a leader, or a leader also be a manager?

EXERCISE 9–2

Think of some individuals whom you feel are really exceptional leaders. What, if anything, do they have in common?

Think of some individuals whom you believe are truly poor leaders. What, if anything, do they have in common?

Do your answers identify traits or behaviors? Which, traits or behaviors, do you personally view as dominant in effective leadership?

EXERCISE 9–3

Have you ever known people who were successful leaders in one situation and failures in another? Why is this so?

EXERCISE 9–4 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, while 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 to 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 jobs.
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 Question	Task Question
1. _____	2. _____
4. _____	3. _____
6. _____	5. _____
9. _____	7. _____
10. _____	8. _____
12. _____	11. _____
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 getyour final score)

Matrix Section

Plot your final scores on the following graph (**Figure 9–5**) by drawing a horizontal line from the approximate people score (vertical axis) to the right of the matrix, and drawing a vertical line from the approximate task score on the horizontal axis to the top of the matrix. Then, draw two lines from each dot until they intersect. The area of intersection is the leadership dimension that you operate out of.

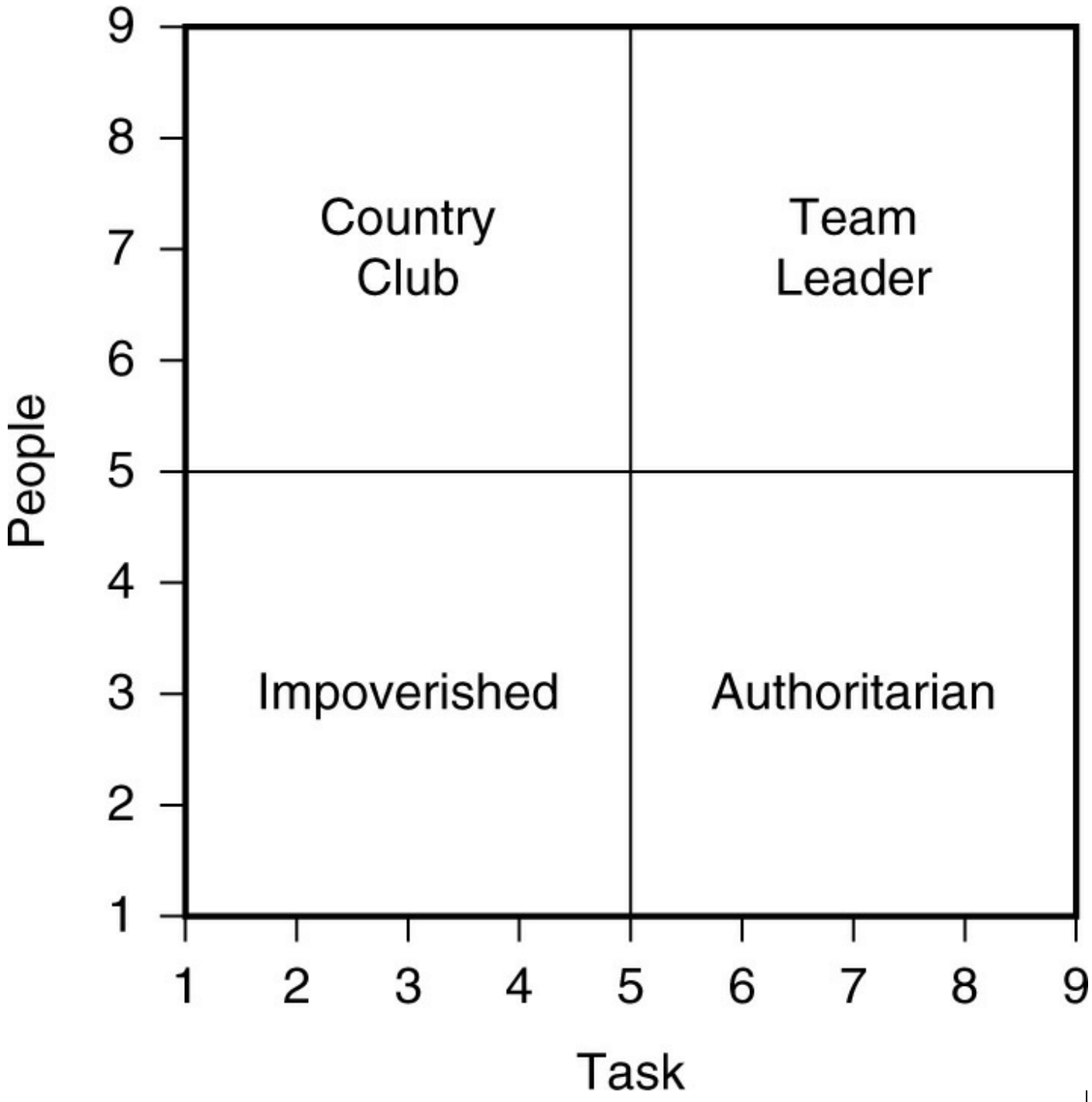

Figure 9–5

The Results

This chart will give you an idea of your leadership style. But, 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, whether you get your job done, if you take care of your employees, if you are growing your organization, and so on.

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?" If the answer is yes, then it should become a personal action item.

SOURCE Available at www.nwlink.com/~donclark/leader/leader.html. Created January 27, 1998; last update October 20, 2013. Copyright 1998 by Donald Clark. Reprinted with permission.

REFERENCES

Bass, B. M. (1990). *Bass & Stodgill's handbook of leadership* (3rd ed.). New York, NY: The Free Press.

Blake, R. R., & Mouton, J. S. (1964). *The managerial grid*. Houston, TX: Gulf Publishing Co.

Blake, R. R., & McCanse, A. A. (1991). *The leadership grid*. Houston, TX: Gulf Publishing Co.

Gladding, S. T. (1995). *Groupwork: A counseling specialty*. Englewood Cliffs, NJ: Prentice-Hall Inc.

Geier, J. G. (1967). A trait approach to the study of leadership in small groups. *Journal of Communications, 17*(4), 316–323.

Hellriegel, D., Slocum, J. W., & Woodman, R. W. (1995). *Organizational behavior*. New York, NY: West Publishing Company.

Khan, A. (2010). The dilemma of leadership styles and performance appraisal: Counter strategies. *Journal of Managerial Sciences, 4*(1), 1–30.

Kotter, J. (1988). *The leadership factor*. New York, NY: Free Press.

Kirkpatrick, A., & Locke, E. (1991). Leadership: Do traits matter. *Academy of Management Executive, 5*(2), 48–60.

Lewin, K. (1951). *Field theory in the social sciences*. New York, NY: Harper & Row.

Likert, R. (1961). *New patterns of management*. New York, NY: Garland Science Publishing.

Lussier, R., & Achua, C. (2012). *Leadership: Theory, application, and skill development*. Mason, OH: Cengage Learning.

Luthans, F. (2002). *Organizational behavior* (9th ed.). Boston, MA: McGraw-Hill Book Company.

Mann, R. D. (1959). A review of the relationship between personality and performance in small groups. *Psychological Bulletin, 66*(4), 241–270.

Osland, J., Kolb, D., & Rubin, I. (2001). *Organizational behavior: An experiential approach* (7th ed.) (p. 290). Upper Saddle River, NJ: Prentice Hall.

Razik, T. A., & Swanson, A. D. (1995). *Fundamental concepts of educational leadership and management* (pp. 51–52). Upper Saddle River, NJ:

Prentice Hall.
Robbins, S. P. (2005). *Organizational behavior* (8th ed.). Upper Saddle River, NJ: Prentice Hall.
Stogdill, R. M. (1948). Personal factors associated with leadership: A survey of the literature. *Journal of Psychology, 25*, 35–71.
Stogdill, R. M. (1974). *Handbook on leadership*. New York, NY: Free Press. Winder, R. (2003). Organizational dynamics and development. *Futurics, 27*(1/2), 5.
Zaccaro, S. J., Kemp, C., & Bader, P. (2004). Leader traits and attributes. In J. Antonakis, A.T. Cianciolo, & R.J. Sternberg (eds.). *The nature of leadership* (pp. 101-123). Thousand Oaks, CA: Sage Publications, Inc.

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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 related to 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 becomes more complex 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 the individual. Analyzing contingent factors and properly matching leadership style 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

that are constantly arising 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 one'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.

Contingency, by definition, means an event that may occur but that is not likely or intended; a possibility that must be prepared for; the condition of being dependent on chance or uncertainty. As such, contingency 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 for 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 possess dominant leadership characteristics that are well established and generally inflexible. Leaders are characterized into one of two styles, 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; thus, 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 his or her 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 structure of 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; highly dependent upon the support the leader receives from senior management. This factor asks if 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 the successful performance by his or her group is determined by the leader's style (i.e., task or relations) in conjunction with situational 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 style were based upon 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 he or she had ever worked and then to describe the person with whom he or she worked best (i.e., most preferred coworker) and then the person with whom he or she worked least well (i.e., least preferred coworker or 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- or relations-oriented. Fiedler believed that the ratings individuals ascribed to their least preferred coworker, a person they least enjoyed working with, reflected more about themselves than the person they chose to describe. 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 10–1** 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), if 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), if 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.

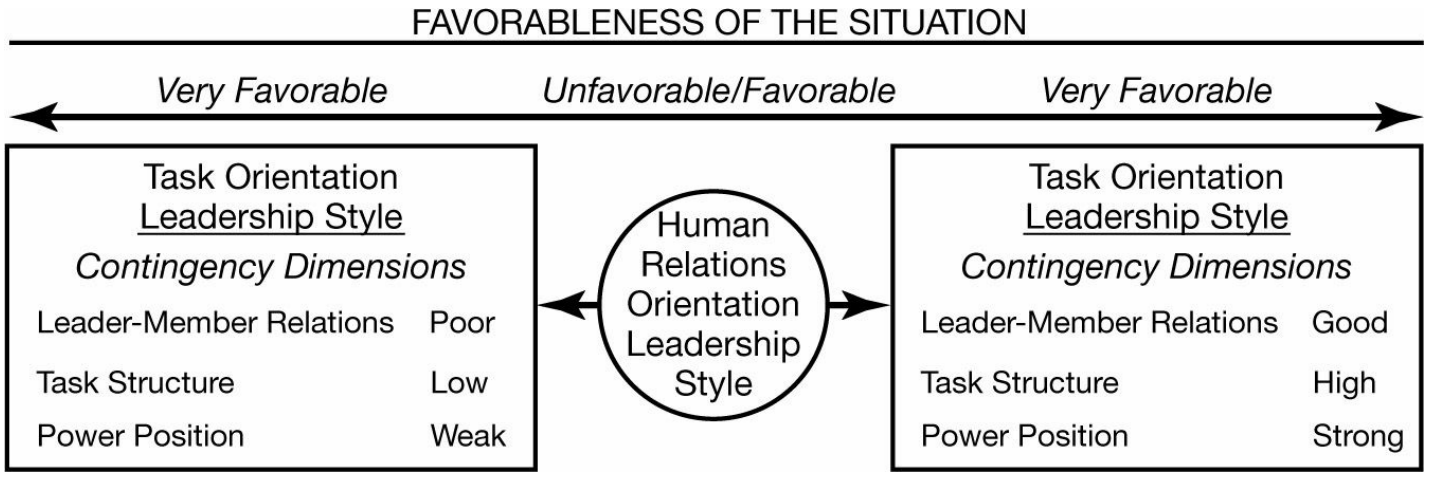

Figure 10–1 Fiedler's Contingency Theory

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 provides an environment in which individuals are prepared to be guided and expect to be told what to do. For example, Fiedler suggests one consider the captain of an airliner in its final landing; we would hardly want him or her 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 his or her 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 his or her 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. As such, an organization should not choose a leader who fits a situation, but should change the situation to agree with the style of its leader, since the leader's personality is not likely to change (Fiedler, 1970). (See **Case Study 10–1**: The New Chief Safety and Compliance Officer Position.)

Over the past 25 years, Fiedler (1995; Fiedler, Potter, et al., 1979; Fielder & Garcia, 1987) introduced other variables into the original Contingency Theory. 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. Under low-stress conditions, more experienced leaders are not challenged and tend to be bored and cut corners (Fiedler, 1996).

Case Study 10–1 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 a 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 percent 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 very shocked to hear this news, considering that two months ago the hospital had to report to the state's Medical Error Oversight Board that a metal clamp was left inside a patient after surgery because the surgeon forgot to order a postsurgical X-ray. Thank goodness 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 and instructed him to notify the state's Medical Error Oversight Board and that he would personally meet with the family to express his sympathy for the loss of their loved one and inform the family that "we" will be looking into the matter.

After Paul left, Ben knew 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, Harry was not doing enough and things were going to have to change—now! He would deal with Harry later, but his first priority was creating a new position—Chief Safety and Compliance Officer. This new position would report directly to him and would have full authority to do whatever was needed to ensure that these problems did not occur again. He 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, 10 years of experience in the safety and

compliance area, including seven years in the health care industry and five 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 Ben change situational factors instead of hiring a new leader? If so, what changes would you recommend?

HOUSE'S PATH–GOAL LEADERSHIP THEORY

Path–Goal Leadership Theory was first 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 theories of motivation.

Four separate, but fully integrated, components make up House's Path–Goal Leadership Theory: Leadership Behaviors, Environmental Contingency Factors, Subordinate Contingency Factors, and Outcomes (see **Figure 10–2**). The first component, Leadership Behavior, identifies four specific leadership styles:

1. The *directive* leader provides employees a detailed understanding of expectations, a plan to accomplish those expectations, and the resources to achieve the tasks. The directive leadership style can increase employee motivation and satisfaction where role ambiguity exists.
2. The *supportive* leader shows concern for people, ensuring 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, where the leader acknowledges the workforce's abilities to accomplish organizational goals.

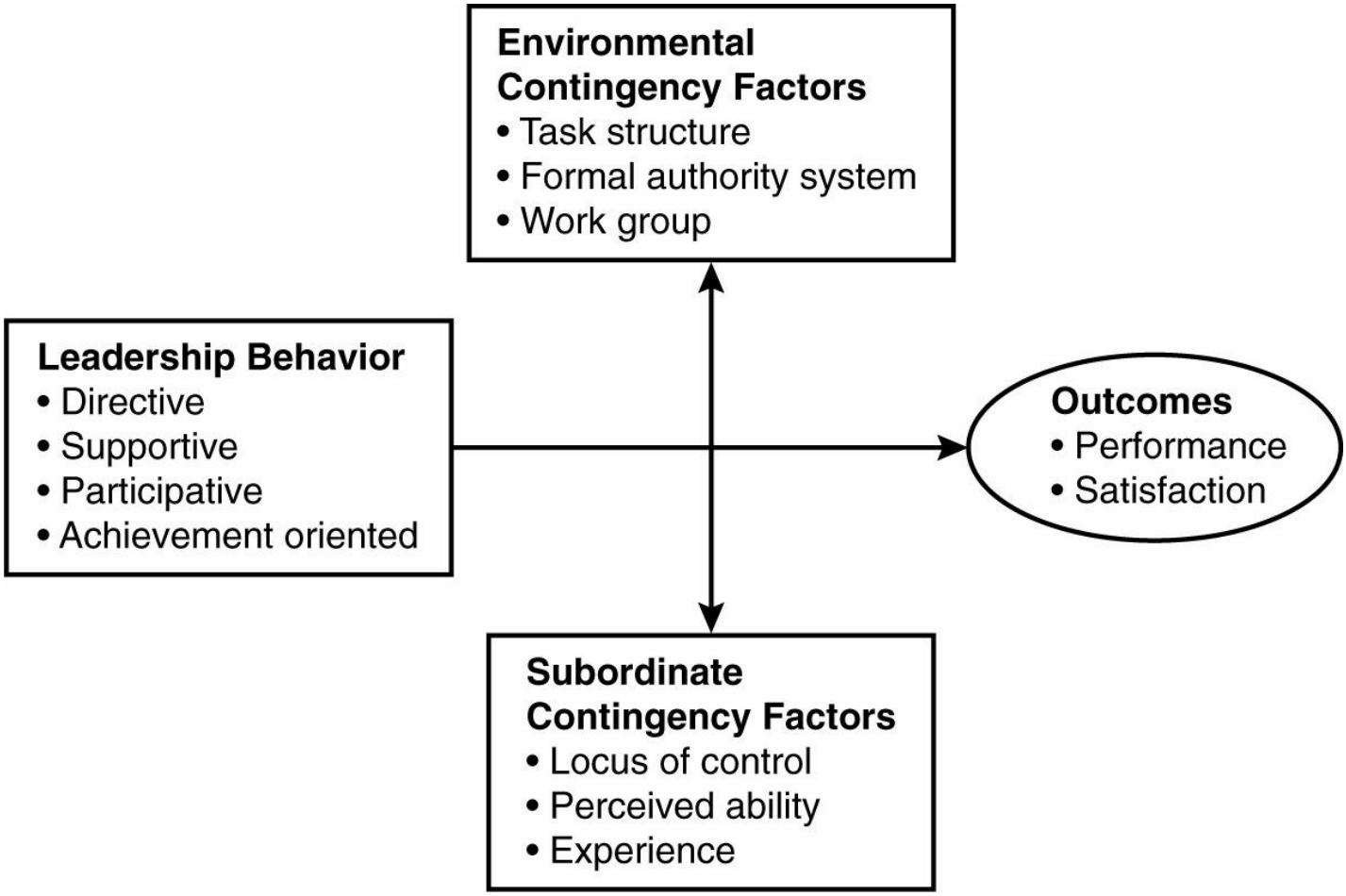

Figure 10–2 House's Path–Goal Leadership Theory

Reproduced from Robbins, S. P. (2003). Organizational behavior (10th ed.). Upper Saddle River, NJ: Prentice Hall, p. 326.

Whereas Fiedler proposed that leadership styles were grounded and inflexible, House proposed that leadership styles are adaptable and that managers may be called upon to utilize any one of the four identified styles of leadership, depending on the situation (Razik & Swanson, 1995; Robbins, 2005).

Leadership style is dependent 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., work-group 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, is 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 (i.e., performance and satisfaction). To be effective, managers should:

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 item absent from the employee (i.e., experience, ability) or the work setting (i.e., task structure). The leadership style should not duplicate what the employee already has available to him or her. For example, the nurse manager should not provide direction (i.e., directive leadership style) as to how to complete a patient's history and physical to a nurse with 20 years of experience. However, the nurse manager should provide direction and/or training to a nurse with 20 years of clinical experience but limited or no experience with technology or use of electronic medical records for documenting a patient's history and physical for the first time.

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 prior to the implementation of 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 that occur across a continuum, from boss-centered (task) through subordinate-centered (relationship).

As illustrated in **Figure 10–3**, 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 is dependent upon situational (contingent) factors.

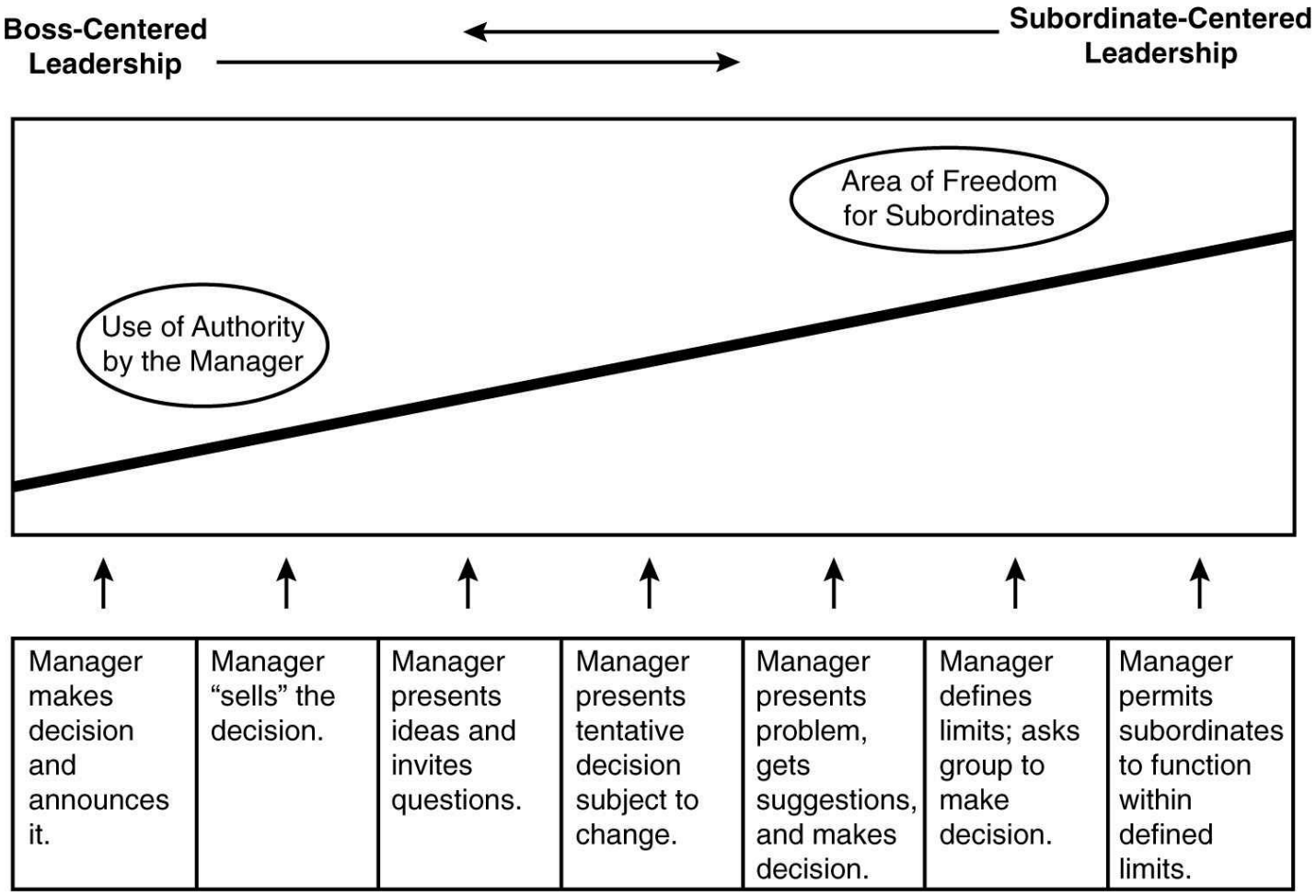

Figure 10–3 Tannenbaum and Schmidt Continuum of Leadership Behavior

Reproduced from Robert Tannenbaum and Warren H. Schmidt, Harvard Business Review, How to Choose a Leadership Pattern, March–April 1958, p. 96. Used with Permission.

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 level of comfort in delegating a task or seeking participation in the decision process. Another situational factor important to the process is the level of acceptance by the employee to participate and acknowledge responsibility for delegated tasks. When an employee conveys a desire to participate, the subordinate-centered leadership is appropriate. Conversely, when a manager is faced with an employee who avoids involvement beyond what is minimally expected, the boss-centered leadership style would be the suitable approach.

One approach is not preferred over the other. The situational factors will determine appropriateness. 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 placement 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 is faced with making a decision that requires information that employees may not possess or when the situation is so critical that it prevents 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 most often are less threatened by the impending change by feeling more a part of the solution rather than as an observer who has 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 he or she should be positioned is critical to both the task and how he or she is perceived by those affected by the positioning.

HERSEY AND BLANCHARD'S SITUATIONAL LEADERSHIP MODEL

The work of Hersey and Blanchard (1988) suggests leaders should adapt their leadership style based on 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. The *level of maturity* or development of the subordinate 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 10–4), as the employee cultivates knowledge, skills, and abilities to perform at increasing levels of expectations, the manager modifies his or her leadership style. As the subordinate passes through different 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 "matures" and 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.

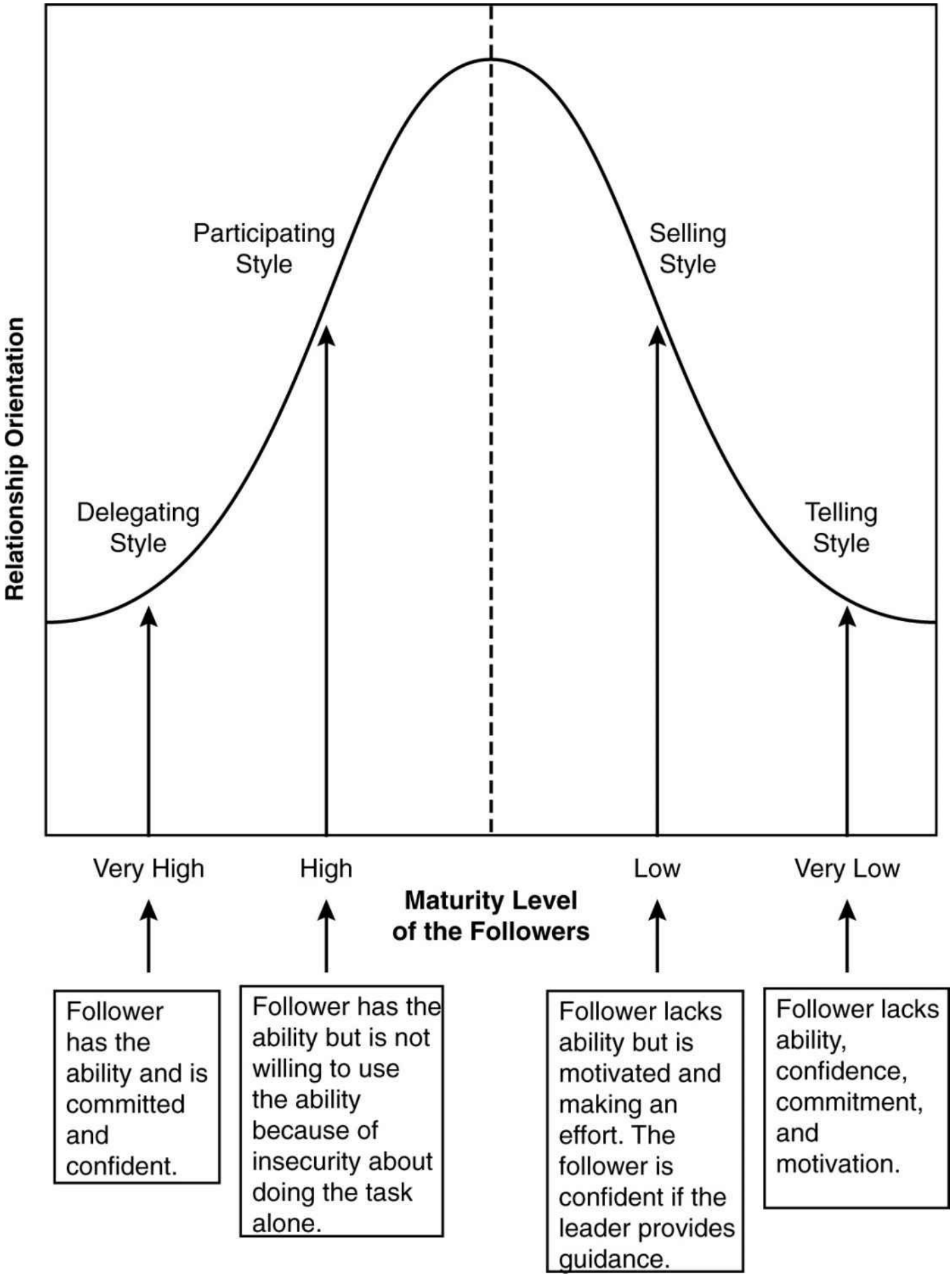
Relationship Orientation
Participating Style
Selling Style
Delegating Style
Telling Style
Very High
High
Low
Very Low
Maturity Level of the Followers
Follower has the ability and is committed and confident.
Follower has the ability but is not willing to use the ability because of insecurity about doing the task alone.
Follower lacks ability but is motivated and making an effort. The follower is confident if the leader provides guidance.
Follower lacks ability, confidence, commitment, and motivation.

Figure 10–4 Hersey and Blanchard's Situational Leadership Model

Reproduced from Luthans, F. (2002). Organizational behavior (9th ed.). Boston, MA: McGraw-Hill, p. 616.

The Situational Leadership Model identified that when the level of maturity of the follower (i.e., subordinate) is very low, a high-task, low-relationship style of leadership is most effective. As an 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, new to the environment, seeks direction by being told what to do; hence, the effective leader uses a telling style of leadership.

As the new employee better develops knowledge, skills, and abilities, thereby increasing his or her 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 his or her role is important 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.

As the maturity of the employee continues to increase to higher levels, 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 employee.

Upon full maturity, the employee has fully developed by exhibiting an unquestionable ability to perform expected tasks. This subordinate's maturity level is very high (low-task, low-relationship), creating an environment conducive to a delegating style of leadership. At this point in the model, the leader modifies his or her own behavior to a level where the leader is comfortable to not only delegate, but to allow the employee to

identify innovative ways to accomplish the task.

Empirical research, as in other leadership studies, is critical of the Situational Leadership Model. Critics question the coherence of the results of the model, where a questionnaire identifies 12 situations that are supposed to represent levels of subordinate maturity and that managers have only one of four styles of leadership. Hersey and Blanchard admit 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 with general situational and subordinate factors across a group of employees, Leader–Member Exchange (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 the leader and the subordinate. Over time and through a process of role-taking, role-making, and routinization (see **Exhibit 10–1**), the leader cognitively assigns subordinates as belonging to an in-group or an out-group. Individuals 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. 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, where they must interact with the vice president of human resources, the facilitator of the program. Those young careerists who are considered to be in the in-group may have a higher number of interactions with the vice president than those 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 they will develop a high-quality relationship. Additionally, Valerie may be given special projects during the development program that further enhances her career opportunities within the hospital

because she is within 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 they 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 belonging 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 followers to be more friendly, approachable, and similar in personality to the leader him- or herself. 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.

Exhibit 10–1 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.

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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."

SUMMARY

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. One should not underestimate the importance of the interrelationship of applying the appropriate leadership style based upon 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 the 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 follower maturity (development) as presented in the work of Hersey and Blanchard.
5. What impact does the assignment of followers to the in- or out-group (LMX) have on worker 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 10–1

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 some questions about it, such as: Did it work? Could a different style have worked better? Which style do you prefer your supervisor to use with you? Which style are you most comfortable using yourself? Why?

Form a group of three to four individuals, and share and discuss your

questions with your group.

Case Study 10–2 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 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 felt 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 employees worked best at what they wanted to work at. But his problem still remained: There was no money in the training budget and no other employees as skilled with the system as Betty was. Was there an approach to convincing her to help that he hadn't thought of?

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 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 since 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 10–3 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 4,000 employees. You wish 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 can save the health system thousands of dollars each year. Frank is a person 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 OT is understaffed and overworked. You have permission from Frank's boss, Jane, to use some of his time only if it doesn't interfere with his regular duties.

Scenario One:

Upon 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-related scheduling. This needs to be completed within two 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.

"Frank, 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 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 under each of the preceding scenarios. Why?

Exhibit 10–2 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 his or her 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 One. 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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REFERENCES

Evans, M. G. (1970). The effects of supervisory behavior on the path–goal relationship. *Organizational Behavior and Human Performance, 5*, 277–298.

Fiedler, F. E. (1965). Engineer the job to fit the manager. *Harvard Business Review, 43*, 115–122.

Fiedler, F. E. (1967). *A theory of leadership effectiveness*. New York, NY: McGraw-Hill Book Company.

Fiedler, F. E. (1970). The contingency model: A theory of leadership effectiveness. In C. W. Backman & P. F. Secord (Eds.). *Problems in social psychology* (pp. 279–289). New York, NY: McGraw-Hill Book Company.

Fiedler, F. E. (1995). Cognitive resources and leadership performance. *Applied Psychology—An International Review, 44*, 5–28.

Fiedler, F. E. (1996). Research on leadership selection and training: One view of the future. *Administrative Science Quarterly, 41*(2), 241–250.

Fiedler, F. E. (2008). The curious role of cognitive resources in leadership. In R. E. Riggo, S. E. Murphy, & F. J. Pirozzolo (Eds.). *Multiple intelligences and leadership*. Mahwah, NJ: Lawrence Erlbaum Associates.

Fiedler, F. E., & Chemers, M. M. (1974). *Leadership and effective management*. Flenview, IL: Scott, Foresman.

Fiedler, F. E., & Garcia, J. E. (1987). *New approaches to effective leadership: Cognitive resources and organizational performance*. New York, NY: John Wiley & Sons.

Fiedler, F. E., Potter, E. H., Zais, M. M., & Knowlton, W. (1979). Organizational stress and the use and misuse of managerial intelligence and experience. *Journal of Applied Psychology, 64*, 635–674.

Graen, G., & Ginsburgh, S. (1977). Job resignation as a function of role orientation and leader acceptance: A longitudinal investigation of organizational assimilation. *Organizational Behavior and Human Performance, 19*, 1–17.

Graen, S. G., & Cashman, J. F. (1975). A role-making model of leadership in fromal organizations: A development approach. *Organization and Administrative Sciences, 6*, 143–165.

Hersey, P., & Blanchard, K. H. (1988). *Management of organizational behavior*. Upper Saddle River, NJ: Prentice Hall.

House, R. J. (1971). A path-goal theory of leader effectiveness. *Administrative Sciences Quarterly, 16*(3), 321–338.

House, R. J., & Mitchell, T. R. (1974). Path–goal theory of leadership. *Journal of Contemporary Business, 3*(4), 81–97.

Liden, R. C., & Graen, G. (1980). Generalizability of the vertical dyad linkage model of leadership. *Academy of Management Journal, 23*, 451–466.

Luthans, F. (2002). *Organizational behavior* (9th ed.). Boston, MA: McGraw-Hill Book Company.

Ott, J. S. (1996). *Classic readings in organizational behavior* (2nd ed., p. 168). Albany, NY: Wadsworth Publishing Company.

Razik, T. A., & Swanson, A. D. (1995). *Fundamental concepts of educational leadership and management*. Upper Saddle River, NJ: Prentice Hall.

Robbins, S. P. (2005). *Organizational behavior* (8th ed.). Upper Saddle River, NJ: Prentice Hall.

Tannenbaum, R., & Schmidt, W. (1958). How to choose a leadership pattern. *Harvard Business Review, 36*(2), 95–501.

Tannenbaum, R., & Schmidt, W. (1973). How to choose a leadership pattern. *Harvard Business Review, 51*(3), 1–10.

Tosi, H. L., & Mero, N. P. (2003). *The fundamentals of organizational behavior: What managers need to know* (p. 254). Malden, MA: Blackwell Publishing.

Yukl, G. (1998). *Leadership in organizations* (4th ed.). Englewood Cliffs, NJ: Prentice-Hall.

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Contemporary Leadership Theories

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. These theories build upon 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 possesses 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. 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 and expand the multiplicity of variables impacting leadership, they also return us to the examination of individual characteristics and behaviors. Novick, Morrow, and Mays (2008) suggest that transformational leadership seemingly appears as the reemergence of trait-based theories. Indeed, numerous studies in recent years have focused on personality traits of effective transformational, transactional, and charismatic leaders (DeHoogh, Den Hartog, & Koopman, 2005). Many 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. By organizing similar traits 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 he or she must also have knowledge, skills, vision, and values to effectively influence followers and facilitate individual and organizational performance. Therefore, we 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" and "transformational" to establish a foundation in regard to how each approach is appropriate and vital to organizational 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 upon completion of the agreement. As DeHoogh, Den Hartog, and Koopman (2005, p. 840) put it, "transactional 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 the follower.

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 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 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 11–1**, Kotter identified eight transformational phases and associated transformational errors, which he accompanies with strategies to enhance the success of the leader by addressing the errors. Tichy and Devanna (1986), cited in 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 possessed the capability to face complexity, ambiguity, and uncertainty.
7. They were imaginative, creative, innovative, and visionary.

Table 11–1 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

"Leading Change: Why Transformational Efforts Fail," by J. P. Kotter, 1995. *Harvard Business Review, 73*(2), 61. Reprinted with permission.

THE IMPLICATIONS OF TRANSFORMATIONAL

LEADERSHIP ON THE HEALTH CARE INDUSTRY

Due to the Affordable Care Act (2010) and other factors, health care organizations will transform in many ways in the years to come. The health care manager must acquire the skills, abilities, and knowledge necessary 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 calls to demonstrate high performance and quality outcomes while reducing costs in the midst of decreasing revenues. Leaders must demonstrate increasing transformational skills while balancing the requirements of transactional management. However, as previously noted, the transactional leadership model has been considered the most dominant leadership model 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. In his study, Thyler reported that the healthcare 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 regarding 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. These results provide strong support 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.
- Possesses excellent communication skills.
- Exhibits a passion for work.
- Maintains a focus on the organizational mission.

"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" (Chaffee, 2001). These leadership characteristics support four managerial competencies sustained by successful leaders:

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. (Bennis, 1984; Chaffee, 2001)

Transformational leadership is, without question, very well suited to the needs of today's economic, social, political, and technological conditions. Why? Transformational leadership thrives on change and innovation. Transformational leadership provides the knowledge, skills, and abilities to facilitate innovation and transformation, beyond that which is available through a traditional approach. Doing things because that is the way they were always done will be replaced with 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). The implications of this statement provoke questions as to how the health care industry will respond

to an environment where 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 50 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 him- or herself in motion, demonstrated how to accomplish a goal and whose successes encouraged others to join in the pursuit of the goal(s). 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 focus 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 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 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 superleader 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, Kolb, & Rubin, 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 ideological vision and purpose 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. This 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 that the charismatic leader exhibits high ethical standards. This presumption, in most cases, would be correct. The ethical charismatic leader will, in general, exhibit the characteristics outlined in **Exhibit 11–1** (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).

Exhibit 11–1 Characteristics Exhibited by the Ethical Charismatic Leader

The ethical charismatic leader:

- Uses power to serve others;
- Aligns vision with followers' needs and aspirations;
- Considers and learns from criticism;
- Stimulates followers to think independently and to question the leader's view;
- Uses open, two-way communication;
- Coaches, develops, and supports followers; shares recognition with others;
- Relies on internal moral standards to satisfy organizational and societal interests.

Organizational Behavior (9th ed., p. 591), by F. Luthans, 2002. Boston, MA: McGraw-Hill Book Company. Reprinted with permission.

Though the components of transformational leadership and charismatic leadership differ somewhat (Yukl, 1999), these theories are often seen as equivalent. As discussed, 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, if one combines the desire to lead with learning and understanding the position and responsibility of a transformational leader, he or she may develop the capacity to transform organizations. Given this supposition and the close association of transformational and charismatic leadership brings us to the question: 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. He suggests that many people accept the fact that, given organizational constraints and the competition among organizational leaders, many potential change agents acquiesce to acknowledge that they will only achieve a certain level of success. He 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 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" (p. x). Benton's (2003, p. 10) 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 your willingness to accept uncertainty head-on; to acknowledge 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 cyclical optimism that can pervade others involved in the transformative effort.

The third step proffers 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 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 won't—without overdoing it! By this Benton suggests 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 (or 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 others in an effort to help others 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, Hamilton, & Niles, 2014).

As such, 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 within 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 within a large health system. The results of Ornelas's study showed that employees working in departments that reported managers with servant leadership characteristics reported lower turnover rates, higher job satisfaction, and increased commitment to the organization than those 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 employee job satisfaction within departments where the nursing staff perceived that their managers had higher 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 healthcare climate; exhibit a high level of passion, excitement, and drive to perpetuate their success" (p. 282).

Many 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, Russell, and Patterson (2003, p. 1) explain that

> the transformational lethe 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, 2014). Al-Sawai (2013) states that collaborative health care leadership requires a synergistic work environment, wherein 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, with individuals being unified by shared visions and values.

Borkowski and Deppman (2014) 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 as well as 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 regarding the issues needing 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 **Exhibit 11–2**) can be learned by dedicated leaders who commit the necessary time and effort (Borkowski & Deppman, 2014).

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 **Exhibit 11–3**).

ANOTHER LOOK AT TRAITS AND BEHAVIOR

As mentioned in the Overview section, many see contemporary theories of leadership as a resurgence of interest in individual traits and behaviors. Two such theoretical constructs currently 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. Identifying 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. These factors as identified (DeHoogh, Den Hartog, & Koopman, 2005; Robbins, 2005) include:

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 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, Den Hartog, and Koopman (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, Den Hartog, and Koopman (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

Emotional intelligence (EI) is relatively new to 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 his or her 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 the possession of the 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 others 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 emotional intelligence can be identified, assessed, and upgraded.
- At the group level, it means fine-tuning the interpersonal dynamics that make groups smarter.
- At the organizational level, it 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 select 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 11–2**.

Table 11–2 Health Care Administration Application to Emotional Intelligence

Component	*Definition*	*Examples of Application*
Self-awareness	Having a deep understanding of one's emotions, strengths, weaknesses, needs, and drives	1. Confidently making decisions when budgets must be trimmed in medical areas 2. Knowing that the values of the health care system are not congruent with yours 3. Recognizing that the late-night committee meetings are affecting your family relations
Self-regulation	A propensity for reflection, ability to adapt to changes, saying no to impulsive urges	1. Knowing when to step away if having an argument with a provider 2. Acting to correct medical billing compliance issues rather than ignoring them 3. Accepting responsibility over additional health care facilities
Self-motivation	Driven to achieve, being passionate about enjoying challenges in the profession	1. Setting up a senior manager retreat to allow the best environment for planning 2. Being optimistic even when consensus is low 3. Embracing diverse populations of patients and employees
Social awareness	Thoughtfully considering someone's feelings when acting	1. Thinking of the family's perspective when involved in bioethical decisions 2. Being compassionate when dealing with employees and their personal problems affecting their work 3. Being patient-centered
Social skills	Moving people in the direction you desire	1. Being able to negotiate a favorable managed care contract 2. Having employees satisfied with their performance evaluation 3. Using good listening skills when talking with governing board members

"Emotional Intelligence: A Core Competency for Healthcare Administrators," by B. Freshman and L. Rubino, 2002, *Health Care Manager, 20*(4), p. 6. Reprinted with permission.

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 a growing interest in the development of competencies since McClelland (1961, 1985) published his work on achievement and motivation. In the past decade, 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 (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 vast 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 Web site at 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 may wish to

improve performance.

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. Further, 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 one of the variables within a context (e.g., health care climate) that ultimately impacts performance outcomes (i.e., patient outcomes, patient satisfaction, and financial results).

SUMMARY

Contemporary theories recognize the complexity of leadership, and yet also bring us back to examining the role of traits and behaviors as 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. Despite the fact that tasks and processes would be accomplished, 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. Fortunately, this scenario is unlikely, but it does portray the

importance of balance of leadership styles within organizations.

It is essential to create the proper 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? You can see there is not a 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 most 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 the 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. 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 dependent upon 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 (or opposition).
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 five years as the health care environment transforms as a result of industry reform.

EXERCISE 11–1

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). As such, 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 11–2 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 clarify goals and how to reach them.
2. Give people a sense of mission and overall purpose.
3. Help get jobs out 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 in exchange for high performance from subordinates.
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 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 others. 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; Bernard M. Bass, *Leadership and Performance Beyond Expectations* (New York, NY: Free Press, 1985); and Lawton R. Burns and Selwyn W. Becker, "Leadership and Managership," in S. Shortell and A. Kaluzny (Eds.), *Health Care Management* (New York, NY: Wiley, 1986).

Case Study 11–1 The Mall-Based Teen Services Center

The Problem: Lack of accessibility of services for teens was an ongoing problem for key providers of health, social, and employment services. Services were funded and available, but those in greatest need were not using them.

The Solution: Co-locate a variety of teen-focused services at a popular teen hangout: a mall. The state health department signed a memorandum of understanding with the three local health departments whose counties surrounded the mall area and the governor's job training program. One local health department hired a coordinator to develop and launch the project. Two stakeholder groups were formed: an adult advisory council and a youth advisory council. The adult group was composed of school officials, representatives from youth service agencies, and social services agencies. Members of the youth advisory committee were drawn from the potential client group: middle- and high-school students. The coordinator enlisted the support of local construction groups who agreed to donate labor for the build-out.

The Outcome: There was much enthusiasm and support for the project from members of the adult and youth advisory committees. School officials, in particular, liked that they could support sensitive teen services like family planning in an off-site location. Members of the youth advisory committee were empowered by a process in which they were making decisions about how the clinic would be constructed and promoted. However, the project ultimately failed. The mall owner, a resident of another state, refused to donate or rent at low cost space in the mall. Space in buildings surrounding the mall was too expensive. An amendment to the host state's constitution made it impossible for the local health departments to finance the initial startup costs.

As a collaborative leader, what would you have done differently?

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EXERCISE 11–3 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 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 it is an inborn characteristic?

EXERCISE 11–4

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?

REFERENCES

Al-Sawai, A. (2013). Leadership of healthcare professionals: Where do we stand. *Oman Medical Journal, 28*(4), 285–287.

Anderson, R. J. (2003). Building hospital–physician relationships through servant leadership. *Frontiers of Health Services Management, 20*(2), 45–47.

Bass, B. M. (1990a). *Bass and Stogdill's handbook of leadership: Theory, research and managerial applications* (3rd ed.). New York, NY: The Free Press.

Bass, B. M. (1990b). From transactional to transformational leadership:

Learning to share the vision. *Organizational Dynamics, 18*(3), 19–31.
Bass, B. M. (2008). *The Bass handbook of leadership: Theory, research and managerial applications* (4th ed.). New York, NY: The Free Press.
Bennis, W. (1984). The four competencies of leadership. *Training and Development Journal*, August, 144–149.
Bennis, W., & Nanus, B. (1985). *Leaders: The strategies for taking charge*. New York, NY: Harper & Row.
Benton, D. A. (2003). *Executive charisma*. New York, NY: McGraw-Hill Book Company.
Blanchard, K., & Hodges, P. (2003, May 12). The journey to servant leadership in work, life. *San Diego Business Journal*, A2.
Bolman, L. G., & Deal, T. E. (1997). *Reframing organizations: Artistry, choice, and leadership* (2nd ed.). San Francisco, CA: Jossey-Bass.
Borkowski, N., & Deppman, B. (2014). Collaborative leadership. In L. Rubino, S. Esparza, and Y. R. Chassiakos (Eds.). *New leadership for today's healthcare professionals: Concepts and cases*. Burlington, MA: Jones and Bartlett Publishers.
Bryman, A. (1992). *Charisma and leadership in organizations*. London, UK: Sage.
Burns, J. M. (1978). *Leadership*. New York, NY: Harper & Row.
Carter, M. (2006). The importance of collaborative leadership in achieving effective criminal justice outcomes. Center for Effective Public Policy. Available at: www.cepp.com
Chaffee, M. W. (2001). Navy medicine: A health care leadership blueprint for the future. *Military Medicine, 166*(3), 240–247.
Curtin, L. L. (1997). How—and how not—to be a transformational leader. *Nursing Management, 28*(2), 7–8.
DeHoogh, A., Den Hartog, D., & Koopman, P. (2005). Linking the Big Five factors of personality to charismatic and transactional leadership; perceived dynamic work environment as a moderator. *Journal of Organizational Behavior, 26*, 839–865.
Den Hartog, D., & Koopman, P. (2001). Leadership in organizations. In N. Anderson, D. Ones, H. Kepir-Sinangil, & C. Viswesvaran (Eds.). *International handbook of industrial, work & organizational psychology* (Vol. 2). London, UK: Sage.
Dessler, G. (1998). *Management: Leading people and organizations in the 21st century*. Upper Saddle River, NJ: Prentice Hall.
Digman, J. (1990). Personality structure: The emergence of the five-factor

model. *Annual Review of Psychology, 41*, 417–440.
Druskat, V. U., & Wolff, S. B. (2001), Building the emotional intelligence of groups, *Harvard Business Review, 79*(3), 80–90.
Dye, C. F., & Garman, A. N. (2006). *Exceptional leadership: 16 critical competencies for healthcare executives*. Chicago, IL: Health Administration Press.
Freshman, B., & Rubino, L. (2002). Emotional intelligence: A core competency for health care administrators. *Health Care Manager, 20*(4), 1–9.
Gibbs, N. (1995, October 2). The EQ factor. Time. Available at: www.time.com/time/magazine/article/0,9171,983503,00.html
Goleman, D. (1998). *Working with emotional intelligence*. New York, NY: Bantam Books.
Grossman, R. J. (2000). Emotions at work. *Health Forum Journal, 43*(5), 18–22.
Gummer, B. (1995). Go team go: The growing importance of teamwork in organizational life. *Administration in Social Work, 19*, 85–100.
Howell, J. M., & Avolio, B. J. (1992, May). The ethics of charismatic leadership: Submission or liberation. *Academy of Management Executive*, 43–54.
Ibarra, H., & Hansen, M. T. (2011). Are you a collaborative leader. *Harvard Business Review, 89*(7/8), 69–74.
Jenkins, M., & Stewart, A. C. (2010). The importance of a servant leader orientation. *Health Care Management Review, 35*(1), 46–54.
Judge, T., Bono, J., Ilies, R., & Gerhardt, M. (2002). Personality and leadership: A qualitative and quantitative review. *Journal of Applied Psychology, 87*, 755–768.
Kotter, J. P. (1995, March/April). Leading change: Why transformational efforts fail. *Harvard Business Review, 73*, 59–67.
Luthans, F. (2002). *Organizational behavior* (9th ed.). Boston, MA: McGraw-Hill Book Company.
McClelland, D. C. (1961). *The achieving society*. New York, NY: The Free Press.
McClelland, D. C. (1985). *Human motivation*. Glenwood, IL: Scott-Foresman.
Medley, F., & Larochelle, D. R. (1995). Transformational leadership and job satisfaction. *Nursing Management, 26*(9), 64JJ–64NN.
Novick, L., Morrow, C., & Mays, C. (2008). *Public health administration:*

Principles for population-based management. Sudbury, MA: Jones and Bartlett Publishers.

Ornelas, J. (2003). The effect of servant leadership on organizational outcomes. Poster presentation at the American College of Healthcare Executives 2003 Congress, Chicago, IL.

Osland, J., Kolb, D., & Rubin, I. (2001). *Organizational behavior: An experiential approach* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

Pelote, V., & Route, L. (2007). *Masterpieces in health care leadership*. Sudbury, MA: Jones and Bartlett Publishers.

Robbins, S. P. (2005). *Organizational behavior* (8th ed.). Upper Saddle River, NJ: Prentice Hall.

Romm, C., & Pliskin, N. (1999). The role of charismatic leadership in diffusion and implementation of e-mail. *Journal of Management Development, 18*(3), 273–291.

Salovey, P., & Mayer, J. (1990). Emotional intelligence. *Imagination, Cognition, and Personality, 9*, 185–211.

Schwartz, R. W., & Tumblin, T. F. (2002). The power of servant leadership to transform health care organizations for the 21st-century economy. *Archives of Surgery, 137*(12), 1419–1427.

Sellers, P. (1996). What exactly is charisma. *Fortune, 133* (15), 68–72.

Sofarelli, D., & Brown, D. (1998). The need for nursing leadership in uncertain times. *Journal of Nursing Management, 6*(4), 201–207.

Spears, L. C. (2004). Practicing servant-leadership. *Leader to Leader, 34*, 7–11.

Spencer, L., & Spencer, S. (1993). *Competency at work models for superior performance*. New York, NY: John Wiley & Sons.

Stone, A. G., Russell, R. F., & Patterson, K. (2003, August). Transformal versus servant leadership: A difference in leader focus. Servant Leadership Research Roundtale: School of Leadership Studies, Regent University. Available at: www.regent.edu/acad/global/publications/sl_proceedings/2003/stone_transf

Thyler, G. (2003). Dare to be different: Transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management, 11*(2), 73–79.

Tichy, N. M., & Devanna, M. A. (1986). *The transformational leader*. New York, NY: John Wiley & Sons.

Trastek, V. F., Hamilton, N. W., & Niles, E. E. (2014). Leadership models in health care—a case for servant leadership. *Mayo Clinic Proceedings,*

89(3), 374–381.
Trofino, A. J. (1995). Transformational leadership in health care. *Nursing Management, 26*(8), 42–47.
Trofino, A. J. (2000). Transformational leadership: Moving total quality management to world-class organizations. *International Nursing Review, 47*(4), 232–242.
Yukl, G. (1999). An evaluation of conceptual weaknesses in transformational and charismatic leadership theories. *Leadership Quarterly, 10*, 285–305.

OTHER SUGGESTED READING

Atchison, T. (2005). Leadership's deeper dimensions: Building blocks to superior performance. Chicago, IL: Health Administration Press.
Conger, J. A., & Kanungo, R. N. (1988). Behavioural dimensions of charismatic leadership. In J. A. Conger & R. N. Kanungo (Eds.). *Charismatic leadership* (pp. 79–91). San Francisco, CA: Jossey-Bass.
Dixon, D. L. (1998). The balanced CEO: A transformational leader and capable manager. *Healthcare Forum Journal, 41*(2), 26–29.
Lee, F. (2008). *If Disney ran your hospital: 9% things you would do differently*. Chicago, IL: Health Administration Press.
Yukl, G. (1989). Managerial leadership: A review of theory and research. *Journal of Management, 15*(2), 266.

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Intrapersonal and Interpersonal Issues

In Part IV, we explore various intrapersonal and interpersonal issues. Chapters 12 and 14 discuss stress and conflict and how the negative effects of both can be avoided or at least miniminized. 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, levels of productivity may decrease and problems may be created with our physical and mental health.

In Chapter 13, we discuss the various ways 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!

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 available to organizations and individuals.
- The concepts of learned optimism and hardiness training.
- The definition of stress management and the various programs used by organizations.

OVERVIEW

Stress is a complex and highly personalized process. As such, stress levels in individuals can vary widely, even in identical situations, because of people's 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, adaptability, and resources available.

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, et al., 1985) argue that

individuals may perceive the same stressful situation differently on the basis of their cognitive appraisal; some individuals see a specific situation as a threat, whereas other individuals see the same situation as a challenge or opportunity.

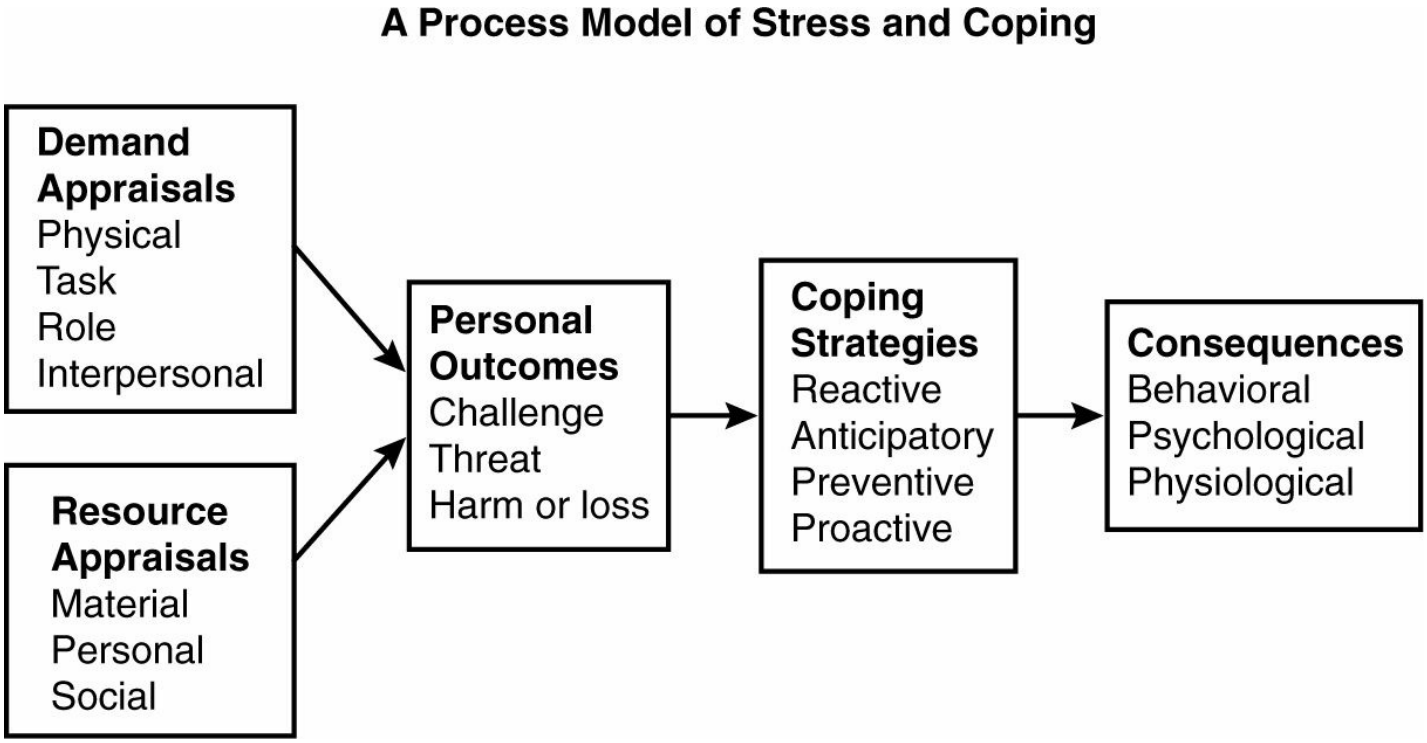

Figure 12–1 The Process Model of Stress and Coping

Adapted from Schwarzer, R. (2004). Manage stress at work through preventive and proactive coping. In E. A. Locke (Ed.), Handbook of Principles of Organizational Behavior. London: Blackwell Publishing, p. 344.

Table 12–1 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

Source: *Preventive Stress Management in Organizations* (p. 22), by J. C. Quick, J. D. Quick, D. L. Nelson, and J. J. Hurrell, 1997, Washington, DC: American Psychological Association. Reprinted with permission.

As illustrated in **Figure 12–1**, an individual's assessment of the situation includes demand appraisals or resource appraisals. Demand appraisals relate to the person's perception as to (1) physical demands, (2) task demands, (3) role demands, and (4) interpersonal demands (see **Table 12–1**). 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 appraisal refers to an individual's internal coping options. Individuals who are affluent, healthy, capable, and self-confident are 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).

As a result of the person's appraisal of the situation, one of three

perceptual outcomes occurs. These perceptual outcomes are: 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, either by 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 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, social standing, or physical injury (Lazarus, 1991; Schwarzer, 2004). Building on Lazarus's work, Schwarzer's (2004) process model illustrates that, on the basis of an individual's perception of the situation, he or she 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 12–2**).

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 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 from both an organizational perspective and an individual perspective, which is referred to as stress management.

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 has been called the "health epidemic of the 21st century" by the World Health Organization and is estimated to cost American businesses up to $300 billion a year (Smith, 2012) in terms of accidents; absenteeism; employee turnover; loss of productivity; direct medical, legal, and insurance costs; workers' compensation awards; as well as tort and Federal Employers' Liability Act judgments (American Institute of Stress, 2004).

The National Institute for Occupational Safety and Health (NIOSH), the federal agency within the U.S. Department of Health and Human Services

responsible for conducting research and making recommendations for the prevention of work-related injury and illness, found that:

- 40 percent of workers reported that their jobs were very or extremely stressful;
- 25 percent viewed their jobs as the number-one stressor in their lives;
- 75 percent of employees believed that workers have more on-the-job stress than a generation ago;
- 29 percent of workers felt quite a bit or extremely stressed at work;
- 26 percent 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 financial or family problems. (NIOSH, 1999)

Table 12–2 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)

SOURCE Preventive Stress Management in Organizations (p. 66), by J. C. Quick, J. D. Quick, D. L. Nelson, and J. J. Hurrell, 1997, Washington, DC: American Psychological Association 66. Reprinted with permission.

Furthermore, stress 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 yelling and verbal abuse were common in their workplaces. In a recent study, 51 percent of British workers reported experiencing rage at work (The Telegraph, 2013). Desk 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. Integra's survey reported that:

- 65 percent of workers said that workplace stress had caused difficulties, and more than 10 percent described these as having major effects;
- 10 percent said they work in an atmosphere where physical violence has occurred because of job stress, and of this group, 42 percent reported that yelling and other verbal abuse is common;
- 29 percent had yelled at coworkers because of workplace stress, 14 percent said they worked where machinery or equipment had been damaged because of workplace rage, and 2 percent admitted that they had actually personally struck someone;
- 19 percent, or almost one in five respondents, had quit a previous position because of job stress, and nearly one in four had been driven to tears because of workplace stress;
- 62 percent routinely found that they ended the day with work-related neck pain, 44 percent reported stressed-out eyes, 38 percent complained of hurting hands, and 34 percent reported difficulty in sleeping because they were too stressed out;
- 12 percent had called in sick because of job stress;
- Over half said they often spent 12-hour days on work-related duties, and an equal number frequently skipped lunch because of the stress of job demands.

Workplace rage is a common problem within the health care industry. In fact, a recent Securitas USA (2013) report reflected that workplace violence prevention/response remained the top concern in the health care industry from 2010 to 2012. For example, almost one-third of physician executives participating in a recent national study conducted by the American College of Physician Executives reported that serious problems erupted within their organization on either a monthly or weekly basis as a result of disruptive

behavior by physicians (Weber, 2004). Furthermore, 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. Other comments cited were berating the nurse in front of patients, family members, or other staff. 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). Due to 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 Leadership 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 their daily lives, 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 optimum performance, whereby we achieve our goals. Hans Selye (1956, 1974), a Canadian physiologist referred to as the grandfather of stress research, coined the term "eustress" to describe good or positive stress. Eustress is from the Greek root *eu* for "good." Selye suggested thinking of eustress as euphoria + stress. It is only when stress is poorly managed or becomes overwhelming that the negative effects appear, which is referred to as distress (see **Figure 12–2**).

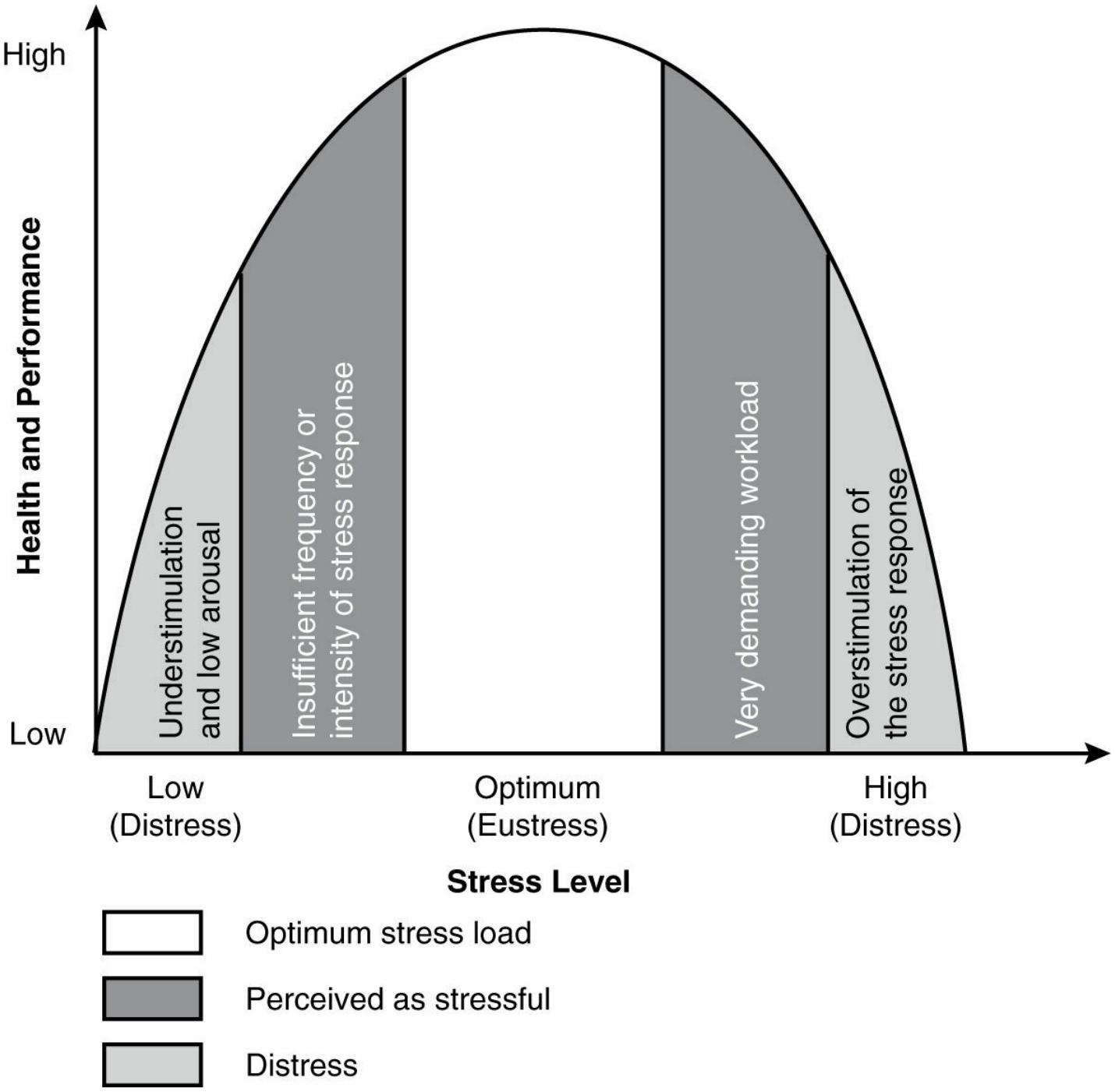

Figure 12–2 Distress–Eustress (An Expanded Yerkes–Dodson Curve)

Preventive Stress Management in Organizations (p. 156), by J. C. Quick, J. D. Quick, D. L. Nelson, and J. J. Hurrell, 1997. Washington, DC: American Psychological Association. Reprinted with permission.

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 physiologic changes of individuals when confronted with a negative stimulus or environmental

change. This is referred to as an individual's "fight-or-flight" response. The fight-or-flight response is when the brain and certain chemicals within the brain cause a reaction to potentially harmful stressors or warnings (e.g., danger, harassment, noise). Selye (1956) studied the physiologic effects of the fight-or-flight response, which resulted in his description of General Adaptation Syndrome (GAS). GAS describes the three phases an individual undergoes when a stressful situation is encountered: the alarm phase, the resistance phase, and the exhaustion phase.

The first stage of GAS, the alarm phase, is when an individual's fight-or-flight response is elicited for mobilization and geared for a fight or flight. The second stage, resistance, is when the individual fights the stressor and the acute fight-or-flight response ceases. The third stage, exhaustion, is 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.

It is only in the final stage, exhaustion, that an individual may reflect behavioral, physiological, and/or psychological illnesses. Physiological illnesses may include chronic headaches or fatigue, hypertension, ulcers, and heart disease. Psychological illnesses or the emotional symptoms of stress in the exhaustion stage relate to 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 leads to impaired performance, poor judgment, and indecisiveness, as well as a negative attitude toward life and work, with the possibility of this 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 (the fight-or-flight

response). Long-term chronic stressors are those that are continuous, such as work pressures, relationship problems, and financial concerns (see **Table 12–3**).

Table 12–3 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	Lifestyle—Unhealthy lifestyles, such as excessive caffeine, smoking, drinking, drugs, lack of sleep, trying to do too much (e.g., supermom)
Others—Rude, domineering, aggressive, peer pressures, and discrimination	Mental State—Pessimistic, self-critical, self-helplessness, unrealistic expectations, and lack of flexibility
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	Personality—Perfectionist, workaholic, perceived expectation of others and ourselves, and other Type A personality characteristics
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	

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 those who are more prone to experience higher levels of stress, such as certain personality types, belonging to a minority group, and gender.

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 people with Type B personality traits (e.g., patient, low-key, noncompetitive) (Young, 1974). Although Type B individuals are equally intelligent and may be just as ambitious as those who are Type A, 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) found that anger and hostility were the lethal dimensions of TABP when they studied 255 physicians over a 25-year period. At this time, researchers are still unsure what component or components of TABP constitute the greatest 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 he or she has over the environment, whether direct or indirect, to make it less threatening or more rewarding (Ganster & Fusilier, 1989). Within 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 his or her 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 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 et al., 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/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 highly stressed positions as related to the need to respond to others' demands and project deadlines, with 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 older managers because of less autonomy, closer supervision, and confusion over lines of authority within the organization.

However, a perceived lack of control may 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 the reverse effect on the employee's well-being.

Minorities

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 ethnic minority groups may be more prone to stress than majority (i.e., nonethnic minority) groups because of issues associated with prejudice and discrimination, whether perceived or real, potential language difficulties, and 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. In a more recent national study, Roberts, Swanson, and Murphy (2004) found that American minorities reported perceptions of discrimination at work at greater frequencies than nonminority Americans, and that whites, African Americans, and Hispanic Americans 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.

James, Lovato, and Khoo (1994) argue that differences in cultural values and attitudes between minority workers and majority workers constitute a major source of minority worker stress. 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 shifts from a work role in which he or she attempts 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 within his or her collectivist community. Assimilation is the process by which an individual develops a new cultural identity, whereby the individual may eventually lose identification with his or her culture of origin in order to become successful in the dominant culture. Since minority cultures may have a more collectivist orientation, minority members may experience stress as they attempt to assimilate into the majority culture dominating the workplace. As an example, Bell, as cited in 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. Since minority cultures may differ in race, attitudes, and beliefs from the majority culture within an organization, minority members would find the workplace to be more

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 percent 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 Global 2000 Consumer Study of 30,000 people between the ages of 13 and 65 in 30 countries showed that increased stress is felt worldwide, with women consistently reporting being more stressed than men. The most stressed women are: (1) mothers with children under the age of 13, (2) full-time working mothers, and (3) full-time working mothers with children under 13. In addition, one-fourth of women executives and professionals say 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 percent more health problems than their male counterparts and noticeably higher stress. Furthermore, Swanson (2000) found that:

- 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 increased 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 on psychological distress and absenteeism beyond that attributable to regular job stressors (pp. 77–78).

Burnout

Stress occurs when job requirements do not match the capabilities, resources, or needs of the employee. 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. Burnout, first discovered in the 1970s, has been recognized as an occupational hazard for 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. Sadly, health care professionals have reported substantially higher degrees of burnout than managers not employed in the health care industry (Golembiewski & Boudreau, 1991).

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 the rope." As emotional resources are depleted, health care professionals feel they cannot give of themselves at an emotional or psychological level.
- Depersonalization is characterized by the development of negative and cynical attitudes toward the workplace, as well as toward people with whom the employee interacts (patients and coworkers). Individuals distance themselves and see others 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, with health care workers experiencing the most advanced phases (Golembiewski & Boudreau, 1991). As illustrated in **Table 12–4**, 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, such as:

Table 12–4 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 Accomplishment (reversed)	Lo	Lo	Hi	Hi	Lo	Lo	Hi	Hi
Emotional Exhaustion	Lo	Lo	Lo	Lo	Hi	Hi	Hi	Hi

"The Epidemiology of Progressive Burnout: A Primer," by R. T. Golembiewski, 1986. *Journal of Health and Human Services Administration, 9*(1), p. 18. Reprinted with permission.

- 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 grows.
- Self-esteem falls.
- Various clinical indicators of mental health deteriorate.
- Declining quality of social and emotional life at work; 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 an urban Midwest city who reported higher levels of burnout experienced (1) decreased job satisfaction, (2) decreased satisfaction with interpersonal relationships, and (3) lower levels of organizational commitment reflected by either job turnover or increased intentions to leave their jobs.

Presenteeism

As previously noted, symptoms of burnout may include lower job performance and satisfaction, higher job tension and turnover, and increased absenteeism. However, increased absenteeism is not always an indicator that an employee may be suffering from burnout. A 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 is its largest health-related economic impact, 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 conducted by Tufts–New England Medical Center researchers at Lockheed Martin Corporation 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 the organization approximately $34 million (Hemp, 2004). (See **Case Study 12–1**: Presenteeism: A Public Health Hazard.)

Case Study 12–1 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 12–5**).

- Individual task demands would 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, excess rules and regulations, organizational structure and culture, lack of career development activities, and change without clear strategic direction.

Table 12–5 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

Source: "Occupational Stress Management: Current Status and Future Directions," by L. R. Murphy, 1995. In C. L. Cooper and D. M. Rousseau (Eds.), *Trends in Organizational Behavior* (Vol. 2, pp. 1–14). New York, NY: John Wiley & Sons. Reprinted with permission.

How these various demands can affect employees' stress levels is illustrated in **Case Study 12–2**.

Case Study 12–2 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 complete sense of exhaustion. At first he tried to ignore these problems, but eventually he became so short-tempered and irritable that his wife insisted he get a checkup. Now, sitting in his primary care physician's office and wondering what the verdict would be, he 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, but he hadn't seen her since she left three 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. Theresa is tied to the computer, allowing 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 her family needs.

Interpersonal Relationship: Poor social environment and lack of support or help from coworkers and supervisors.

Example: Theresa's physical isolation reduces 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 hospital equipment 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 "Stress at Work," DHHS (NIOSH) Publication No. 99–101, 1999. Washington, DC: National Institute for Occupational Safety and Health.

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 inherent in 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 experienced stress 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, for stress management interventions to be successful, they 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 12–3**). The distinction between each perspective is 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 is either 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 (minimizing severity of impact) if a critical event should occur in the future. For example, an individual returns to school to earn a master's degree in health administration or completes the requirements to become a board-certified health care executive in case of a possible job loss due to a merger or buyout.
- 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).

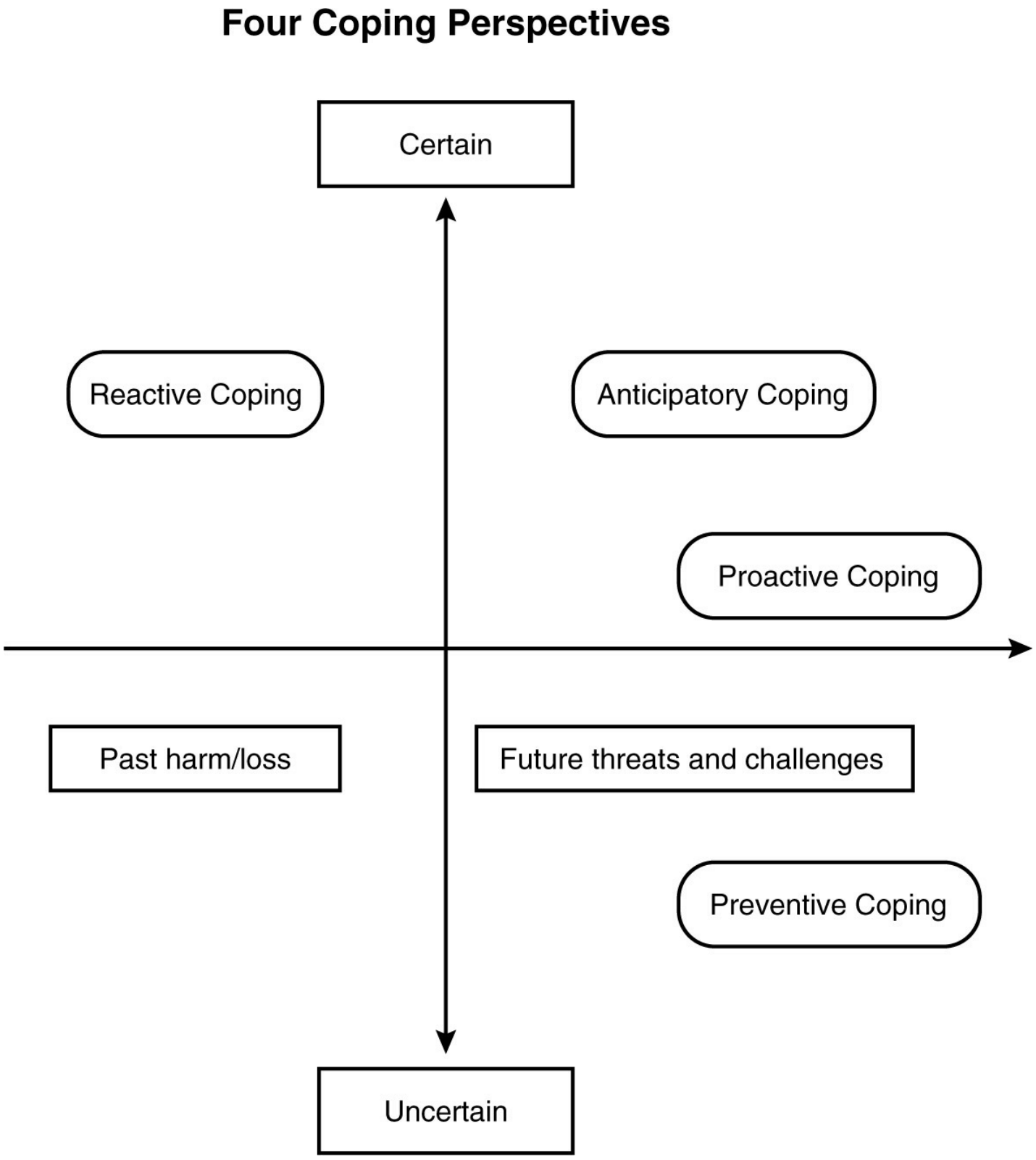

Figure 12–3 Four Coping Perspectives

Reproduced from Schwarzer, R. (2004). Manage stress at work through preventive and proactive coping. In E. A. Locke (Ed.), Handbook of Principles of Organizational Behavior. London: Blackwell Publishing, p. 347.

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 or anticipatory coping occurs, managers' efforts are involved with reducing the harm or loss to the organization. Managers are concerned with putting out fires as opposed to 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 regarding the envisioned future shortage of health care leaders due to an aging workforce. For example, among its 191 hospitals, HCA, Inc., anticipates that many of its baby boom–generation chief executive officers (CEOs) will retire within the next 10 years. Furthermore, given the likelihood that those vacancies will be filled by incumbent chief operating officers (COOs), HCA anticipates that it will face a hospital leadership gap at the COO level. To address this challenge proactively, HCA created an intensive COO development program. This program is 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 are given the title of "associate administrator" and assigned to an HCA hospital. The current CEO of the hospital serves as the associate administrator's mentor and superior over a two- to four-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 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. These methods 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 12–4**).

To illustrate these coping concepts, consider the following: A physician displays inappropriate behavior* toward a nurse (a stressor), which leads to the nurse experiencing anxiety (a stress response), and in turn, the nurse resigns (an organizational consequence of distress). Primary prevention would attempt to eliminate the stressor by the hospital establishing 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, as such, interactions are based on mutual respect and trust. Tertiary prevention might include establishing an employee assistance program designed to assist nurses to cope with confrontational behavior that may be displayed by physicians.

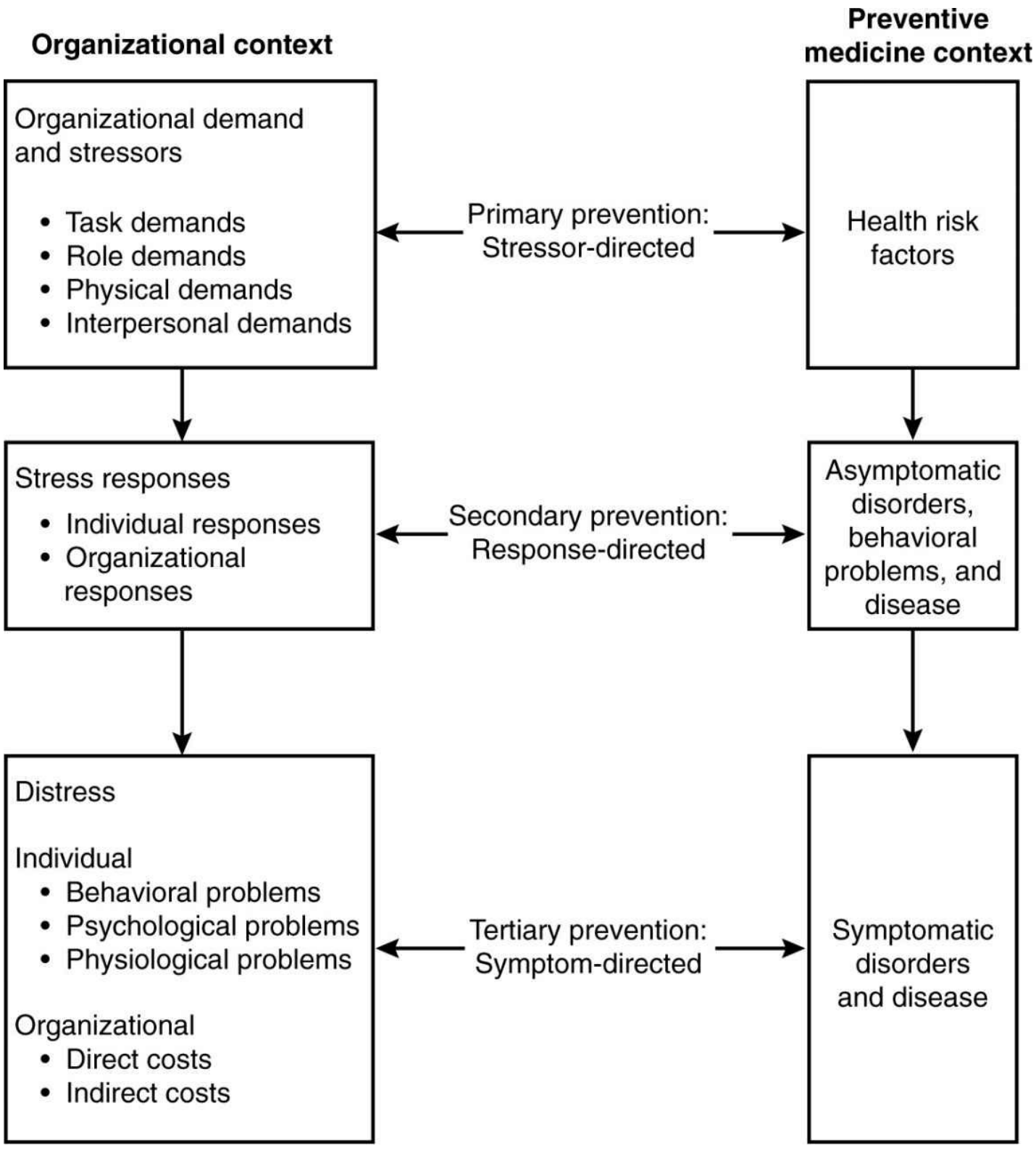

Figure 12–4 Stages of Preventive Stress Management

Preventive Stress Management in Organizations (p. 155), by J. C. Quick, J. D. Quick, D. L. Nelson, and J. J. Hurrell, 1997. Washington, DC: American Psychological Association. Reprinted with permission.

The preceding example is based on a recent study that linked

inappropriate physician behavior with nurses leaving the nursing profession. Rosenstein (2002) surveyed 1,200 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 percent 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 percent 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, 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 noted earlier, The Joint Commission issued a 2008 standard requiring hospitals to develop a disruptive behavior policy and provide necessary education about this topic.

Work Setting

As discussed previously, an employee's work setting may create physical stress because of noise, lack of privacy, poor lighting or ventilation, and so forth. As such, an organization 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 occupations than those in the management, business, finance, or science fields. 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 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:

- 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;
- 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 most well-documented techniques for reducing stress is through the relaxation response (see **Exhibit 12–1**). 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 very little if anything to solve the underlying problems; therefore, employees need to learn to use preventive and proactive coping strategies so that the fight-or-flight response is not automatically engaged at the first sign of stress (Schwarzer, 2004).

Exhibit 12–1 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," January 2003. *Tufts University Health and Nutrition Letter, 20*(11), pp. 4–5.

I. Friedman (1999) suggests training employees to cope with stressful situations by improving their abilities for problem solving and conflict resolution, and developing their leadership skills. For example, when an employee is facing a stressful episode due to increasing workload, he or she can be trained beforehand how to delegate tasks, use good time management skills, and increase his or her 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 hardiness 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. However, when optimistic people encounter obstacles, they try harder. Seligman's learned optimism theory suggests that people can learn optimism by undoing pessimistic thinking by recognizing and then disputing 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 his or her 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 it's an isolated incident. If the outcomes are positive, the optimist tends to think they will reoccur in the future. On the other hand, 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 it to his or her whole life. With a negative event, the optimist will tend to isolate the incident as specific to that situation. The opposite holds true for the pessimist: positive events are viewed as "strokes of luck," and negative events are viewed as representative of his or her whole life.
- Locus of control refers to whether the individual believes the outcome is attributable to his or her actions or to factors in the environment. For example, when a positive event occurs, the optimist attributes the success to his or her efforts. With a negative event, the optimist looks to causes outside of his or her control to explain the outcome, such as bad luck, whereas the pessimist will view positive events as attributable to luck, other people's hard work, or something else outside of his or her control, and will view negative events as being caused by his or her personal deficiencies.

Pessimists tend to attribute failure and negative events to permanent, personal, and pervasive factors. Optimists tend to attribute bad events to nonpersonal, nonpermanent, and nonpervasive factors. They 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; as such, they view setbacks, obstacles, and a noncontingent environment as challenges that provide excitement in their life (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 so as to make progress toward their goal, pessimists do not try to do so, because they have learned that giving up is a rational response. This is because their attribution leads to what is referred to as learned helplessness (see **Exhibit 12–2**) (Seligman, 1991). An individual's habitual blaming of him- or herself undermines self-efficacy (Bandura, 1997).

Exhibit 12–2 Learned Helplessness

Helplessness is a learned condition that has a negative impact on an individual's physical, emotional, mental, and spiritual well-being. Learned helplessness is a phenomenon in which people experience failure at a task, often numerous times. They determine that the task cannot be accomplished, at least not by them, and thus 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 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 first group that had the option of turning off the noise only considered the noise "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.

Optimism may serve as a buffer against the physiological effects of stress. Research suggests that the immune function in optimists is better than in pessimists. It is not that optimists experience fewer stressful situations than pessimists; they 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.

Hardiness Training

The hardiness concept has been applied frequently to prevent and alleviate stress at work (Schwarzer, 2004). The HardiTraining® program (see The Hardiness Institute, Inc., at www.hardinessinstitute.com) comprises building an employee's attitudes of commitment, control, and challenge.

- Commitment refers to an individual's belief that involving oneself in life

changes is the way to deepen meaning and purpose. Individuals high in commitment immerse themselves in a proactive coping process that transforms the stressfulness of a problem so that it becomes manageable and growth promoting.

- Control refers to one's belief that if he or she tries, he or she can positively influence much of what happens in his or her life. An individual maintains that even when a personal or professional problem has unchangeable aspects to it, if he or she is resourceful, there are ways to use the stressful circumstance as an opportunity for new learning. By constructively influencing outcomes, a person strengthens his or her view of oneself as capable, hardy, and a participant in the world.
- Challenge refers to an individual's attitude that everything that happens to him or her, whether negative or positive, is an opportunity to enhance one's performance, leadership, morale, conduct, and health.

Individuals high in HardiAttitudes® engage fully in their personal and work life, use life changes to promote learning and renewal, and report greater life meaning, purpose, and satisfaction (Maddi, 1998). HardiTraining® outcome studies have demonstrated their effectiveness in strengthening one's ability to resist the stressful impact of personal and professional changes.

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 percent after prevention activities were implemented in a 700-bed hospital. In a second study, there was a 70 percent 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).

Another example is Baptist Health South Florida (BHSF). Baptist Health, 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 designated "healthy" meals in the system's cafeterias. For those facing life-threatening illnesses, the system offers flexible, reduced scheduling so that staff 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 and colleagues (1995) related 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 work pace, 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. Assist employees to identify their stressors and stress-tolerance levels. Before learning how to deal with stress, employees first have to identify those stressors they react to, because not everyone responds the same way to the same stressors. To aid this process, organizations might 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 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 they can handle.
3. Communicate with employees. Providing more information about their jobs and other factors that affect them will help employees feel more in control of their circumstances and can help build cohesion. Organizations must also communicate and describe the stress management strategies available to employees and help them develop personalized action plans.

Reactive Coping (tertiary prevention)

1. Make sure employees learn to recognize symptoms of distress. For example, symptoms 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 available is to provide 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 deal with a variety of problems that range from learning to cope to dealing with substance abuse.
3. Assist employees to keep a positive perspective on life and feel a sense of purpose. It is important for employees to feel they are making a valuable contribution to the organization.

SUMMARY

Stress has become a widely used but misunderstood term. As a result, 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 recent studies of "healthy organizations" suggest that policies benefiting workers' health also benefit the organization's bottom line. Today, the healthy organization means not only financial soundness but also the physical and mental well-being of those who make up the organization—its employees. Healthy employees create stronger businesses and healthier profits (Berry, Mirabito, & Berwick, 2004).

DISCUSSION QUESTIONS

1. Define what stress means and 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 and 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 within 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 12–3 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 she is concerned about the practice's capacity to staff the medical clinics for the upcoming flu season. In conducting exit interviews, she learned that the employees who are leaving generally like their work and they feel their salaries are fair; however, they are unhappy with the way their managers are treating them, and it is 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 the employees experience less stress on the job?
2. What strategies can the organization use so 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 12–4 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.

REFERENCES

American Institute of Stress. (2004). Job stress. Available at: www.stress.org

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: W. H. Freeman & Company.

Baptist Health South Florida (2015). Awards and recognition. Available at: baptisthealth.net.

Barefort, J. C., Dahlstrom, W. G., & Williams, R. B. (1983). Hostility, CHD incidence, and total mortality: A 25-year follow-up study of 255 physicians. *Psychosomatic Medicine, 45*, 59–63.

Berry, L. L., Mirabito, A. M., & Berwick, D. M. (2004). A health care agenda for business. *MIT Sloan Management Review, 45*(4), 56–64.

Corporate Alliance to End Partner Violence. (2014). Workplace statistics. Available at: www.caepv.org/getinfo/facts_stats.php?factsec=3

Cox, T. H., Lobel, S. A., & McLeod, P. L. (1991). Effects of ethnic group cultural differences on cooperative and competitive behavior on a group task. *Academy of Management Journal, 34*(4), 827–847.

Crampton, S. M., Hodge, J. W., Mishra, J. M., & Price, S. (1995). Stress and stress management. *Advanced Management Journal, 60*(3), 10–18.

Evans, G. W., & Carrere, S. (1991). Traffic congestion, perceived control, and psychophysiological stress among urban bus drivers. *Journal of Applied Psychology, 76*, 658–663.

Fox, M. L., Dwyer, D. J., & Ganster, D. C. (1993). Effects of stressful job demands and control on physiological and attitudinal outcomes in a hospital setting. *Academy of Management, 36*(2), 289–318.

Friedman, I. A. (1999). Turning over schools into a healthier workplace; bridging between professional self-efficacy and professional demands. In R. Vandenberghe & A. M. Hubermann (Eds.). *Understanding and preventing teacher burnout* (pp. 166–175). Cambridge, UK: Cambridge University Press.

Friedman, M. D., & Rosenman, R. H. (1974). *Type A behavior and your heart*. New York, NY: A. A. Knopf.

Ganster, D. C., & Fusilier, M. R. (1989). Control in the workplace. In C. L. Cooper & T. Roberston (Eds.). *International review of industrial and organizational psychology*. Chichester, UK: John Wiley & Sons.

Golembiewski, R. T. (1986). The epidemiology of progressive burnout: A primer. *Journal of Health and Human Resources Administration, 8*(1), 16–37.

Golembiewski, R. T. (1990). Differences in burnout, by sector: Public vs. business estimates using phases. *International Journal of Public Administration, 13*(4), 545–559.

Golembiewski, R. T., & Boss, R. W. (1991). Shelving levels of burnout for individuals in organizations: A note on the stability of phases. *Journal of Health and Human Resources Administration, 13*(4), 409–420.

Golembiewski, R. T., & Boudreau, R. (1991). Healthcare professional attend thyself: The epidemiology of burnout in several settings. *International Journal of Public Administration, 14*(1), 43–57.

Hardiness Institute, Inc. (n.d.). Available at: www.hardinessinstitute.com

HCA prepares future executives. (2004, July/August). *Healthcare Executive, 19*, 4.

Hemp, P. (2004). Presenteeism: At work—but out of it. *Harvard Business Review, 82*(10), 49–58.

Homsted, L. (2003). Professional practice advocacy. *Florida Nurse, 19*, 4–5.

Integra Realty Resources. (2001). Second annual "desk rage" survey of American workers. —Available at: www.irr.com. Last accessed February 1, 2004.

Jacobs, G. D. (2001). The physiology of mind-body interactions: The stress response and the relation response. *The Journal of Alternative and Complementary Medicine, 7*(Suppl. 1), S83–S92.

James, K., Lovato, C., & Khoo, G. (1994). Social identity correlates of minority workers' health. *Academy of Management Journal, 37*(2), 383–396.

Jones, J. W., Barge, B. N., Steffy, B. D., Fay, L. M., Kuntz, L. K., & Wuebker, L. J. (1988). Stress and medical malpractice: Organizational risk assessment and intervention. *Journal of Applied Psychology, 73*(4), 727–735.

Kalliath, T. J., O'Driscoll, M. P., Gillespie, D. F., & Bluedorn, A. C. (2000). A test of the Maslach Burnout Inventory in three samples of healthcare professionals. *Work and Stress, 14*(1), 35–50.

Karasek, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly, 24*, 285–310.

Karasek, R. A., Baker, D., Marxer, F., Ahlbom, A., & Theorell, T. (1981). Job decision latitude, job demands, and cardiovascular disease: A prospective study of Swedish men. *American Journal of Public Health, 71*(7), 694–705.

Kasschau, P. L. (1977). Age and race discrimination reported by middle-aged and older persons. *Social Forces, 55*, 728–742.

Keita, G. P., & Hurrell, J. J., Jr. (1994). *Job stress in a changing workforce:*

Investigating gender, diversity, and family issues. Washington, DC: American Psychological Association.
Kim, J. S., Yoon, S. S., Lee, S. I., Yoo, H. J., Kim, C. Y., Choi-Kwon, S., et al. (1998). Type A behavior and stroke: High tenseness dimension may be a risk factor for cerebral infarction. *European Neurology, 39*(3), 168–173.
Kinicki, A., & Williams, B. K. (2003). *Management: A practical introduction*. New York, NY: McGraw Hill Book Company.
Kushnir, T., & Kasan, R. (1991). Work-load, perceived control, and psychological distress in Type A/B industrial workers. *Journal of Organizational Behavior, 12*, 155–168.
Lazarus, S. R. (1991). Progress on a cognitive-motivational-relational theory of emotion. *American Psychologist, 46*, 819–834.
Lazarus, S. R., DeLongis, A., Folkman, S., & Gruen, R. (1985). Stress and adaptational outcomes: The problem of confounded measures. *American Psychologist, 40*, 770–779.
Lazarus, S. R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer.
Maddi, S. R. (1998). Dispositional hardiness in health and effectiveness. In H. S. Friedman (Ed.). *Encyclopedia of mental health*. San Diego, CA: Academic Press.
Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied Preventive Psychology, 7*, 63–74.
Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior, 2*, 99–113.
May, E. L. (2004). Are people your priority? How to engage your workforce. *Healthcare Executive, 19*(4), 8–16.
MFL Occupational Health Centre, Inc. (2000, March). Stress at work. Available at: www.mflohc.mb.ca/. Last accessed January 25, 2004.
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*). West Sussex, UK: John Wiley & Sons.
National Institute for Occupational Safety and Health. (1999). *Stress at work. DHHS (NIOSH)* Publication No. 99-101. Cincinnati, OH: Author. Available at: www.cdc.gov/niosh/stresswk.html. Last accessed January 23, 2004.
Peterson, M. (2004). Creating healthy corporate cultures for both genders: A national employee survey. *Occupational Hazards, 66*(7), 19.
Quick, J. C., Quick, J. D., Nelson, D. L., & Hurrell, J. J. (1997). *Preventive*

stress management in organizations. Washington, DC: American Psychological Association.
Richard, O. C., & Grimes, D. (1996, December). Bicultural interrole conflict: An organizational perspective. *Mid-Atlantic Journal of Business, 32*(3), 155–170.
Roberts, R. K., Swanson, N. G., & Murphy, L. R. (2004). Discrimination and occupational mental health. *Journal of Mental Health, 13*(2), 129–142.
Roper Starch Worldwide (2000). Global 2000 consumer study. Available at: www.roper.com. Last accessed February 3, 2004.
Rosenman, R. H., Friedman, M., Wurm, M., Jenkins, C. D., Messinger, H. B., & Strauss, R. (1966). Coronary heart disease in the Western Collaborative Group Study. *Journal of the American Medical Association, 195*, 86–92.
Rosenstein, A. H. (2002). Nurse–physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing, 102*(6), 26–34.
Rosenstein, A. H., & O'Daniel, M. (2005). Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians. *American Journal of Nursing, 105*(1), 54–64.
Rosenstein, A. H., & O'Daniel, M. (2006). Impact and implications of disruptive behavior in the perioperative arena. *Journal of the American College of Surgeons, 203*(1), 96–105.
Rosenstein, A. H., & O'Daniel, M. (2008). Managing disruptive physician behavior: Impact on staff relationships and patient care. *Neurology, 70*(17), 1564–1570.
Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs, 80*, 1–28.
Savery, L. K., & Hall, K. (1986). Tight rein, more stress. *Harvard Business Review, 65*, 160–164.
Schwarzer, R. (2004). Manage stress at work through preventive and proactive coping. In E. A. Locke (Ed.). *Handbook of principles of organizational behavior*. London, UK: Blackwell Publishing.
Securitas USA. (2013). Top security threats and management issues facing corporate America. Available at: www.securitas.com/Global/United%20States/2012%20Top%20Security%20
Seligman, M. E. P. (1991). *Learned optimism*. New York, NY: A. A. Knopf. Reissue edition; 1998, New York, NY: Free Press.
Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology. *American Psychologist, 55*(1), 5–14.

Selye, H. (1956). *The stress of life*. New York, NY: McGraw Hill Book Company.

Selye, H. (1974). *Stress without distress*. London: Hodder and Stoughton.

Simmons, B. L., & Nelson, D.L. (2001). Eustress at work: The relationship between hope and health in hospital nurses. *Health Care Management Review, 26*(4), 7–18.

Smith, N. (2012). Employes reveal how stress affects their jobs. *Business News Daily*. Available at: www.businessnewsdaily.com/2267-workplace-stress-health-epidemic-perventable-employee-assistance-programs.html

Spector, P. E. (1986). Perceived control by employees: A meta-analysis of studies concerning autonomy and participation at work. *Human Relations, 39*, 1005–1016.

Stewart, W. F., Ricci, J. A., Chee, E., Morganstein, D., & Lipton, R. (2003). Lost productive time and cost due to common pain conditions in the U.S. workforce. *Journal of the American Medical Association, 290*(18), 2443–2454.

Swanson, N. G. (2000). Working women and stress. *Journal of the American Medical Women's Association, 55*, 76–79.

The Telegraph. (2013, August 19). Average worker "suffers desk rage twice a day." Available at: www.telegraph.co.uk/health/healthnews/10251946/Average-worker-suffers-desk-rage-twice-a-day.html

Von Onciul, J. (1996, September 21). Stress at work. *British Medical Journal, 313*, 745–748.

Weber, D. O. (2004, September/October). Poll results: Doctors' disruptive behavior disturbs physician leaders. *Physician Executive, 30*, 6–14.

Whetton, D. A., & Cameron, K. S. (1993). *Developing managerial skills: Managing stress*. New York, NY: HarperCollins.

Williams, C. (2003). Sources of workplace stress. Perspectives on Labour and Income. *4*(6), Statistics Canada Catalogue no. 75–001-XIE.

Wyatt, R. M. (2013). Revisiting disruptive and inappropriate behavior: Five years after standards introduced. The Joint Commision, JC Physician Blog. Available at: www.jointcommission.org/jc_physician_blog/revisiting_disruptive_and_ina

Yerkes, R. M., & Dodson, J. D. (1908). The relation of strength of stimulus to rapidity of habit-formation. *Journal of Comparative Neurology and Psychology, 18*, 459–482.

Young, P. (1974). Stay calm and stay alive. *Management Review, 63*(4), 37–

39.

OTHER SUGGESTED READING

Golembiewski, R. T., Hilles, R., & Daly, R. (1987). Some effects of multiple OD interventions on burnout and work site features. *Journal of Applied Behavioral Science, 23*(3), 295–313.

Hackman, J. R., & Oldham, G. R. (1980). *Work design*. Reading, MA: Addison-Wesley.

Jick, T. D., & Mitz, L. F. (1985). Sex differences in work stress. *Academy of Management Review, 10*(3), 408–420.

Keenan, A., & McBain, G. D. (1979). Effects of Type A behaviour, intolerance of ambiguity, and locus of control on the relationship between role stress and work-related outcomes. *Journal of Occupational Psychology, 52*, 277–285.

Keita, G. P., & Jones, J. M. (1990). Reducing adverse reaction to stress in the workplace. *American Psychologist, 45*(10), 1142–1145.

Kowalski, R., Harmon, J., Yorks, L., & Kowalski, D. (2003). Reducing workplace stress and aggression: An action research project at the U.S. Department of Veterans Affairs. *Human Resource Planning, 26*(2), 39–53.

Kushnir, T., & Melamed, S. (1991, March). Work-load, perceived control and psychological distress in Type A/B industrial workers. *Journal of Organizational Behavior, 12*(2), 155–168.

National Institute for Occupational Safety and Health. (2002, April). The changing organization of work and the safety and health of working people. Available at: www.cdc.gov/niosh. Last accessed February 15, 2004.

Noblet, A. (2003). Building health promoting work settings: Identifying the relationship between work characteristics and occupational stress in Australia. *Health Promotion International, 18*(4), 351–359.

Rahe, R. H., Meyer, M., Smith, M., & Kjaer, G. (1964). Social stress and illness onset. *Journal of Psychosomatic Research, 8*, 35–44.

Savery, L. K., & Hall, K. (1986). Managers and decision making—"People" and "things". *Journal of Managerial Psychology, 1*(2), 19–24.

Sparks, K., Faragher, B., & Cooper, C. L. (2001, November). Well-being and occupational health in the 21st century workplace. *Journal of Occupational and Organizational Psychology, 74*(Pt. 4), 489–509.

*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).

Decison Making

LEARNING OUTCOMES

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

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

OVERVIEW

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

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

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

Rational Approach

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

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

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

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

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

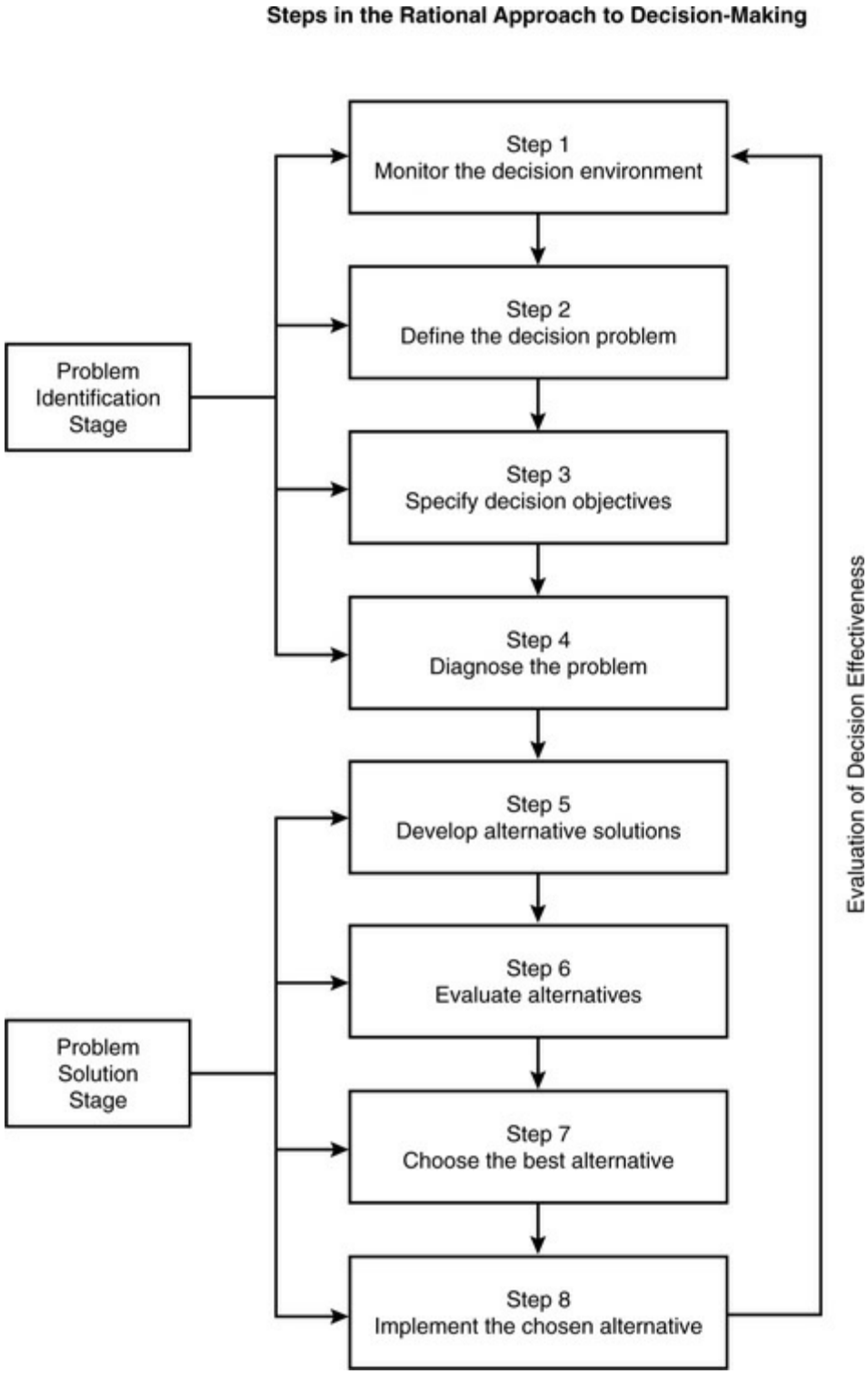

Figure 13–1 Steps in the Rational Approach to Decision Making

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

Bounded Rationality Model

The bounded rationality model of decision making, proposed by Simon

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

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

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

Intuition

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

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

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

Heuristics or Biases Approach

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

Discussion

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

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

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

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

Case Study 13–3 Cognitive Errors in Clinical Decision Making

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

Consider the following clinical examples illustrating commonly used heuristics:

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

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

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

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

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Escalation of Commitment and Framing Heuristic

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

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

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

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

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

Decision-Style Model

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

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

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

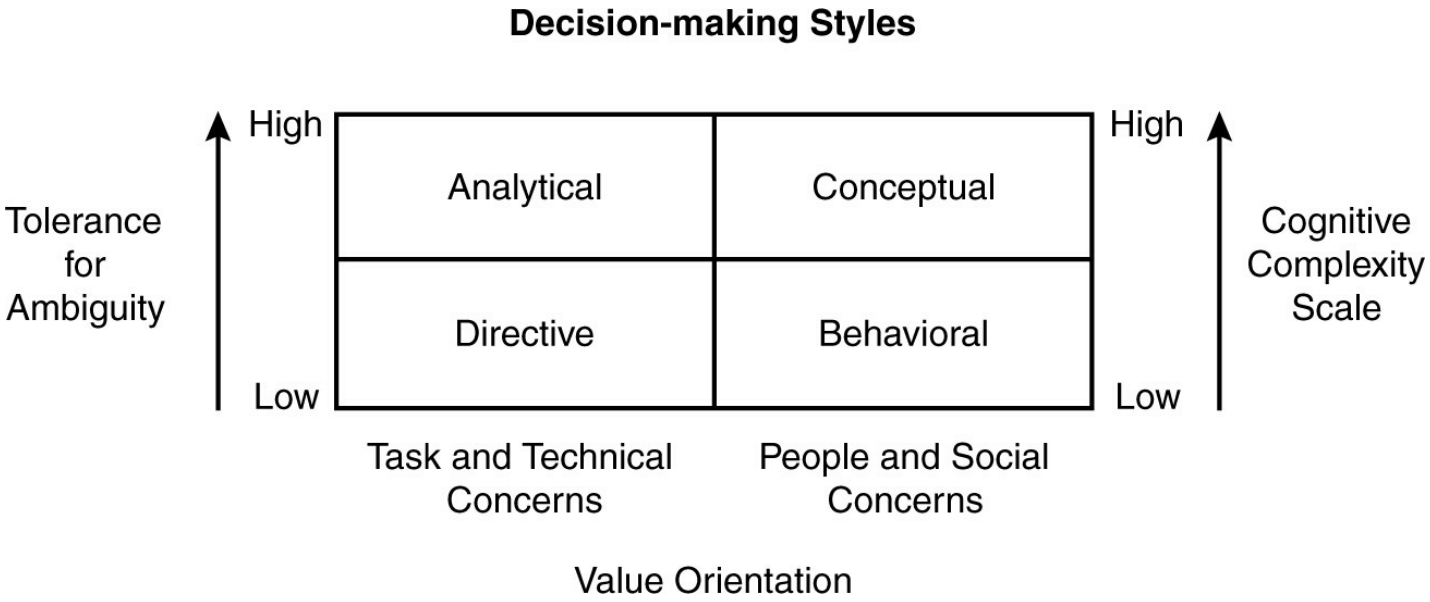

Figure 13–2 Decision-Making Styles

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

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

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

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

VROOM-YETTON DECISION-MAKING MODEL

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

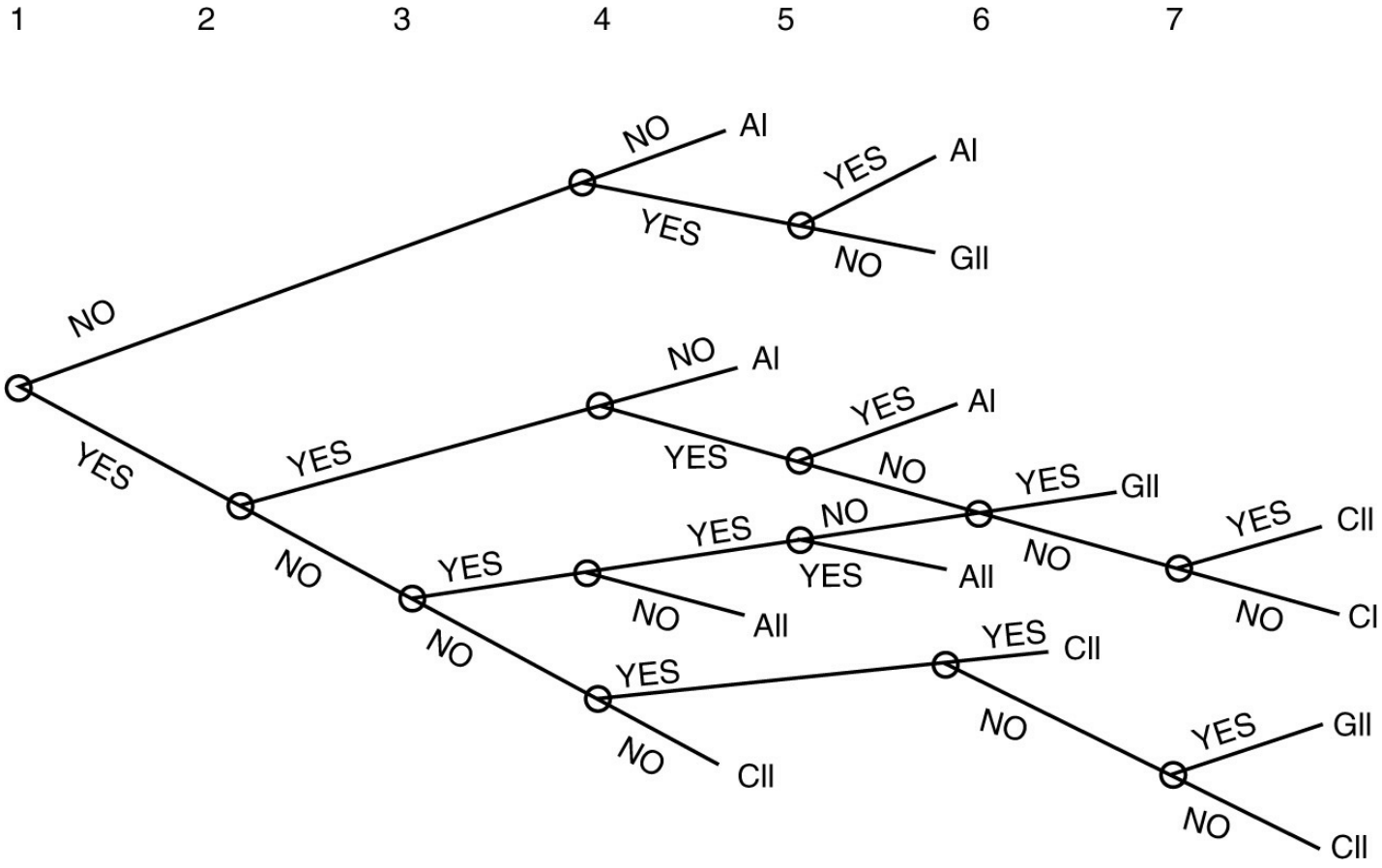

Figure 13–3 Vroom-Yetton Decision-Making Method

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

The five decision processes are:

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

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

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

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

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

Situational factors that may influence the model are:

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

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

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

SUMMARY

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

DISCUSSION QUESTIONS

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

EXERCISE 13–1

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

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

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

decisions.

EXERCISE 13–2

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

Describe each step in your decision-making process.

REFERENCES

Agor, W. H. (1985). Intuition as a brain skill in management. *Public Personnel Management Journal, 14*(1), 15–24.

Agor, W. H. (1986a). How top executives use their intuition to make important decisions. *Business Horizons, 29*(1), 49–53.

Agor, W. H. (1986b). The logic of intuition: How top executives make important decisions. *Organizational Dynamics, 14*(3), 5–18.

Behling, O., & Eckel, N. (1991). Making sense out of intuition. *Academy of Management Executive, 5*(1), 46–54.

Bennett, R. H. (1998). The importance of tacit knowledge in strategic deliberations and decisions. *Management Decision, 36*(9), 589–600.

Bottles, K. (2001). The good leader—Management skills. *Physician Executive, 27*(2), 74–76.

Boulgarides, J. D., & Cohen, W. A. (2001). Leadership style vs. leadership tactics. *Journal of Applied Management and Entrepreneurship, 6*(1), 59–73.

Cross, J. (1969). *The economics of bargaining*. New York, NY: Basic Books.

Daft, R. L. (2004). *Organization theory and design* (8th ed.). Mason, OH: South-Western.

Dequech, D. (2001). Bounded rationality, institutions, and uncertainty. *Journal of Economic Issues, 35*(4), 911–929.

Eisenhardt, K., & Bourgeois, L. (1988). Politics of strategic decision making in high velocity environments: Towards a mid-range theory. *Academy of Management Journal, 31*, 737–770.

Forest, J., & Mehier, C. (2001). John R. Commons and Herbert A. Simon on the concept of rationality. *Journal of Economics, 3*(35), 591–605.

Hall, K. H. (2002). Reviewing intuitive decision-making and uncertainty: The implications for medical education. *Medical Education, 36*, 216–224.

Hayashi, A. M. (2001). When to trust your gut. *Harvard Business Review, 79*(2), 59–65.

Kahneman, D., Slovic, P., & Tversky, A. (Eds.). (1982). *Judgment under uncertainty: Heuristics and biases*. Cambridge, UK: Cambridge University Press.

Levin, I. P., Schnittjer, S. K., & Thee, S. L. (1988). Information framing effects in social and personal decisions. *Journal of Experimental Social Psychology, 24*, 520–529.

Maidique, M. A. (2011). Decoding intuition for more effective decision-making. Harvard Business Review Blog Network. Available at: http://blogs.hbr.org/2011/08/decoding-intuition-for-more-ef/

Morrow, K. A., & Deidan, C. T. (1992). Bias in the counseling process: How to recognize and avoid it. *Journal of Counseling & Development, 70*(5), 571–577.

Myers, I. (1980). *Introduction to type*. Palo Alto, CA: Consulting Psychologists, Inc.

Peters, T. J., & Waterman, Jr., R. H. (1984). *In search of excellence: Lessons from America's best-run companies*. New York, NY: Warner Books.

Rowe, A. J., & Boulgarides, J. D. (1983). Decision styles: A perspective. *Leadership & Organization Development Journal, 4*(4), 3–9.

Rowe, A. J., & Boulgarides, J. D. (1998). *Managerial decision making*. New York, NY: Macmillan Publishing Company.

Simon, H. A. (1957). *Administrative behavior* (2nd ed.). New York, NY: Macmillan Publishing Co.

Simon, H. A. (1987). Making management decisions: The role of intuition and emotion. *Academy of Management Executive, 1*, 57–64.

Sox, H. C., Marshal, A. B., Higgins, M. C., & Marton, K. I. (1988). *Medical decision-making*. New York, NY: Butterworths.

Staw, B. M., (1981). The escalation of commitment to a course of action. *Academy of Management Review, 6*(4), 577–587.

Staw, B. M., & Ross, P. (1987). Knowing when to pull the plug. *Harvard Business Review, 65*(2), 68–74.

Thompson, C. (2003). Clinical experience as evidence in evidence-based practice. *Journal of Advanced Nursing, 43*(3), 230–237.

Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science, 185*, 1124–1131.

Vroom, V. H., & Jago, A. G. (1988). *The new leadership: Managing participation in organisations*. Englewood Cliffs, NJ: Prentice Hall.

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

Wally, S., & Baum, R. (1994). Personal and structural determinants of the pace of strategic decision making. *Academy of Management Journal, 37*, 932–956.

OTHER SUGGESTED READING

Agor, W. H. (1984). *Intuitive management: Integrating left and right brain management skills*. Upper Saddle River, NJ: Prentice Hall.

Ashford, B. E. (2001). *Role transitions in organizational life: An identity-based perspective*. Mahwah, NJ: Lawrence Erlbaum Associates.

Bates, B. (1975). Physician and nurse practitioners: Conflict and reward. *Annals of Internal Medicine, 82*, 702–706.

Brett, J. F., Northcraft, G. B., & Pinkley, R. L. (1999). Stairways to heaven: An interlocking self-regulation model of negotiation. *Academy of Management Review, 24*(3), 435–451.

Davis, M. H., Capobianco, S., & Kraus, L. (2004). Measuring conflict-related behaviors: Reliability and validity evidence regarding the conflict dynamics profile. *Educational and Psychological Measurement, 64*(4), 707–731.

Elangovan, A. R. (2002). Managerial intervention in disputes: The role of cognitive biases and heuristics. *Leadership & Organization Development Journal, 23*(7), 390–399.

Friedman, R. A., Tidd, S. T., Currall, S. C., & Tsai, J. C. (2002). What goes around comes around: The impact of personal conflict style on work conflict and stress. *International Journal of Conflict Management, 11*(1), 32–55.

Gigerenzer, G. (2007). *Gut feelings: The intelligence of the unconscious*. New York: Penguin Group.

Kahneman, D. (1991). Judgment and decision making: A personal view. *Psychological Science, 2*(3), 142–154.

Kilmann, R. H., & Thomas, K. W. (1977). Developing a forced-choice measure of conflict-handling behavior: The mode instrument. *Education*

and Psychological Development, 37, 309–325.

Kolb, D. M., & Putman, L. L. (1992, May). The multiple faces of conflict in organizations. *Journal of Organizational Behavior, 13*, 311–324.

McWilliams, C. (2003). Healthcare decision making for dementia patients: Two problem cases. *Internet Journal of Law, Healthcare and Ethics, 2*(1), 12–19.

O'Connor, K. M., DeDreu, C. K., Schroth, H., Barry, B. Lituchy, T. R., & Bazerman, M. H. (2002). What we want to do versus what we think we should do: An empirical investigation of intrapersonal conflict. *Journal of Behavioral Decision Making, 15*, 403–418.

Shelton, C. D., & Darling, J. R. (2004). From chaos to order: Exploring new frontiers in conflict management. *Organization Development Journal, 22*(3), 22–41.

Thomas, K. W. (1992). Conflict and conflict management: Reflections and update. *Journal of Organizational Behavior, 13*, 265–274.

Conflict Management and Negotiation Skills

LEARNING OUTCOMES

After completing this chapter, the student should 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 inevitable and unavoidable because it is a natural part of human relationships. It is a part of our everyday professional and personal lives, and therefore, it is inherent in any type of work setting (Thomas, 1976). Although there are numerous definitions of conflict, Thomas (1992) suggests that there are three common components to most definitions: (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; however, the health care setting has been referred to as one of the highest conflictual environments because of factors such as high stress, high 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). For example, research has shown that managers, both health care and non–health care, spend an

average of 30 percent of their time dealing with conflict, and this is frequently 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. If they are 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 percent of performance problems result from strained relationships and that conflict accounts for up to 50 percent 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, which can result in increased mortality and morbidity rates due to medical errors.

Lewicki, Weiss, and Lewin (1992) identify six major areas in conflict research: the microlevel (psychological) approach, the macrolevel (sociological) approach, the economic-analysis approach, the labor-relations approach, the bargaining and negotiation approach, and the third-party dispute approach. The microlevel approach includes research on factors that affect intrapersonal and interpersonal conflict (i.e., within and among individuals), whereas the macrolevel approach focuses on factors affecting 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 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 14–1**, the different types of conflict are not mutually exclusive.

Case Study 14–1 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.

SOURCE: "Musical Operating Rooms: Mini-Cases of Health Care Disputes," by R. Friedman, 2002. *International Journal of Conflict Management, 13*(4), pp. 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 is important to the individual, whether positive or negative (Locke et al., 1994). Brehm and Cohen (1962) identified three types of intrapersonal conflict, which may develop involving alternative courses of action:

- *Approach/Approach*: The approach/approach type occurs when an individual must choose among 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 both positions are comparable.

- *Avoidance/Avoidance*: The avoidance/avoidance type occurs when an individual must choose among two or more alternatives, each of which is expected to be or 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: to retain her position by relocating to the organization's headquarters, which is 1,000 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 Judy realizes she will gain valuable experience working in the organization's corporate headquarters with opportunities for advancement, she is saddened by the fact that she must 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 thoughts and behavior. Individuals seek consistency among their beliefs and/or opinions (i.e., cognitions), and when an inconsistency arises between an individual's attitude or 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, it is more likely that the individual's attitude will change to accommodate his or her behavior, thereby reducing or eliminating the intrapersonal conflict (Brehm & Cohen, 1962).

In the workplace, dissonance occurs most often within 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 who believes that making untested claims about a new drug is unethical, but whose work role requires him or her to do so. Intrarole conflict occurs when an individual experiences different expectations from his or her role. For example, a hospital's purchasing manager reporting

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 family needs or demands 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 regarding expectations about an individual's work performance. Often, the misunderstanding is the

result of perceptual differences regarding an issue or process. Unclear performance expectations may 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. Similar to 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 void of the intense interpersonal negative emotions that are more 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 different people should be assigned. 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 14–2**). 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 controls infringe 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 for its own goals, disregarding the goals of other departments and teams, especially if those goals are incompatible (see **Case Study 14–3**; also Pondy, 1967).
- 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 imposing on their areas of legitimate authority. Staff personnel may specify the methods and partially control the resources used by line managers. Line managers often believe that staff managers reduce their authority over employees, although their responsibility for the outcomes remains unchanged (March & Simon, 1993).
- Diversity-based conflict relates to issues of race, gender, ethnicity, and religion. These conflicts may encompass all five levels of conflict—intrapersonal, interpersonal, intragroup, intergroup, and interorganizational.

Case Study 14–2 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 the Turf Battle case study.

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Case Study 14–3 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 percent 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 1,000 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 the Managed Care Factor case study.

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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 (IDS). As integration levels increase due to health reform, senior managers increasingly become involved in interorganizational conflict. Integration that involves extensive linking of providers at different points in the patient care continuum—and even more so 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; knowledge and skills useful in managing them effectively are imperative. Interpersonal/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

Winder (2003, p. 20) points out that:

> 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 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 within 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 14–1**).

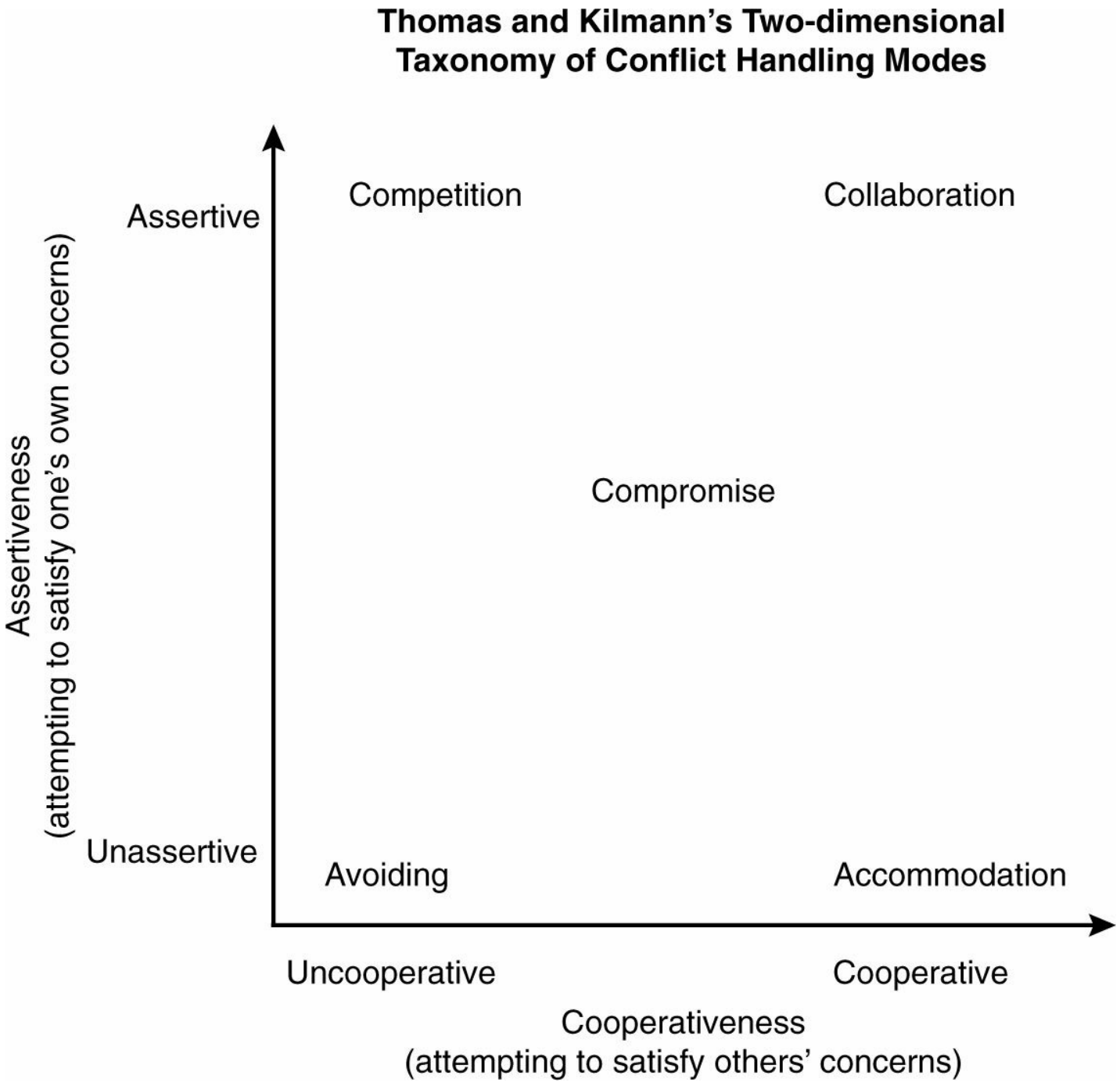


Figure 14–1 Thomas and Kilmann's Two-Dimensional Taxonomy of Conflict-Handling Modes

Competition involves assertive and uncooperative behaviors and reflects a win–lose approach to conflict. A dominating or competing person goes all out to win his or her 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 his or her own way by appealing to his or her supervisor in an attempt to use the supervisor to force the decision on his or her peer (Blake & Mouton, 1984b).

However, in some situations competition-style management is appropriate. For example, when the issues involved in a conflict are trivial or when emergencies require quick action, this style may be appropriate. 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 the strategies and policies formulated by higher-level management (Dewine, Nicotera, & Perry, 1991; Rahim, Garrett, & Buntzmann, 1992).

Collaboration involves highly assertive and cooperative behaviors and reflects a win–win approach to conflict. A collaborating-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 means to a more creative solution, which would be fully acceptable to everyone involved (Winder, 2003). This 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 so forth. However, as Winder (2003) points out, this style requires sufficient interdependence and parity in power among individuals so that they feel free to interact candidly, regardless of their formal superior/subordinate status. 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," with managers displaying both assertive and cooperative behaviors. It involves give-and-take, whereby both parties give up something to reach a mutually acceptable agreement. According to Rahim, Garrett, and Buntzmann (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 both parties, who are equally powerful (e.g., labor and management), have reached a deadlock in their negotiation.

According to Winder (2003), heavy reliance on this style may be dysfunctional because the compromising style may create several problems if used too early in trying to resolve conflict. First, the people involved may be encouraged to compromise on the stated issues rather than on the real issues. The first issues 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 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 person 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 person'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 the differences and emphasizing commonalities to satisfy the concern of the other party. An obliging person neglects his or her own concern to satisfy the concern of the other party; as such, accommodating-style managers may be perceived as weak and submissive because these individuals try to reduce tensions and stress by reassurance and support (Rahim, Garrett, & Buntzmann, 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 he or she may be wrong or the other party is right and the issue is much more important to him or her. 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, Garrett, & Buntzmann, 1992).

Avoiding involves unassertive and uncooperative behaviors and is the opposite of collaborating. It is associated with withdrawal, buck-passing, or sidestepping situations (Rahim, Garrett, & Buntzmann, 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 conflict-handling mode usually results in frustration by 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 most appropriately applied in different contexts (Winder, 2003).

Distributive Model

The distributive model originated within the field of labor negotiations (Lewicki, Weiss, & Lewin, 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 who reach agreement through a series of concessions with the goal of obtaining the greater "piece of the pie." Tactics 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 game 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 a one-sided agreement, where resolved issues favor one side more than the other.

Winder (2003) outlines the four win–lose strategies practiced by negotiators 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. One party hopes to wear down the resolve of the other by pressuring the other to make significant concessions and forcing the other party 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 negotiators will relate to the other party that an offer is only good 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 negotiator by alternating sympathetic with 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, similar to the distributive model, evolved primarily within the field of labor negotiations (Follett, 1940, 1942; Lewicki, Weiss, & Lewin, 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 versus 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, Weiss, & Lewin, 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, Weiss, & Lewin, 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, Ury, and Patton (1991) define integrative negotiation as "principled negotiation." The researchers suggest that negotiations should be grounded in substantive concerns when the participants:

- Separate the people from the problem. In other words, separate the issues 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, prior to and during meetings, will assist in developing creative alternatives.
- Insist on using only objective criteria to judge solutions. When negotiations are based on objective versus 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 14–4**: Creating a Win–Win Situation.)

Case Study 14–4 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, he or she 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.

SOURCE: "The Role of the Physician Executive in Negotiation," by D. P. Tarantino, 2004. *Physician Executive, 30*(5), pp. 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, Weiss, & Lewin, 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 14–4), 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 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 versus a fight to be won. Interactive negotiation is less focused on directly helping parties reach binding agreements (excluding arbitration) and is 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).

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 his or her perceived effectiveness as a leader and suitability for promotion. The sample for the study consisted of 172 employees (90 male, 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 good at creating solutions, expressing emotions, and reaching out were considered more effective. Destructive behaviors, on the other hand, such as winning at all costs, displaying anger, demeaning others, and retaliating were found to be the worst career advancement and leadership behaviors. Avoidance behaviors were found to be particularly problematic for would-be negotiators because individuals who are uncomfortable with negotiating, or 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.

SUMMARY

In this chapter, we have discussed the positive and negative outcomes of conflict, and that conflicts originate from a variety of sources. 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.

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 14–5 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 1,000 doctors in 30 different departments. The facility had an outstanding reputation as a teaching hospital. About 40 percent of its doctors were full-time faculty, while the remaining 60 percent 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 him or her. 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?

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?
4. As Dr. Wilkins, who is 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?

Reproduced from Musical operating rooms: Mini-cases of health care disputes, by R. Friedman, 2002. *International Journal of Conflict Management, 13*(4), pp. 421–422. © Emerald Group Publishing Limited all rights reserved.

Case Study 14–6 What Went Wrong?

Tim Hardwood, CEO of Community Health System, hung up the phone with a heavy sigh. Tim 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 related, "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! The media will have a field day with this!" Tim wondered, "What went wrong?"

Jim Brentward, one of the union negotiators, sat across the table from Mary Martin. Jim related that his members understood that the 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 health system's proposed offer for salary increases and benefits package over the next four years. He related that "unless the health system signed a contract by 5:00 p.m. Friday with acceptable salary and benefit increases, members of the union are threatening to strike." Jim 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'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 in the bottom end of the health system's pay scale. These employees included patient transporters,

housekeeping, and cafeteria workers. Mary also knew that union benefits paid during a strike represented only 50 percent of the employee's/member's weekly salary. Mary felt confident that because of financial restraints, the employees would never vote to strike; they had too much to lose. In addition, she knew that Community Health System was considering outsourcing its dietary departments to Thomson Healthcare Food Services. If the employees did strike, although Mary considered it very unlikely, that aspect of services would continue without interruption. Knowing this inside information, Mary decided she wasn't going to let Jim and the other union negotiators bully her. Mary responded by stating that the health system would not give in to the union's demands and it 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 14–7 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 14–8 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 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 six 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?

SOURCE: "Managing Low-to-Mid Intensity Conflict in the Health Care Setting," by C. A. Aschenbrener-Siders, 1999, *Physician Executive, 25*(5), pp. 44–50. Reprinted with permission.

REFERENCES

Baron, R. A., Fortin, S. P., Frei, R. L., Hauver, L. A., & Shack, M. L. (1990). Reducing organizational conflict: The role of socially induced positive affective. *International Journal of Conflict Management, 1*, 133–152.

Baron, R. A., & Richardson, D. R. (1990). *Human aggression* (2nd ed.). New York, NY: Plenum Books.

Blake, R. R., & Mouton, J. S. (1964). *The managerial grid*. Houston, TX: Gulf Publishing.

Blake, R. R., & Mouton, J. S. (1984a). *Solving costly organizational conflicts*. San Francisco, CA: Jossey-Bass.

Blake, R. R., & Mouton, J. S. (1984b). *The managerial grid III* (3rd ed.). Houston, TX: Gulf Publishing.

Brehm, J., & Cohen, A. (1962). *Explorations in cognitive dissonance*. New York, NY: John Wiley & Sons.

Brett, J. M., & Shapiro, D. L. (1998). Breaking bonds of reciprocity in negotiations. *Academy of Management Journal, 41*(4), 410–424.

Cosier, R. A., & Dalton, D. R. (1990). Positive effects of conflict: A field assessment. *International Journal of Conflict Management, 1*, 81–92.

Dana, D. (2000). Conflict resolution: *Mediation tools for everyday worklife*. New York, NY: McGraw-Hill Book Company.

Dewine, S., Nicotera, A. M., & Perry, D. (1991). Argumentativeness and aggressiveness: The flip side of gentle persuasion. *Management Communication Journal, 4*, 386–411.

Filley, A. C. (1975). *Interpersonal conflict resolution*. Chicago, IL: Scott, Foresman.

Fisher, R., & Ury, W. (1981). *Getting to yes*. New York, NY: Penguin Books.

Fisher R., Ury, W., & Patton, B. (1991). *Getting to yes: Negotiating without giving in* (2nd ed.). New York, NY: Penguin Books.

Follett, M. P. (1940). Constructive conflict. In H. C. Metcalf & L. Urwick (Eds.), *Dynamic administration: The collected papers of Mary Parker Follet* (pp. 30–49). New York, NY: Harper (original work published in 1926).

Follett, M. P. (1942). *Creative experience*. New York, NY: Longmans, Green and Co.

Forte, P. S. (1997). The high cost of conflict. *Nursing Economics, 15*, 119–123.

Friedman, R. (2002). Musical operating rooms: Mini-cases of health care disputes. *International Journal of Conflict Management, 13*(4), 419–420.

Gardner, D. L. (1992). Conflict and retention of new graduate nurses. *Western Journal of Nursing Research, 14*, 76–85.

Golnaz, S., & Rahmatian, M. (2003). Resolving conflict: Examining ethnicracial and gender differences. *Equal Opportunities International, 22*(2), 25–39.

Gross, M. A., & Guerrero, L. K. (2000). Managing conflict appropriately and effectively: An application of the competence model to Rahim's organizational conflict styles. *International Journal of Conflict Management, 11*(3), 200–226.

Jackson, S. E., & Schuler, R. S. (1985). A meta-analysis and conceptual critique of research on role ambiguity and role conflict in work settings. *Organizational Behavior and Human Decision Process, 36*, 16–78.

Jehn, K. A., & Mannix, E. A. (2001, April). The dynamic nature of conflict: A longitudinal study of intragroup conflict and group performance. *Academy of Management Journal, 44*(2), 238–251.

Johnson, M. (1994). Conflict and nursing professionalization. In J. M. McCloskey & H. K. Grace (Eds.), *Current issues in nursing* (4th ed., pp. 643–649). St. Louis, MO: Mosby.

Kabanoff, B. (1991). Equity, equality, power, and conflict. *Academy of Management Review, 16*, 416–441.

Kirkbride, R. S., Tang, S. F. Y., & Westwood, R. I. (1991). Chinese conflict preferences and negotiating behavior: Cultural and psychological influences. *Organization Studies, 12*, 365–386.

Kolb, D. M., & Bartunek, J. M. (1992). *Hidden conflict in organizations: Uncovering behind-the-scenes disputes*. Newbury Park, CA: Sage.

Kottler, J. (1996). *Beyond blame: A new way of resolving conflicts in relationship*. San Francisco, CA: Jossey-Bass Publishers.

Lee, C. (1990). Relative status of employees and styles of handling interpersonal conflict. *International Journal of Conflict Management, 1*, 327–340.

Lewicki, R., Weiss, S., & Lewin, D. (1992). Models of conflict, negotiation and third party intervention: A review and synthesis. *Journal of Organizational Behavior, 13*, 209–252.

Locke, E. A., Smith, K. G., Erez, M., Chah, D. O., & Schaffer, A. (1994). The effects of intra-individual goal conflict on performance. *Journal of Management, 20*, 67–92.

Longest, B. B., & Brooks, D. H. (1998). Managerial competence at senior levels of integrated delivery systems. *Journal of Healthcare Management, 43*(2), 115–135.

Management Development Institute, Eckerd College. (2003). Leadership effectiveness study—Conflict and your career. Available at: http://www.conflictdynamics.org/

McElhaney, R. (1996). Conflict management in nursing administration. *Nursing Management, 24*, 65–66.

March, S., & Simon, H. (1993). *Organizations* (2nd ed.). Cambridge, UK: Blackwell.

Nulty, P. (1993, February). Look at what unions want now. *Fortune*, 128–133.

Pondy, R. L. (1967). Organizational conflict. Concept and models. *Administrative Science Quarterly, 12*, 296–320.

Porter-O'Grady, T., & Epstein, D. G. (2003). When push comes to shove: Managers as mediators. *Nursing Management, 34*(10), 34–38.

Rahim, M. A. (1985). A strategy for managing conflict in complex organizations. *Human Relations, 38*, 81–89.

Rahim, M. A., Garrett, J. E., & Buntzman, G. F. (1992). Ethics of managing interpersonal conflict in organizations. *Journal of Business Ethics,*

11(5/6), 423–432.
Robbins, S. (1990). *Organization theory* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.
Rubin, J. Z., & Brown, B. R. (1975). *The social psychology of bargaining and negotiation*. New York, NY: Academic Press.
Schwarz, R. M. (1994). *The skilled facilitator: Practical wisdom for developing effective groups*. San Francisco, CA: Jossey-Bass.
Shelton, C. D., & Darling, J. R. (2004). From chaos to order: Exploring new frontiers in conflict management. *Organization Development Journal, 22*(3), 22–41.
Stamato, L. (2004, July/August). The new age of negotiation. *Ivey Business Journal Online*. Available at: www.iveybusinessjournal.com/archives
Stevens, C. M. (1963). *Strategy and collective bargaining negotiation*. New York, NY: McGraw-Hill Book Company.
Tarantino, D. P. (2004). The role of the physician executive in negotiation. *Physician Executive, 30*(5), 71–73.
Thomas, K. W. (1976). Conflict and conflict management. In M. Dunnette (Ed.), *Handbook of industrial and organizational psychology* (pp. 889–935). Chicago, IL: Rand McNally College Publishing Company.
Thomas, K. W. (1992). Conflict and negotiation processes in organizations. In M. Dunette (Ed.), *Handbook of industrial and organizational psychology* (2nd ed., Vol. 3, pp. 651–717). Palo Alto, CA: Consulting Psychologists Press.
Thomas, K. W., & Kilmann, R. H. (1974). *Thomas-Kilmann conflict mode instrument*. Tuxedo, NY: Xicom, Inc. (Currently available through Consulting Psychologist's Press.)
Thomas, K., & Schmidt, W. (1976). A survey of managerial interests with respect to conflict. *Academy of Management Journal, 19*(2), 315–318.
Thomas, K. W. (1992). Conflict and conflict management: Reflections and update. *Journal of Organizational Behavior, 13*, 265–274.
Walton, R. E., & McKersie, R. B. (1965). *A behavioral theory of labor negotiations: An analysis of a social interaction system*. New York, NY: McGraw-Hill Book Company.
Watson, C., & Hoffman, L. R. (1996). Managers as negotiators. *Leadership Quarterly, 7*(1), 63–85.
Winder, R. (2003). Organizational dynamics and development. *Futurics, 27*(1/2), 5–30.

OTHER SUGGESTED READING

Agor, W. H. (1984). *Intuitive management: Integrating left and right brain management skills*. Upper Saddle River, NJ: Prentice Hall.

Ashford, B. E. (2001). *Role transitions in organizational life: An identity-based perspective*. Mahwah, NJ: Lawrence Erlbaum Associates.

Bates, B. (1975). Physician and nurse practitioners: Conflict and reward. *Annals of Internal Medicine, 82*, 702–706.

Brett, J. F., Northcraft, G. B., & Pinkley, R. L. (1999). Stairways to heaven: An interlocking self-regulation model of negotiation. *Academy of Management Review, 24*(3), 435–451.

Davis, M. H., Capobianco, S., & Kraus, L. (2004). Measuring conflict-related behaviors: Reliability and validity evidence regarding the conflict dynamics profile. *Educational and Psychological Measurement, 64*(4), 707–731.

Elangovan, A. R. (2002). Managerial intervention in disputes: The role of cognitive biases and heuristics. *Leadership & Organization Development Journal, 23*(7), 390–399.

Friedman, R. A., Tidd, S. T., Currall, S. C., & Tsai, J. C. (2002). What goes around comes around: The impact of personal conflict style on work conflict and stress. *International Journal of Conflict Management, 11*(1), 32–55.

Gigerenzer, G. (2007). *Gut feelings: The intelligence of the unconscious*. New York, NY: Penguin Group.

Kahneman, D. (1991). Judgment and decision making: A personal view. *Psychological Science, 2*(3), 142–154.

Kilmann, R. H., & Thomas, K. W. (1977). Developing a forced-choice measure of conflict-handling behavior: The mode instrument. *Education and Psychological Development, 37*, 309–325.

Kolb, D. M., & Putman, L. L. (1992, May). The multiple faces of conflict in organizations. *Journal of Organizational Behavior, 13*, 311–324.

McWilliams, C. (2003). Healthcare decision making for dementia patients: Two problem cases. *Internet Journal of Law, Healthcare and Ethics, 2*(1), 12–19.

O'Connor, K. M., DeDreu, C. K., Schroth, H., Barry, B., Lituchy, T. R., & Bazerman, M. H. (2002). What we want to do versus what we think we should do: An empirical investigation of intrapersonal conflict. *Journal of Behavioral Decision Making, 15*, 403–418.

Shelton, C. D., & Darling, J. R. (2004). From chaos to order: Exploring new frontiers in conflict management. *Organization Development Journal, 22*(3), 22–41.

Groups and Teams

As we learned in Chapter 5, people are social beings and require satisfying a need for affiliation or achieving a sense of belonging. Groups help satisfy this need. In Chapter 15, we examine group dynamics. Group dynamics is a term, created by Kurt Lewin, 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, other groups, and their environments. In Chapter 16, we discuss the various types of groups and their related functions. Chapter 17 examines the use of teams in today's complex health service organizations. Health care delivery "takes a village." Few jobs can be performed 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.

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 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 4,000 employee teams, Motorola used 2,200 problem-solving teams, and at any given time 75 percent of Xerox's employees serve on some type of task force or on advisory teams. It is estimated that, on

average, managers spend 50 to 80 percent 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 give further impetus to the growing importance of teams in health care (Taplin, Foster, & Shortell, 2013). Therefore, managers need to understand the variables involved relating to groups: (1) formation and development, (2) structure, and (3) interrelationships with individuals, other groups, and the organizations within which they exist, so that they may effectively manage them (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 many use the terms "groups" and "teams" interchangeably, there are differences. The concept of groups is broader than the concept of teams. 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, and therefore, a stable environment does not exist for future interactions; (3) although patients may share 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) they 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

medical team 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 the other(s). 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, and any other behavior to which people assign meaning. Can we observe these interactions to better understand the dynamics within a group? Yes, we can. On a formal level, researchers may use a sociogram to record their observations of the interactions between members of a group (see **Figure 15–1**).

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 15–1, 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. Where an arrow points outward, that indicates a contribution made to the group as a whole, rather than to an individual member. Where a member addresses the group in general, rather than a particular member, arrows are shown pointing outward to reflect that.

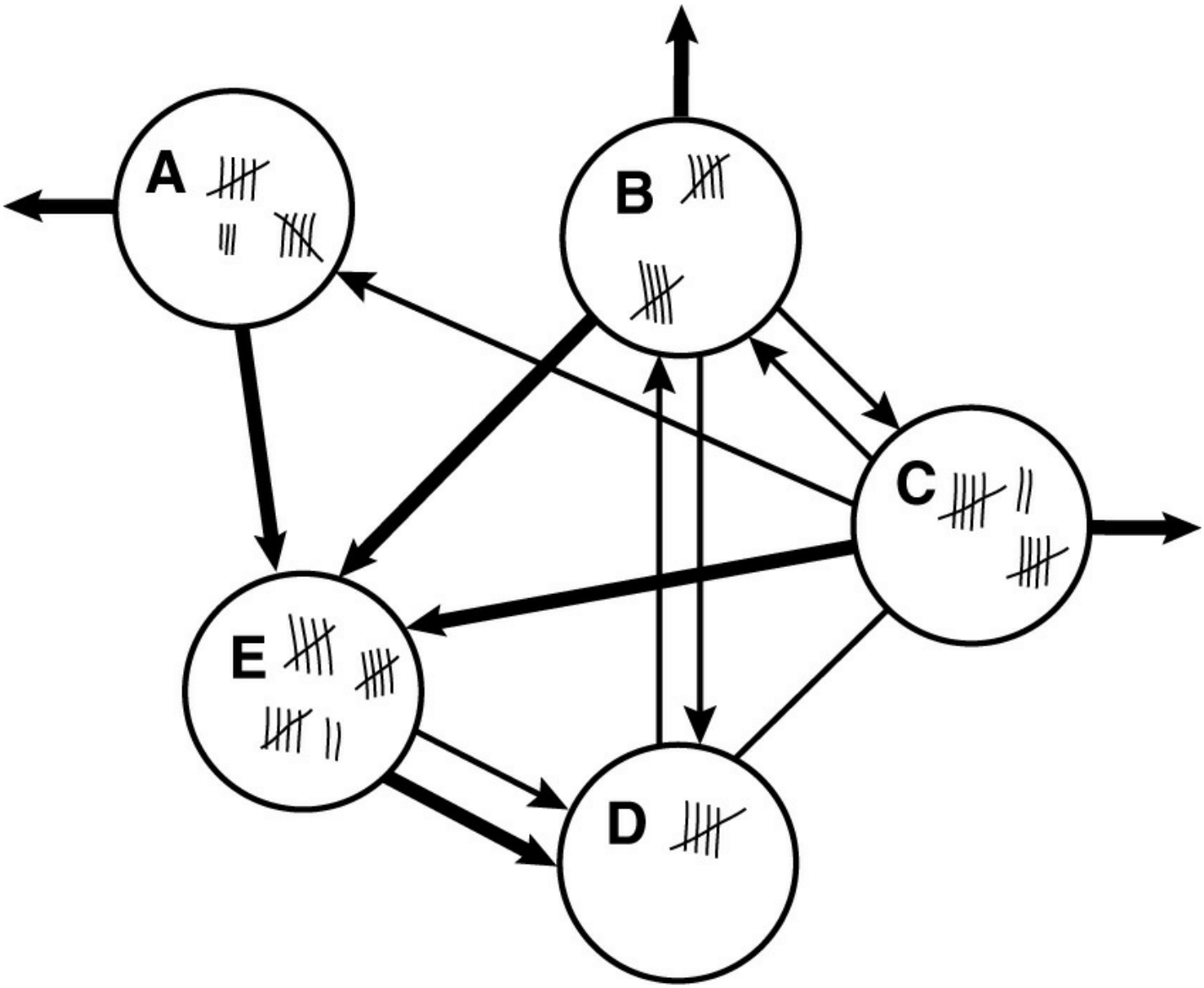
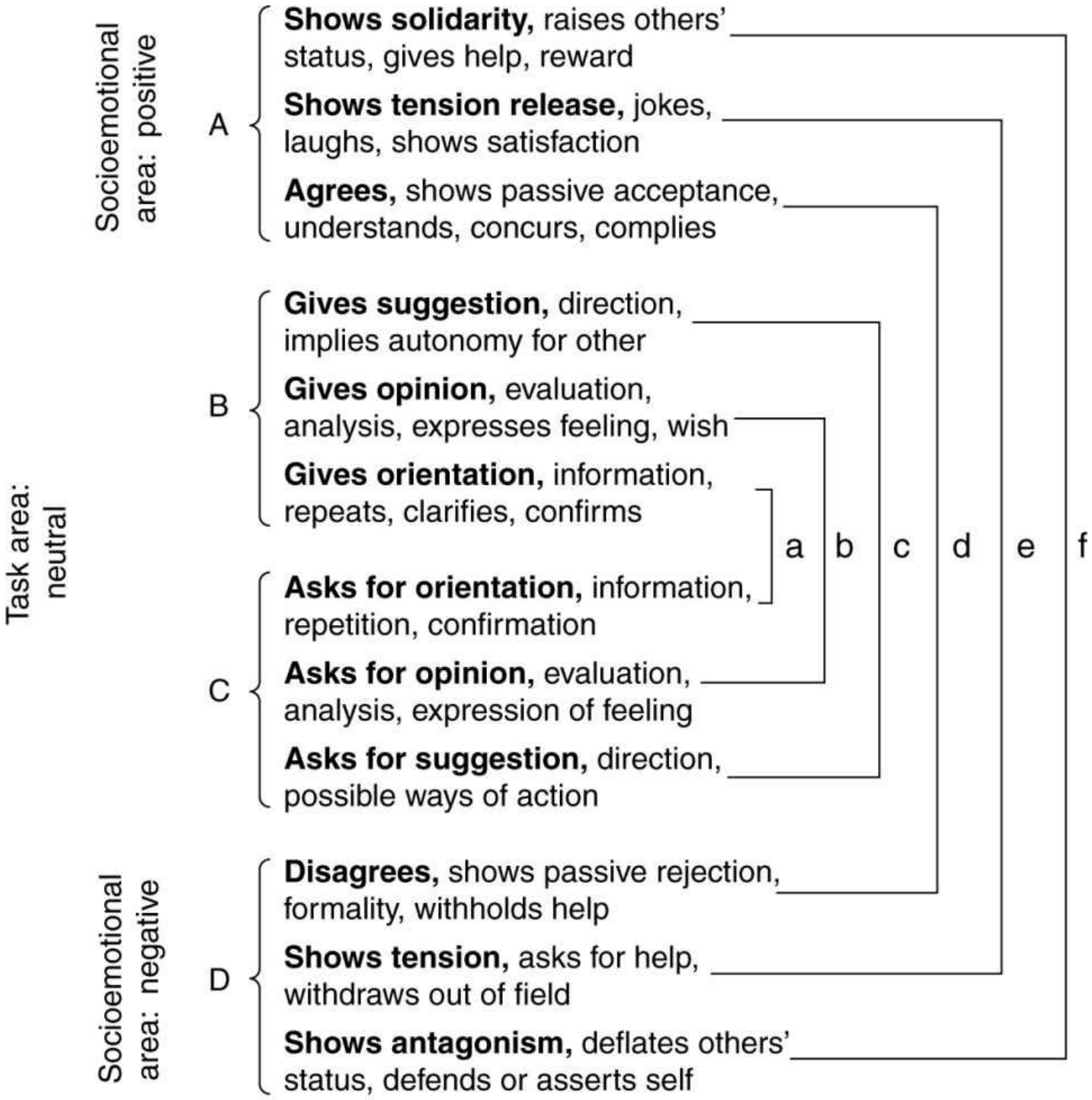


Figure 15–1 A Typical Sociogram

However, a sociogram is limited to documenting the direction and intensity of communication, not the content of what was communicated by the members in their attempt to influence one another. Therefore, researchers can use other assessment tools, such as Bales's Interaction Process Analysis, that can provide insight about the content of the members' communication (see **Figure 15–2**).

As noted by Sprott (1958), there are 12 categories of interactions with Bales' Interaction Process Analysis; these interactions are classified as relating to either emotion or task. The emotional responses are either positive (items 1 to 3) or negative (items 10 to 12). Task responses are either giving (items 4 to 6) or asking for information (items 7 to 9). The 12

categories are also grouped into pairs, as noted in **Table 15–1**. The interactions of these 12 categories greatly influence the roles assumed by members and group norms.



a Problems of Communication
b Problems of Evaluation
c Problems of Control
d Problems of Decision
e Problems of Tension Reduction
f Problems of Reintegration

A Positive Reactions
B Attempted Answers
C Questions
D Negative Reactions

Figure 15–2 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.

WHY DO PEOPLE JOIN GROUPS?

Individuals join groups for many reasons, and many of these reasons are explained with 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 one may experience 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 arises 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 achieve stated goals that the member, by himself or herself, could not have achieved alone. 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 with a group poses an approach/avoidance conflict for people. As such, 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's Equity Theory of Motivation.

Table 15–1 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	
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.

Source: *Interaction Process Analysis: A Method for the Study of Small Groups*, by R. F. Bales, 1950, Chicago: University of Chicago Press. Reprinted with permission.

ROLES OF GROUP MEMBERS

Functional Role Theory, as introduced by Benne and Sheats (1948), identified the functional roles they observed individual group members assuming in small group interactions. The three roles identified were task, maintenance, and individual (sometimes called "self-centered") roles (see **Exhibit 15–1**). Task-oriented roles focus on goal accomplishment, maintenance roles focus on relationships, and individual roles focus on individual needs, 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 were identified by Bales (1950, 1953, 1970, 1999) with 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 he or she performs to promote harmonious relations within the group (e.g., concern for people) (refer to Figure 15–2).

Exhibit 15–1 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 his or her beliefs about a group issue.
- *Elaborator*: Explains ideas within the group, 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 group accomplishing its 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 himself or herself.
- *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.

SOURCE: "Functional Roles of Group Members," by K. Benne and P. Sheats, 1948. *Journal of Social Issues, 4*, 41–49. Reprinted with permission.

Members may assume different roles depending on the needs of the individual or group. However, 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. But 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 specialist. Belbin's nine roles can be categorized as either task/task-oriented, maintenance/socioemotional positive, or individual/socioemotional negative with Benne and Sheats's Functional Role Theory and Bales's Interaction Analysis (see **Table 15–2**). All groups need task leadership as well as attention to details and a concern for people for effectiveness. Understanding the various members' roles is important to understanding the interactions that either push toward or hinder a group from meeting its goals, including member satisfaction with the interactions. The role(s) 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 ones. In addition, groups will apply "punishment" or sanctions to members if their 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 (chair of the committee sits at the head of the conference table).

If written, norms become the formal rules of conduct for group members (see **Exhibit 15–2**). Most organizations have formal rules of conduct, which are delineated in their policies and procedures manuals. For example, a hospital would have written policies as to 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.

However, in most instances group norms 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 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).

Table 15–2 Comparison of Members' Roles

Benne and Sheats (1948)	*Bales (1950)*	*Belbin (1981, 1993)*	*Description (Belbin)*
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 his or her 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	Who implements, gets things done to meet goals, and who may be somewhat inflexible
Task	Task-oriented	Resource investigator	Who is out and about, seeking new ideas and exploring opportunities, and who may become bored with routine
Individual (negative)	Socioemotional	Monitor/evaluator	Who is judgmental, looking for faults, and seeking to prevent errors, but who may not inspire others
Task	Task-oriented	Specialist	Single-minded and dedicated, who has unique knowledge but whose contributions are limited to that knowledge

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 he or she may hold, or 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 piece-rate workers. A person produces 50 widgets and is praised by his coworkers; a person produces 60 widgets and receives a sharp teasing from them; a person produces 70 widgets and is ostracized by the group. Not all behavior deviations will be enforced, only those violations that have some significant effect on the group meeting its goals (see **Table 15–3**). Norms are powerful forces not only over the behavior of group members, but also in determining the degree of cohesiveness and conformity of the group.

Exhibit 15–2 Formal Rules of Conduct

Notice of Monthly Meeting of the Biomedical Ethics Committee of Glen Haven Hospital

- Monthly meetings are held on the first Tuesday of each month.
- Meetings begin at 5:00 p.m. and end at 7:00 p.m.
- If you are unable to attend the meeting, please notify the Secretary of the committee.
- No item will be discussed unless noted on the agenda. If you wish to add an item for discussion, please notify the Chair of the committee no less than two weeks prior to the scheduled meeting. The Chair must approve all agenda items.
- Issues requiring a vote of committee members will pass by a majority (hand) vote.
- New business will be discussed during the last 15 minutes of the meeting (no exceptions!).

Table 15–3 Why Norms Are Enforced

Four Conditions Under Which Group Norms Are Most Likely to Be Enforced	*Example*
If norms facilitate group survival	Members do not discuss internal problems with members of other organizational units
If norms simplify, or make predictable, what behavior is expected of group members	Negative comments on presentations or proposals will be made on an individual basis, not during large, formal meetings
If norms help the group avoid embarrassing interpersonal problems	Members do not discuss romantic involvement so that differences in moral values do not become salient
If norms express the central values of the group and clarify what is distinctive about the group's identity	Levels of productivity should remain relatively stable because the group is more concerned with maximizing group security than about individual profits

Source: "The Development and Enforcement of Group Norms," by D. C. Feldman, 1984. The Academy of Management Review, 9, pp. 47–53. Reprinted with permission.

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 et al. (1992) suggest that five members appears to be the optimum group size. 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

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, 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 his or her behavior, social loafing may be eliminated (Kerr, 1983; Kerr & Bruun, 1981; Shepperd, 1993; Szymanski & Harkins, 1987). Beyerlein et al. (2003) stress that personal accountability by each group member for his or her 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 other members of their group are not extending equal efforts toward accomplishing the task.

Experience of Success

Prior success of a group 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 obtain 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—for example, education levels. This perception of status, whether real or not, creates a feeling of being in the "in-group" for those 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 members perceive that an external force may prohibit the group from obtaining 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. As such, 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 when compared with less cohesive groups. 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. If, on the other hand, 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 his or her 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 its members will socially interact and influence one another (Turner, 1987). Because of these interactions, we find that more cohesive groups have a tendency to pressure their members toward a higher degree of conformity, and a high degree of conformity may 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" is 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 to estimate the amount of movement they observed both as individuals and as a member of a group. 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. Of these eight people, seven were actually the experimenters or confederates. However, the eighth person 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 asked to give the incorrect response. The eighth subject sat in the next to last seat so that all but one participant had given an obviously incorrect answer before the subject gave his or her 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 in 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

3. 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.
4. 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

5. Self-censorship of deviation from the apparent group consensus, reflecting each member's inclination to minimize to him- or herself the importance of his or her doubts and counterarguments.
6. 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).
7. 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.
8. 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 15–3**.) Many former senior managers of HealthSouth, a nationwide provider of rehabilitative services headquartered in Birmingham, Alabama, were indicted and/or found guilty of fraudulently and systemically inflating the company's earnings and assets by approximately $4 billion during the 1990s.

Exhibit 15–3 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.

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, they may engage in decision making. For example, consider a health care provider that 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 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 you have to be on guard against groupthink.

Some 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.

SUMMARY

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 15–3**).

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 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 from 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.

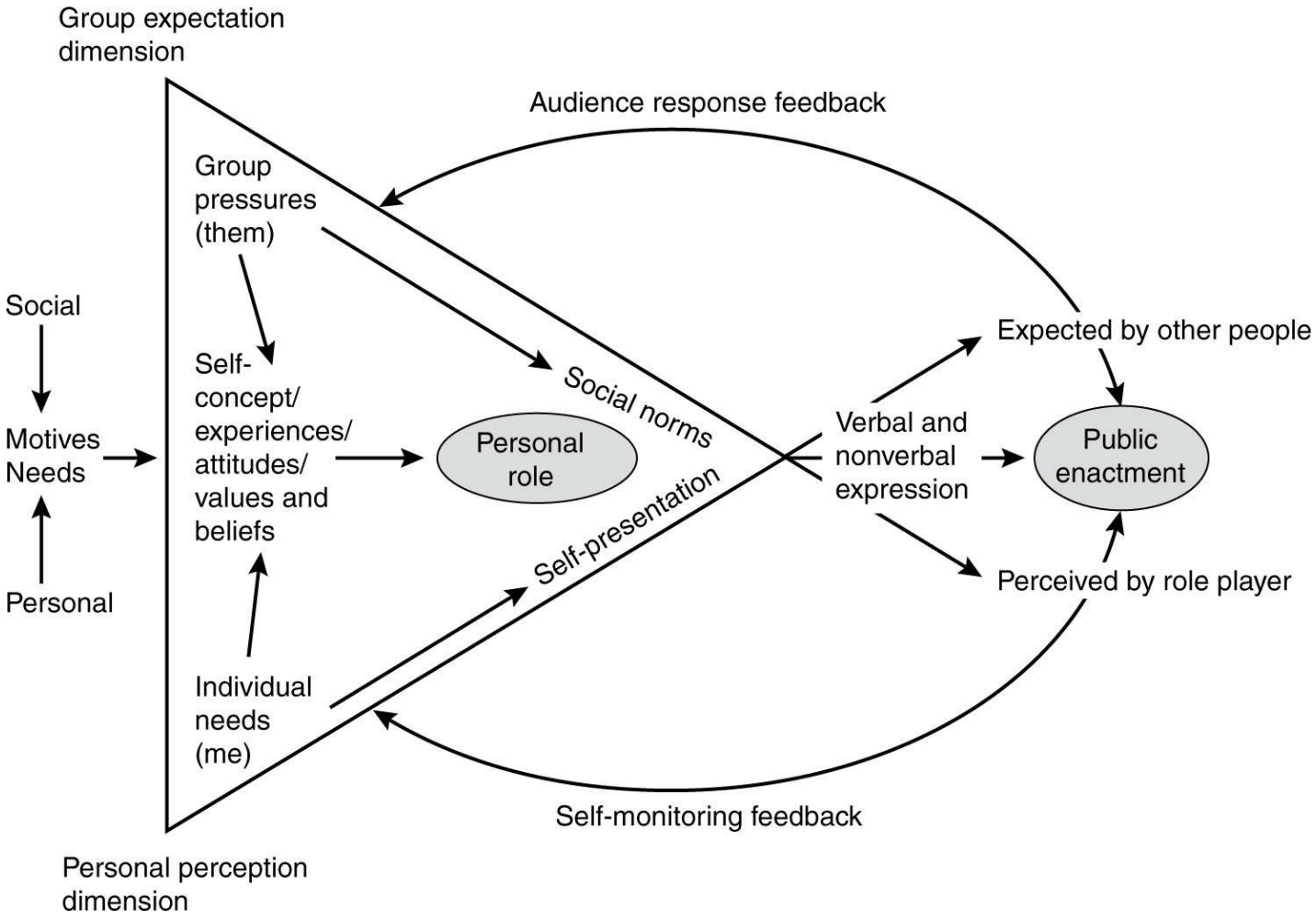


Figure 15–3 The Interface of Me and Them

Reproduced from Burton, G., & Dimbleby, R. (1996). Between ourselves: An introduction to interpersonal communications (2nd ed.). London: Edward Arnold.

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 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 operating under "groupthink."

EXERCISE 15–1

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 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 15–2

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 each member understands his or her 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. One thing I think we could do to resolve differences among us as a team could be:
4. One thing important to me about how we communicate (e-mail, text, F2F, etc.) is:
5. When someone comes to complain to me about so-and-so on our team I/we will:
6. One way I'd like to be recognized or appreciated is:
7. One thing our group could do when we forget our Team Commitments and want to get back on track could be:

Reprinted with permission from Nance Guilmartin: author, *The Power of Pause: How to Be More Effective in a Demanding, 24/7 World*.

EXERCISE 15–3

Analyze the level of group cohesiveness in one of the groups to which you belong.

REFERENCES

Asch, S. (1952). Effects of group pressure on the modification and distortion of judgments. Reprinted in G. E. Swanson, T. M. Newcomb, & E. L. Hartley (Eds.) (1965), *Readings in social psychology* (2nd ed.). New York, NY: Holt, Rinehart & Winston.

Asch, S. (1960). *Social psychology*. Englewood Cliffs, NJ: Prentice Hall.

Bales, R. F. (1950). *Interaction process analysis: A method for the study of small groups*. Chicago, IL: University of Chicago Press.

Bales, R. F. (1953). The equilibrium problem in small groups. In T. Parsons, R. F. Bales, & E. A. Shils (Eds.), *Working papers in the theory of action* (pp. 111–167). Glencoe, IL: Free Press.

Bales, R. F. (1970). *Personality and interpersonal behavior*. New York, NY: Holt, Rinehart & Winston.

Bales, R. F. (1999). *Social interaction systems: Theory and measurement*. New Brunswick, NJ: Transaction.

Belbin, R. M. (1981). *Management teams: Why they succeed or fail*. London, UK: Elsevier/Butterworth-Heinemann.

Belbin, R. M. (1993). *Team roles at work*. London, UK: Elsevier/Butterworth-Heinemann.

Belbin, R. M. (2004). *Management teams: Why they succeed or fail* (2nd ed.). London, UK: Elsevier/Butterworth-Heinemann.

Benne, K., & Sheats, P. (1948). Functional roles of group members. *Journal of Social Issues, 4*, 41–49.

Bennis, W. (1976). *The unconscious conspiracy: Why leaders can't lead*. New York, NY: AMACOM.

Berkowitz, L. (1954). Group standards, cohesiveness, and productivity. *Human Relations, 7*, 509–519.

Beyerlein, M. M., Freedman, S., McGee, C., & Moran, L. (2003). *Beyond*

teams: Building the collaborative organization. San Francisco, CA: Jossey-Bass/Pfeiffer.

Blackburn, R., & Rosen, B. (1993). Total quality and human resources management: Lessons learned from Baldrige Award-winning companies. *Academy of Management Executive, 7*(3), 49–66.

Burton, G., & Dimbleby, R. (1996). *Between ourselves: An introduction to interpersonal communications* (2nd ed.). London, UK: Edward Arnold.

Crandall, C. S. (1988). Social contagion of binge eating. *Journal of Personality and Social Psychology, 55*, 588–598.

Crutchfield, R. (1955). Conformity and character. *American Psychologist, 10*, 191–198.

Feldman, D. C. (1984). The development and enforcement of group norms. *Academy of Management Review, 9*, 47–53.

Hogg, M., & Abrams, D. (1990). Social motivation, self-esteem and social identity. In D. Abrams & M. Hogg (Eds.), *Social identity theory: Constructive and critical advances* (pp. 28–47). New York, NY: Harvester Wheatsheaf.

Janis, I. L. (1982). *Groupthink: Psychological studies of foreign policy decisions and fiascoes* (2nd ed.). Boston, MA: Houghton-Mifflin.

Janis, I. L., & Mann, L. (1977). *Decision making*. New York, NY: Free Press.

Kameda, T., Stasson, M. F., David, J. H., Parks, C., & Zimmerman, S. (1992). Social dilemmas, subgroups, and motivational loss in task-oriented groups: In search of an "optimal" team size. *Social Psychology Quarterly, 55*, 47–56.

Karau, S. J., & Williams, K. D. (1993). Social loafing: A meta-analytic review and theoretical integration. *Journal of Personality and Social Psychology, 65*, 681–706.

Katzenbach, J. R., & Smith, D. K. (1993). *The wisdom of teams: Creating the high performance organization*. Boston, MA: Harvard Business School Press.

Kerr, N. L. (1983). Motivation losses in small groups: A paradigm for social dilemma analysis. *Journal of Personality and Social Psychology, 45*, 819–828.

Kerr, N. L., & Bruun, S. E. (1981). Ringelmann revisited: Alternative explanations for the social loafing effect. *Social Psychology Bulletin, 7*, 224–231.

Luft, J. (1984). *Group processes: An introduction to group dynamics* (3rd

ed.). Palo Alto, CA: National Press.
Ringelmann, M. (1913). Recherches sur les moteurs animes: Travail de l'homme [Research on animate sources of power: The work of man]. *Annales de l'Institut National Agronomique*, 2e serie-tome XIL 1–40.
Sherif, M. (1936). *The psychology of social norms*. New York, NY: Octagon Books.
Shepperd, J. A. (1993). Productivity loss in performance groups: A motivation analysis. *Psychological Bulletin, 113*, 67–81.
Sprott, W. J. H. (1958). *Human groups*. Harmondsworth, England: Penguin Books.
Szymanski, K., & Harkins, S. G. (1987). Social loafing and self-evaluation with a social standard. *Journal of Personality and Social Psychology, 53*, 891–987.
Taplin, S. H., Foster, M. K., & Shortell, S. M. (2013). Organizational leadership for building effective health care teams. *Annuals of Family Practice, 11*(3), 279–281.
Tubbs, S. L. (2001). *A systems approach to small group interaction*. New York, NY: McGraw-Hill Book Company.
Tuddenham, R. (1958). The influences of a distorted norm upon individual judgments. *Journal of Psychology, 46*, 227–241.
Turner, J. (1987). *Rediscovering the social group*. New York, NY: Basil Blackwell.
Turner, M. E. (2000). *Groups at work: Theory and research*. Mahwah, NJ: Lawrence Erlbaum Associates.
U.S. Department of Justice, Northern District of Alabama. (April 3, 2003). Five HealthSouth Officers Charged with Conspiracy to Commit Wire & Securities Fraud [Press Release]. Available at: www.usdoj:gov/usao/aln
Youngreen, R., & Moore, C. D. (2008). The effects of status violations on hierarchy and influence in groups. *Small Group Research, 38*(5), 569–587.

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 those with more. When groups have fewer than five members, problems may arise relating to an inability to make decisions and lower levels of creativity (Tubbs, 2001). If the group size becomes too large, subgroups may form, distracting from the main group's purpose, and a majority of the group's time is used for functioning purposes (e.g., organizing members, assigning roles) versus 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 closest 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 (i.e., 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 the 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 an individual's adult years, associations with work and professional groups will influence his or her 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, and a member of Glen Haven Hospital's neonatal intensive care unit nursing staff and quality improvement committee. After this, Jane's groups become larger. She is a member of the hospital's pediatric department, a member of the hospital's nursing staff, and a member of the hospital's overall community. In addition, she is a member of the American Nurses Association. Some of these group memberships may be short-term and others 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 his or her judgments, preferences, and behaviors. A person uses a reference group as an anchor point for evaluating his or her 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 in a reference group, the group can

have great influence on the person's values, opinions, attitudes, and behavior patterns. A reference group's influence on an individual may be positive or negative. An individual may pattern his or her own beliefs and behavior to be congruent with or opposite to those of the group. The church, labor union, and political party are examples of both positive and negative reference groups for specific individuals. The size of a reference group can range from a single individual (i.e., a movie star, athlete, supermodel, and so on) to a large aggregate of persons, such as a political party or 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 cliques) is organized on the basis of the members' common interests or goals. Membership is voluntary and not part of the official structure of the organization. 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 and often influence others' attitudes, perceptions, group norms, and communication networks.

For example, a small group of nurses, employed at a large community hospital, were unhappy about their work environment and would meet daily during lunch to discuss the situation. There had been a recent change in the hospital's senior management, which caused 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 three years. Furthermore, whenever they approached management with their concerns, they perceived that these concerns were falling on deaf ears since no changes were ever made. This informal group of nurses decided to contact a labor union. The labor union began an organizing effort in the hospital shortly thereafter, holding an aggressive campaign over a six-week period. There was tremendous peer pressure, as some of the well-respected nursing staff became active leaders for unionization, although they were not part of 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 also use informal groups to initiate positive changes. 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. She knew that staff would resist this "new" concept because of her past failures to implement change. Learning from her past mistakes, she enlisted the support of a group of nurses that had developed into a closely knit group. This was also the nursing group that other clinical staff looked to for guidance on patient care issues. The administrator secured the support of the informal group by showing how the change would increase 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., increase in the organization's financial stability). Because of the nursing group's support, the change was successfully implemented with minimum resistance from staff. Furthermore, the outcomes 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, these groups can be enlisted to assist the organization in achieving its goals (see Case Studies 16–1 and 16–2).

Case Study 16–1 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.

SOURCE: "Informal Leadership Support: An Often Overlooked Competitive Advantage," by L. H.

Peters and E. J. O'Connor, 2001. *Physician Executives, 27*(3), pp. 35–39. Reprinted with permission.

Case Study 16–2 Informal Leaders and Cultural Change

Although informal leaders are crucial to the success of a change involving the nursing team, they are often overlooked. In this case study, nursing leaders at Wake Forest Baptist Medical Center tapped into the valuable resource of informal leaders when implementing a new professional practice model, which ultimately transitioned to a theoretical basis for a new model of care. They described their story as follows:

Role of the Informal Leader

Before we could implement a change that significantly impacted nursing culture, we had to understand the nature of informal leadership. Teams may operate without explicitly assigned roles or established authority and as a result are classed as "informal." Informal leaders in nursing are often nurses with a high level of clinical competency who are recognized as experts. This type of leader influences the group, comes from the team, and is chosen by the team.

Informal leaders don't have the power to hire or fire other staff or influence compensation, but they are often charismatic, with an outspoken nature or a strong will. Many informal leaders in nursing can be troubleshooters, super users, and champions who volunteer for extra jobs, serve on unit or hospital-wide committees, and shared governance councils. The informal leader is often tapped to provide feedback for new projects and may assume supportive roles such as preceptor, educator, or charge nurse.

Informal leadership is often an innate characteristic found in many nurses and integral to the role of "advocate." Autonomy and empowerment in the work environment are key attributes supporting advocacy. Advocacy hones communication skills in order to follow through with, or change, interventions to create more positive outcomes for patients.

Informal leaders are in a unique position to influence the groups they work with. The influence can be used in a positive or obstructive way when change is involved. The informal leader is most influential when a group is first exposed to the change and the knowledge base is just beginning to form. As the group becomes more certain and experiences success, the informal leader's influence may diminish.

Informal leaders can also be excellent followers. A follower is often thought of as weak, ineffectual, or prone to failure, but that is usually far from the truth. Followers can easily move in and out of informal leadership roles by supplying energy, enthusiasm, and interest. Followers often have an emotional attachment to the leader. A mentor relationship may exist, and with cultivation the follower may become a formal leader. The relationship between the follower and leader varies depending upon the type of change or intensity of the change that is undertaken. Through the relationship with the leader, the follower may attain a fair degree of power.

Starting the Change

We undertook a redirection of nursing practice: developing a formal model of care, or philosophy of nursing, articulated and owned by staff. The model of care transitioned to a deeper, theoretical format. We enlisted the support of informal leaders within pilot units to facilitate this change.

In preparation for implementing the new model, we used several techniques to strengthen a healthy and caring environment including role playing, team-building exercises, and leveraging empowerment and autonomy. Education and discussion took place in a venue incorporating all selected representatives and was led by a formal leadership team, with delegated responsibility for the model of care by the chief nursing officer (CNO).

Two RN nurse champions were chosen by the unit staff to represent their practice areas with recognized content experts and resources in caring practice. Relationship-based care was

implemented using a wave progression where model units completed small, incremental steps through the Shared Governance structure. The Nurse Champions in Caring Practice led the education, discussion, and implementation of core strategies unique to each area. Strategies addressed care of patient/family, care of self, and care of team.

Staff developed two strategies specific to their work areas. As the model units completed their work, the next wave of practice areas participated in the same process. As all units stabilized, the champions assisted in planning the next transition in the model of care—operationalizing Jean Watson's Theory of Human Caring.

Value of Informal Leaders

Informal leaders are important to any change process. The leader of the change needs to be available and provide information. Team members often address concerns and issues with informal leaders that are not shared with managers. The leader of a significant change event should be visible to coach informal leaders by providing direction with informing, educating, observing, and giving positive feedback. Teachable moments are critical and even small successes should be celebrated. Expectations should be clear, specific, and written. The Nurse Champions in Caring Practice were developed to coach the staff in their areas. Few limitations were put on the strategies and creativity was encouraged. Development occurred within unit-based shared governance councils so that all staff was a part of the projects.

Even when staff agrees that a change is positive, acknowledgement of loss of routine, feelings of competence, the formation of a new team and new role definitions is important in the transition period. Change is more successful if framed in terms of the effect on the team and should be addressed in a direct way. Questions that arise as a result of change often represent different points of view. The manager/leader may be outcome focused and ask:

- What is the goal?
- What will it look like?

The informal leader or staff may question how they are directly impacted by the change and ask:

- What am I getting?
- What am I losing?
- What will be different?

Tangible and discreet events may help smooth a change that impacts culture and allow for time to adjust emotionally within the context of a larger project. The analogy "How do you eat an elephant? One bite at a time," may elicit buy-in and investment from the informal leaders who can then act as coaches with other staff.

The informal leaders formed a core group who acted as role models and assisted other nurses in establishing appropriate patient goals, which helped make the change occur more smoothly. The informal leaders also provided follow-up and assistance if goals were missing.

An early success came when the CNO held town hall meetings about the new professional practice model. The meetings were web-cast throughout the medical center. A nurse in the audience shared her experience with several of the patient-centered strategies while her husband was a patient on a pilot unit. His course was complicated and difficult, but she felt there was a difference in his outcome as a result.

Resistance to Change

When informal leaders do not exert a positive influence, it is important to provide information and directly address their role in the change. Resistance is a natural part of change and demonstrates that staff are engaged. The leader needs to maintain a clear focus during the transition period.

If the informal leader continues to resist, the leader should work to find a part of the plan that the informal leader can live with and enlist support for that part. This endorsement often positively

affects the rest of the project. Regular meetings to provide information to all staff will narrow the gap between an informal leader and other staff, especially if the informal leader is highly resistant and blocking change. Involvement of all staff, focusing on development of the team and assessing the need for skills training, is equally important.

An example of resistance occurred when we began bedside reporting as part of patient care. Bedside reporting was supported as a tool to increase patients' participation in their plan of care by providing direct information and improving communication between the staff at shift change as well as supportive of the development of the nurse–patient relationship.

Report shifted from the conference room to the bedside and included nursing assistants. All staff felt uncomfortable with this change at first and hesitated to share sensitive information. They believed the histories were too complex to deliver in the presence of the patient. Their feedback reflected the challenge with communication skills in this type of report.

Several informal leaders were especially vocal, and unless the manager invited them to move to the bedside, they resisted. Individual discussion and coaching occurred on several levels and actions were taken to avoid making this change a compliance issue.

The resistance was defused in several ways. Nurse managers met with charge nurses, the nurse champions. As informal leaders, the nurse champions addressed the issue through the shared governance process and developed a flow sheet for report that provided more structure for inexperienced nurses. The process was changed so that histories and sensitive information were discussed outside the room and report at the bedside was shorter in preparation for a fuller version in the future when the comfort and skill level of the nurses improved. The patient was asked if he or she preferred report given in front of visitors, or a private report. Additional in-services using low-fidelity simulations were scheduled to discuss scripting, family or visitor appropriateness, privacy issues, and other barriers defined by the staff.

A Valuable Resource

The following strategies may be used to best integrate informal leaders into the change process:

- Obtain staff buy-in and feedback in the selection of informal leaders to lead change.
- Provide information and make it safe for informal leaders to ask questions, take risks, and challenge the change by providing different perspectives.
- Ask for suggestions and find common ground following feedback.
- Incorporate the feedback provided by the informal leader into the change or the process leading to the change.
- Break the change down into parts with the informal leaders sponsoring the different components to avoid the perception of one person "owning" the change.
- Give the informal leader frequent feedback and share outcomes.

Effective change requires a nursing team of members who feel that the environment is supportive, the change has value, and they are acting together. The informal leader is a critical part of this process.

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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., functional or command) or short-term team (e.g., ad hoc committees).

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 16–1**).

For command groups, members are formed into subgroups under the leader's legitimate power position within 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.

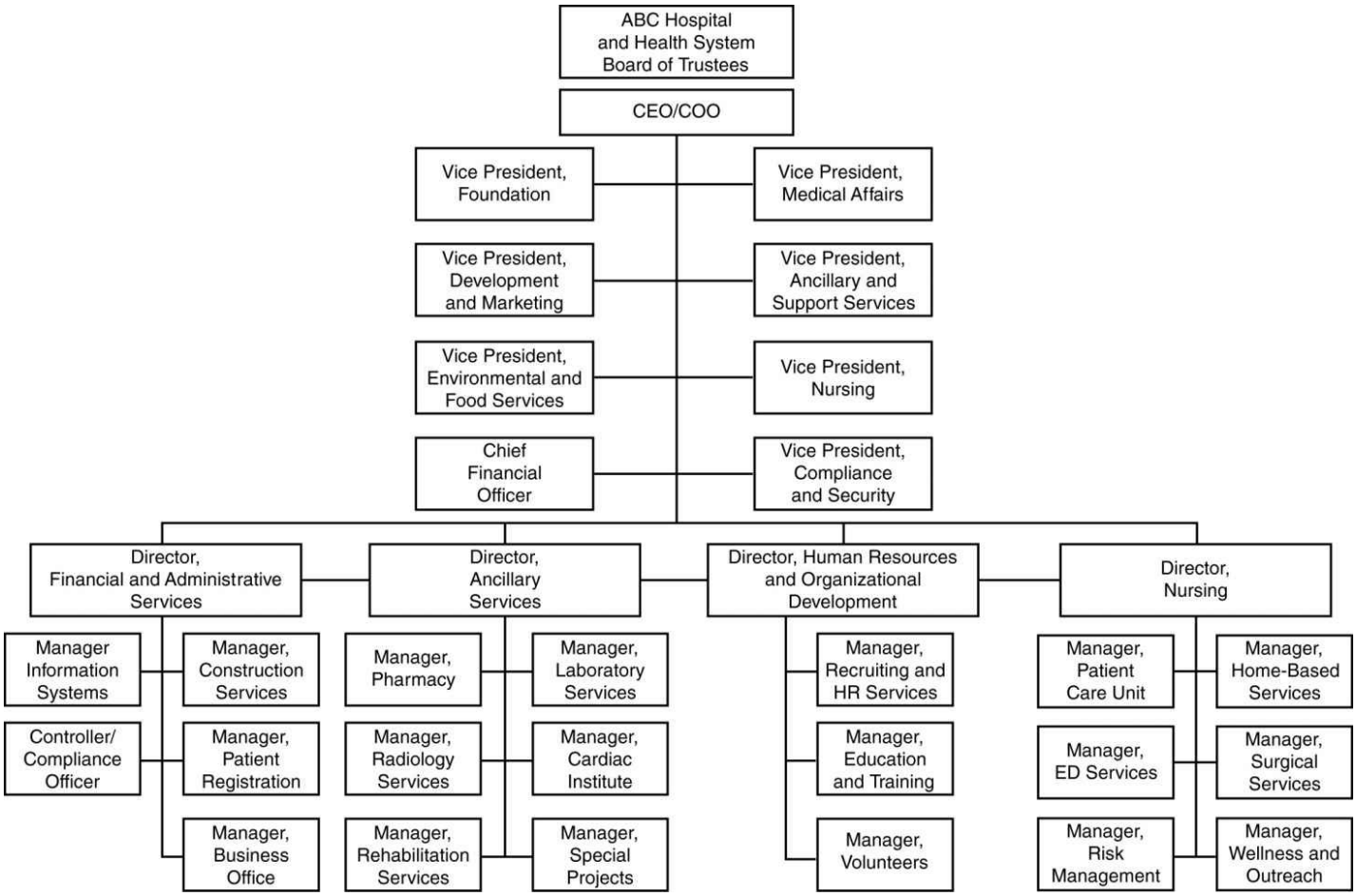

Figure 16–1 Organizational Chart for ABC Hospital and Health System

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- or long-term and may be evaluated on the basis of their identified objectives. Unlike in the functional or command groups, members can be from various functional areas and levels of organizational authority, 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 from one 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 one month up to one year, depending upon 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:

1. *Forming*: During the forming stage, members try to determine what the appropriate behaviors and core values of the group are. 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 about the reason or purpose for joining and find a social niche in the group.
2. *Storming*: The second stage of group development, storming, 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*: Within 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 stage two. 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, performing, we find that members have found their role(s) within the group and that their energy is focused on the task. The group works through the problems confronting it and, when the task is almost near completion, the group moves to the final phase.
5. *Adjourning*: Adjourning is the final stage of group development, which represents the dissolution or termination of the group membership.

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 to 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 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).

There are four factors that play an important part regarding the quality of a group's decision. First, the group should be diverse (i.e., 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 their ideas can be expressed freely (i.e., this will lead to avoidance of conformity and groupthink). Third, the degree of task interdependence must be high (i.e., if the task is simple, members can solve the problem individually with no assistance from other members). Fourth, the group must have the potency for success (i.e., the members believe that the group can be effective) (Shea & Guzzo, 1987).

Peterson (1997) and Burn (2004) provide a model that illustrates the process by which groups make decisions (see **Figure 16–2**).

- *Stage 1—Problem Definition*: The better informed members are, the better they are at formulating the problem or issue at hand. Clarity about the problem is necessary for a quality decision.
- *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 problemsolving 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.

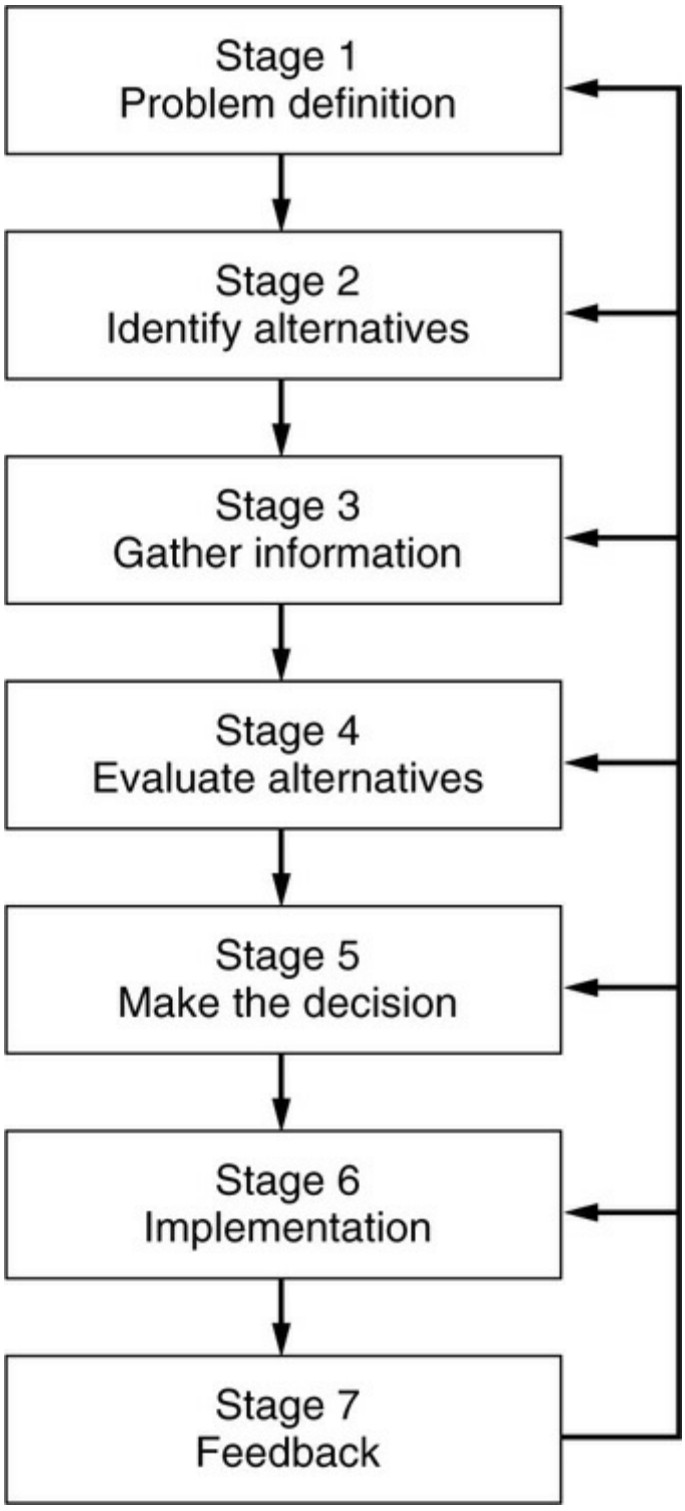

Figure 16–2 Group Decision Process Model

- *Stage 4—Evaluate Alternatives*: The group must objectively analyze all of the available alternatives and potential consequences. The challenges

that emerge during this stage range from developing processes that 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 totally change 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 the identification of all of the needed resources.
- *Stage 7—Evaluate the Outcome*: After implementation, a step that is often disregarded is to evaluate the outcome. Are processes developed so that the decision group can actually 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, and Delphi techniques.

Brainstorming

Brainstorming requires a designated amount of time (usually five to seven minutes) to generate as many ideas as possible without discussion about feasibility or practicality. The originator of this technique (Osborn, 1957) believed that members' tendencies to judge and criticize others' offerings would deter members from freely expressing creative ideas. Osborn hypothesized that the more ideas a group developed, the greater the chance the ideas would be of higher 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, or 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 at the same time, 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. In addition, 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 toward a 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 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.

"GARBAGE CAN" DECISION-MAKING PROCESS

Unlike the rational decision-making model described earlier, where 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 the garbage can process, many types of independently generated problems and solutions are placed in a "garbage can" (see **Figure 16–3**). 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 where the technologies are not clear, the involvement of participants fluctuates in the amount of time and effort given, and choices are inconsistent and not well defined (Cohen, March, & Olsen, 1972; Lovata, 1987; Schmid, Dodd, & Tropman, 1987).

The "garbage can" model is often referred to as political or anti-rational because it disconnects problems, solutions, and decision makers from one another. As such, Cohen, March, and Olsen (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 due to 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 based on the time demands of participants 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).

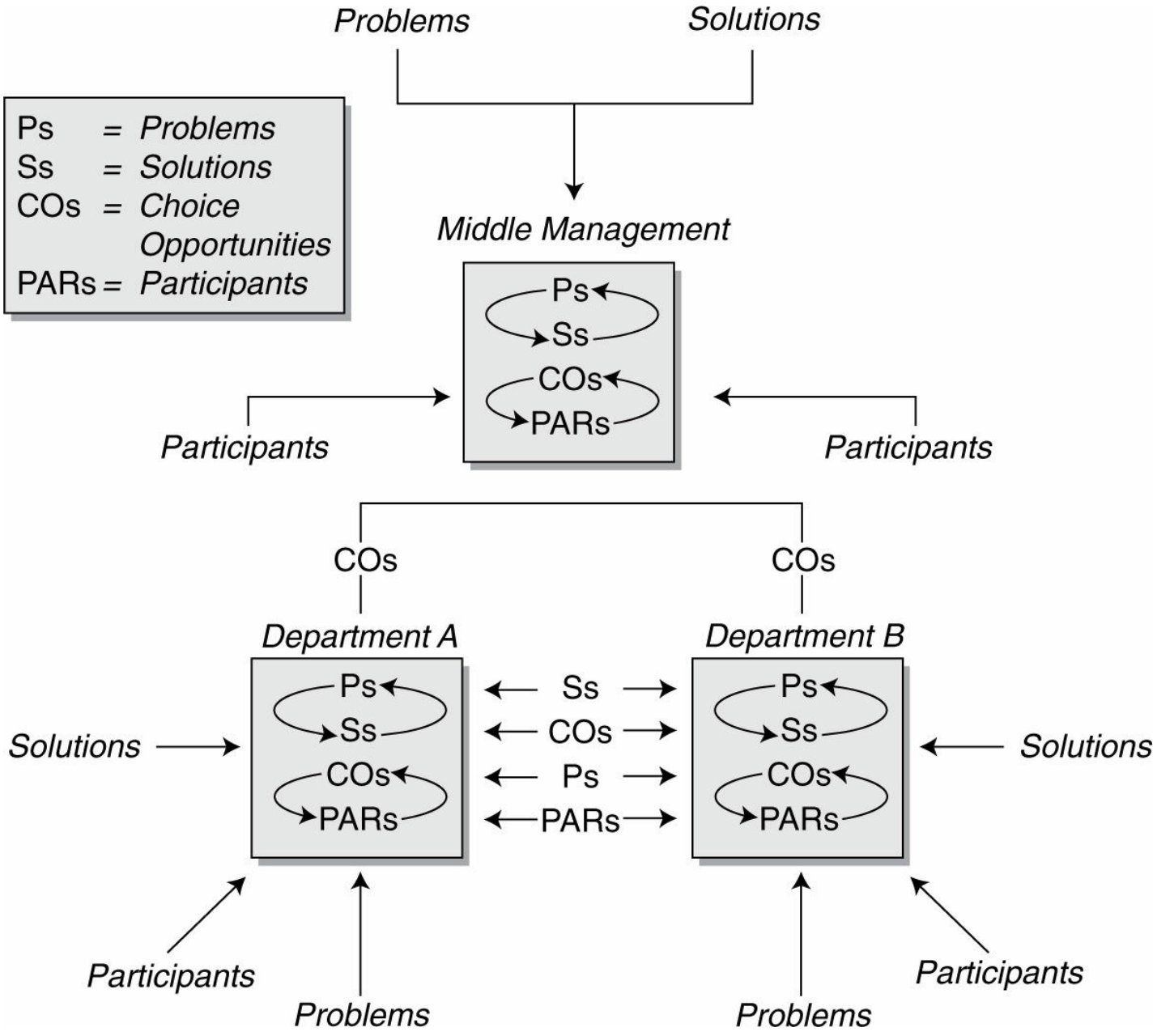

Figure 16–3 Illustration of Independent Streams of Events in the "Garbage Can" Model of Decision Making

Reproduced from Organization Theory and Design (8th ed.), by R. L. Daft, 2004, Mason, OH: Thomson South-Western.

Consequently, the alignment of the problems, solutions, and individuals often occurs after the opportunity to make a decision regarding a problem has passed, or it occurs even before the problem has been discovered (Cohen, March, & Olsen, 1972). The garbage can model provides a real-world representation of the nonrational manner in which decisions are often made within 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, March, & Olsen, 1972).

SUMMARY

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 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 16–1

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 yes, did this cause lack of cooperation or poor communication?

EXERCISE 16–2

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 is completed, personally reflect on the group interactions. Did you notice any factors that may have reduced the performance of the group (i.e., social loafing, apprehension of being criticized by others, dominant behavior by one or more members)?

REFERENCES

Blackler, F., & Shimmin, S. (1984). *Applying psychology in organizations*. London, UK: Methuen.

Burn, S. B. (2004). *Groups: Theory and practice*. Belmont, CA: Thompson and Wadsworth.

Butterfield, J., & Bailey, J. J. (1996). Socially engineered groups in business curricula: An investigation of the effects of team composition on group output. *Journal of Business Education, 72*(2), 103–106.

Cohen, M. D., March, J. G., & Olsen, J. P. (1972). A garbage can model of organizational choice. *Administrative Science Quarterly, 17*, 1–25.

Daft, R. L. (2004). *Organization Theory and Design* (8th ed.). Mason, OH: Thomson South-Western.

Dennis, A. R. (1996). Information exchange and use in small group decision making. *Small Group Research, 27*, 532–551.

Hyman, H. H. (1942). The psychology of status. *Archives of Psychology, 269*, 5–91.

Hyman, H. H. (1968). Reference groups. In D. Sills (Ed.), *International Encyclopedia of the Social Sciences* (Vol. 13, pp. 353–359). New York, NY: Macmillan Company and Free Press.

Lahti, R. K. (1996). Group decision making within the organization: Can models help? Center for Collaborative Organizations, University of North Texas, Denton. Available at: http://www.workteams.unt.edu/literature/paper-rlahti.html

Lovata, L. M. (1987). Behavioral theories relating to the design of information systems. *MIS Quarterly, 11*(2), 147–149.

Mullen, B., Johnson, C., & Salas, E. (1991). Productivity loss in brainstorming groups: A meta-analytic integration. *Basic and Applied Social Psychology, 12*, 3–23.

Nour, M. A., & Yen, D. C. (1992). Group decision support systems, toward a conceptual foundation. *Information and Management, 23*(1), 55–64.

Osborn, A. F. (1957). *Applied imagination*. New York, NY: Scribner.

Peterson, R. S. (1997). A directive leadership style in group decision making can be both virtue and vice: Evidence from elite and experimental groups. *Journal of Personality and Social Psychology, 72*(5), 1107–1121.

Robbins, S. P. (2003). *Organizational behavior* (10th ed.). Upper Saddle River, NJ: Prentice Hall.

Schmid, H., Dodd, P., & Tropman, J. E. (1987). Board decision making in human service organizations. *Human Systems Management, 7*(2), 155–161.

Shea, G. P., & Guzzo, R. A. (1987). Group effectiveness: What really matters? *Sloane Management Review, 8*(3), 25–31.

Tubbs, S. L. (2001). *A systems approach to small group interaction*. New York, NY: McGraw Hill Book Company.

Work Teams and Team Building

LEARNING OUTCOMES

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

- Various types of teams.
- Differences of a virtual team as compared with conventional types of teams.
- Various approaches for building team performance.
- Various organizational barriers to effective team building.
- Common characteristics of successful teams.

OVERVIEW

Case Study 17–1 Dr. R's Office

Dr. R works in a private practice that includes herself and one other general internist. She begins her 20-minute visit with Mr. H by thumbing through the chart to find the dates and results from his most recent hemoglobin (HbA1c), low-density lipoprotein cholesterol, eye examination, and prostate-specific antigen tests. The office has a medical records clerk who is not trained to perform these tasks. Dr. R then spends five minutes comparing the medication bottles brought by Mr. H with her chronic medication list. After reviewing the health maintenance form, she leaves the room to ask a medical assistant to draw up pneumonia and influenza immunizations and finds the medical assistant sitting at her desk waiting for instructions about what to do next. Returning to the examination room, Dr. R learns that Mr. H has been unable to obtain an appointment with the urologist for a prostate biopsy; she promises to arrange the appointment herself. As Mr. H leaves, Dr. R realizes that she did not need a medical degree to accomplish any of the tasks performed during the medical visit.

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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? The answer is obviously "no"—not all groups are teams

(see **Case Study 17–1**).

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 assist or hinder the effectiveness of teams in the workplace.

TEAMS

A team can be defined as a small group of people who are committed to a common purpose, who possess complementary skills, and who have agreed on specific performance goals for which the team members hold themselves mutually accountable (Katzenbach & Smith, 1993; also, see **Case Study 17–2** and **Case Study 17–3**). On the basis of this definition, a team (1) should be composed of a small number of members (preferably an odd number, e.g., five or seven) to ensure consensus without discord; (2) must have specific goals; and (3) must contain members with mutual accountability, requiring interdependence and collaboration of efforts (Gordon, 2002).

Case Study 17–2 Dr. Charles Burger

A Well-Functioning Primary Care Team in a Small Private Office

Charles Burger is a private practitioner in Bangor, Maine. From a distance, his remarkable primary care practice resembles thousands of physician offices throughout the country. Upon entering the office door, it is clear that—within a traditional practice setting—Dr. Burger has created a smoothly functioning primary care team. The entire office functions as one team—two physicians and two nurse practitioners are the clinicians, complemented by medical assistants, greeters, receptionists, and schedulers. The practice is financially stable and is busy, with each clinician seeing 23 to 30 patients per day. The following case typifies how the team model works.

Ms. P called Dr. Burger's office complaining of recurrent abdominal discomfort after eating. The receptionist consulted her computerized triage protocol and provided Ms. P with a same-day appointment. When she arrived, the greeter, already aware of the patient's problem, gave her a medical history questionnaire specifically related to abdominal pain, which Ms. P filled out in the waiting room. Ms. P met with the medical assistant, who checked her vital signs and quickly entered her questionnaire responses into the computer. Ms. P then saw the physician, who reviewed the history, performed a relevant physical examination, and consulted a diagnostic software program. Discussing the options with Ms. P, the physician and patient decided on a diagnostic and treatment plan. Ms. P then met with the scheduler, who arranged laboratory and ultrasound studies.

Dr. Burger's staff members were all trained at a 15-week course in quality management at a nearby college. Greeters, receptionists, and schedulers (who are cross-trained) also received six weeks of in-office training.

All clinical processes in Dr. Burger's office are guided by a system. The practice has adopted advanced-access scheduling, offering patients same-day appointments. For years, the office has

tracked demand and can predict how each day will unfold. On Mondays, heavy with telephone calls, more staff act as receptionists and few scheduled appointments are made.

Whereas in most offices, receptionists are not trained to properly triage patients into emergency, urgent, and routine categories, Dr. Burger designed a triage system that receptionists consult on every telephone call. When Ms. P called with abdominal complaints, the receptionist pulled up the gastrointestinal screen on the triage protocol, which prompted a series of questions including pain severity and presence of vomiting, diarrhea, black and/or bloody stools, or fever. In the case of positive answers, the protocol tells the receptionist to send Ms. P to the emergency department. For milder symptoms, an appointment is made, perhaps with previsit laboratory studies. The interaction is routed to Ms. P's medical record and a clinician's email inbox.

Most communication is routinized by the office's clinical systems. Team members do not attend endless meetings. Incoming calls are routed to the email inbox of the appropriate team member. Urgent messages are delivered in person. Diagnostic studies go to the appropriate email inbox and the medical record. The well-trained medical assistants order clinical preventive studies on the basis of the patient's age and sex. Clinic goals and performance measures are communicated to all staff by posters prominently displayed in the office.

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Case Study 17–3 Kaiser Permanente in Georgia

A Well-Functioning Primary Care Team in a Large Group Practice

In 1997, Kaiser Permanente's Georgia region (KP/Georgia) developed primary care teams with several goals: increased patient satisfaction, improved Health Employer Data and Information Set scores, and lowered costs.

This group practice model currently consists of nine primary care offices with 25 teams. Each team has three to five clinicians (physicians, nurse practitioners, or physician assistants), two registered nurses, one to two receptionists or clerks, and six to seven licensed practical nurses or medical assistants providing care to a panel of 8,000 to 15,000 patients. Prior to the rollout of the team structure, clinicians and staff received training in team-oriented care.

Patients view their clinician, not the team, as their primary caregiver, but are aware that a nonphysician clinician may provide care for acute problems or if the physician is not available. Eighty-five percent of visits are handled by a clinician on the patient's team.

The KP/Georgia team has well-defined systems and protocols for all clinical processes, including triaging telephone calls, reviewing and informing patients of laboratory and X-ray results, making referrals, and renewing prescriptions. One registered nurse is the advice nurse, answering patient questions and triaging patients who telephone or drop in. The other registered nurse is the team co-leader, working with the physician co-leader to solve day-to-day problems, ensure that clinical systems are functioning well, and supervise team members.

Each team receives a budget based on the number of patients on the team's panel with risk adjustment according to age and disease severity. Initially given limited decision-making autonomy, teams demonstrating effective self-management are allowed flexibility in staffing mix and division of labor. Teams can decide whether they want more physicians, more nonphysician clinicians, or more support staff in their personnel mix. Some teams delegate chronic-care management functions to licensed practical nurses and medical assistants; others are less successful in this redesign. Each team decides how chronic disease registries are used to improve its panel's outcome measures. Some use the registries extensively, others minimally.

Each team receives a quarterly report on team functioning, patient satisfaction, staff satisfaction, and clinical quality measures, enabling KP/Georgia's central leadership to assess each team's

functioning and allowing each team to compare itself with other teams.

Copyright © 2004 American Medical Association. All rights reserved. Can health care teams improve primary care practice?" by K. Grumbach and T. Bodenheimer, 2004. *JAMA, 291*(10), p. 1246.

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 used 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, whether in their work design, the composition of the members, or the factors that enable them to achieve high levels of performance and effectiveness.

TYPES OF TEAMS

Cohen and Bailey (1997), following 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 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. They produce one-time outputs, such as a new electronic health record implementation team, or a new facility design and construction team. Typically, project team tasks are nonrepetitive in nature 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. Frequently, project teams 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 concerned with rapid development of new services and/or products due to competition.
- *Management teams* coordinate and provide direction to the subunits under their responsibility, 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 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 health care environment. Management teams can help organizations 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. Virtual teams allow employees to 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 existing to accomplish a particular task, or they may be more permanent teams that address ongoing organizational issues (Roebuck & Britt, 2002).

Organizations 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 he or she lives. However, the dimension of physical distance between members does affect the way 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 providing 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).

Teamwork doesn't 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 patient safety consequences. To deliver safe and effective care, staff 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 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.

BUILDING TEAM PERFORMANCE

Katzenbach and Smith (1993) developed the team performance curve to illustrate how small groups may develop into high-performing teams (see **Figure 17–1**). Katzenbach and Smith (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:

1. *Establish Urgency and Direction*: All team members need to believe 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 job. Three categories of skills are relevant: (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 versus developing the skill levels 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 5,000 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., main role of the team leader) (see **Exhibit 17–1** and **Figure 17–2**).

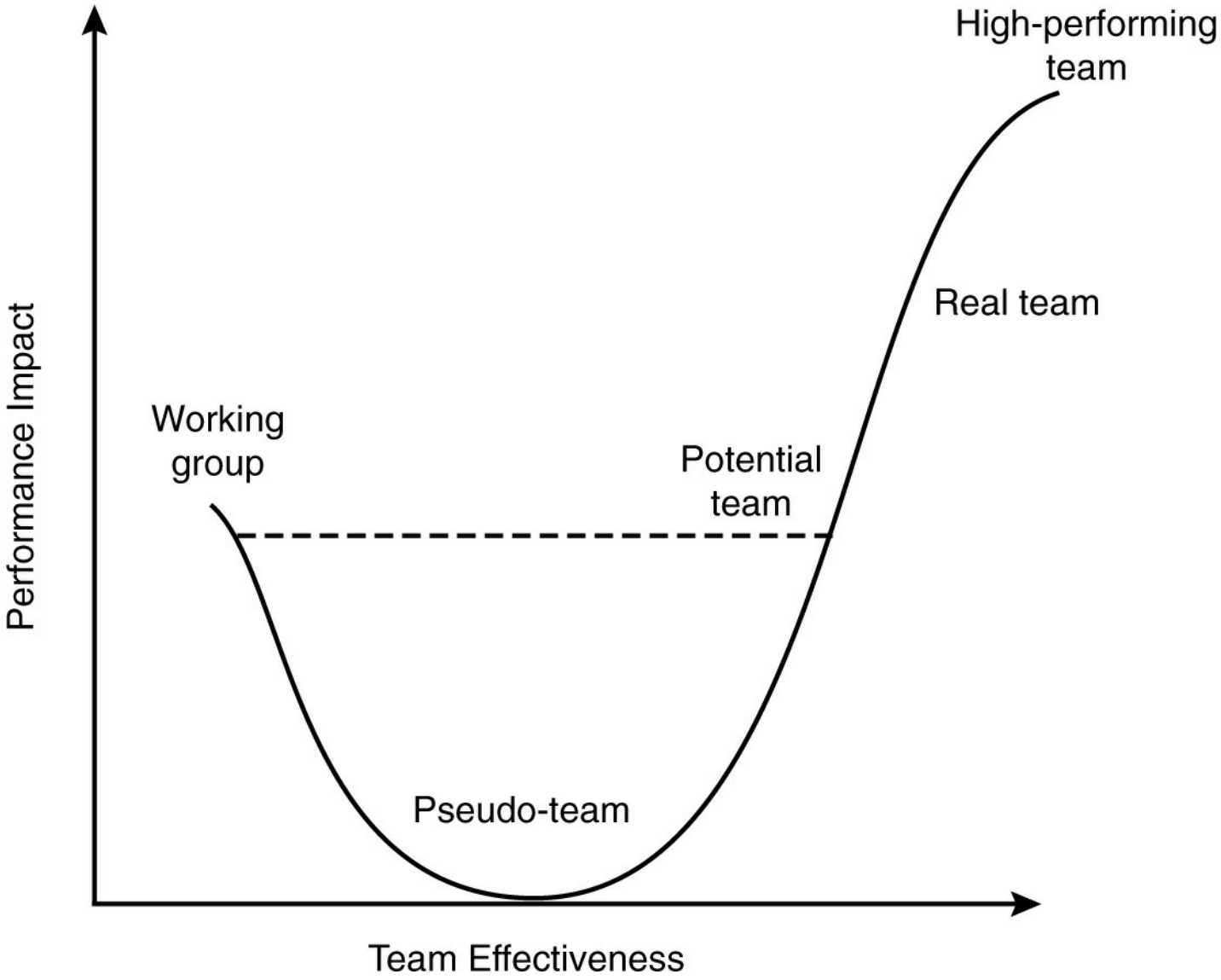

Figure 17–1 The Team Performance Curve

Source: The Wisdom of Teams: Creating the High-Performance Organization, by J. R. Katzenbach and D. K. Smith, 1993. Boston, MA: Harvard Business School Press, p. 84. McKinsey & Company. Used with permission.

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 going-in assumptions and concerns. They pay attention to those 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!

Exhibit 17–1 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 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 all team members need 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. As such, 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

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 within a team, responsible for guiding others. This guiding may be done in either a supportive or directive way, but should not violate the first level of People Linking Skills. The challenge is to find the balance where 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 those of the People and Task Linking Skills to achieve the status of the Linker Leader, a term used to describe someone who is effective at implementing all three levels described in the Linking Skills Wheel.

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").

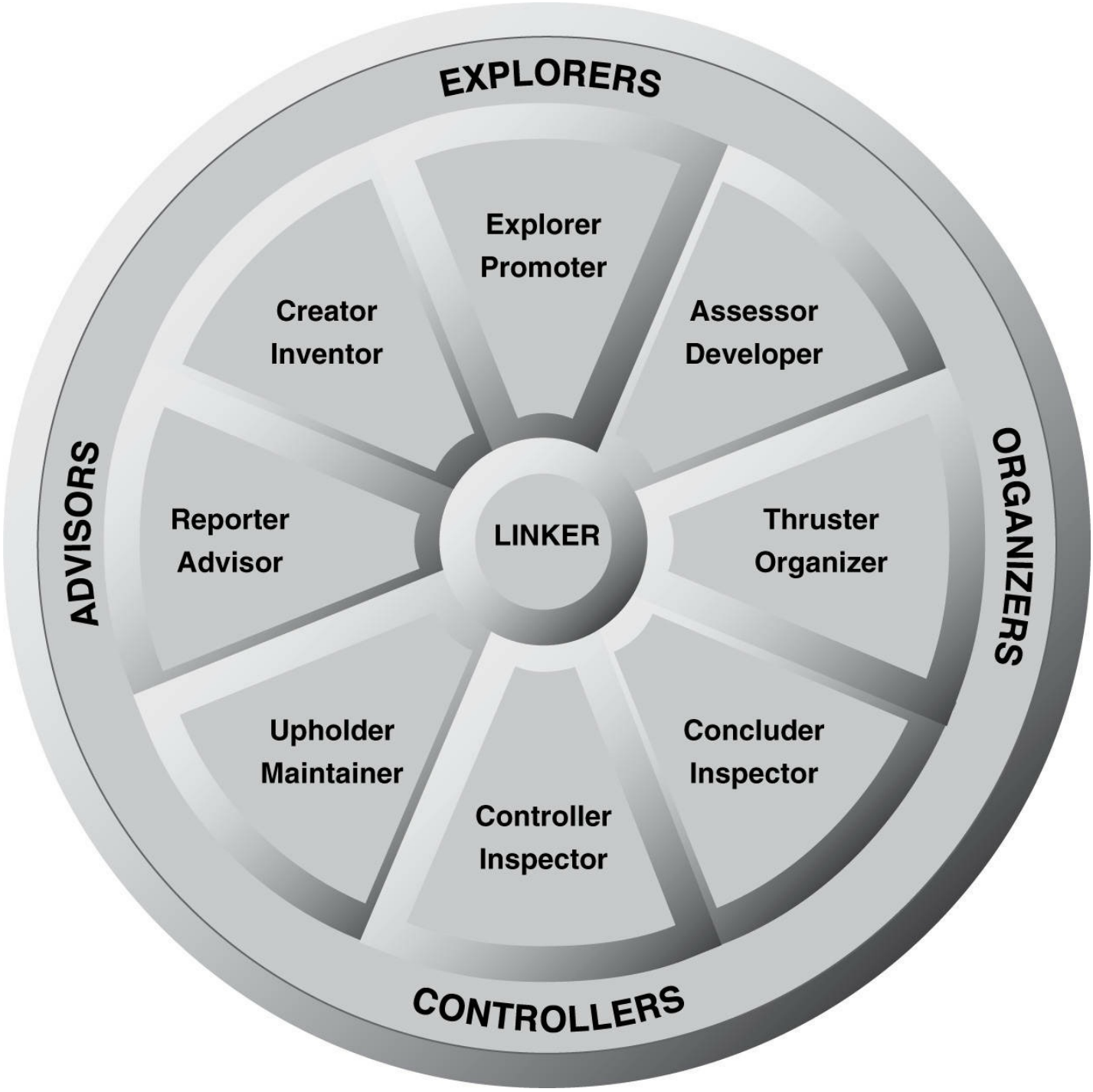

Figure 17–2 The Linking Skills Wheel

Source: Team Management Systems (TMS) by Charles Margerison and Dick McCann. Reprinted with permission.

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 together. 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 shape a common purpose, set clearer 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 be both scheduled and unscheduled. Creative insights as well as personal bonding require impromptu and casual interactions just as much as 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 then, however, potential teams must find other ways to recognize and reinforce their individual and team contributions and commitment.

BARRIERS TO EFFECTIVE TEAMWORK

The 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 (see **Table 17–1**). If these barriers exist within an organization, the likelihood that groups would be provided 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.

Dunphy's (1996) research supports the fact 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/employee satisfaction. Effective and 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.

Table 17–1 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

Source: "Transformation Through Teamwork: The Path to the New Organization?" by S. Drew and C. Coulson-Thomas, 1996. *Management Decision, 34*(1), p. 7. Reprinted with permission.

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 under a highly supportive context, and (6) receive well-timed team coaching. Elaine Biech, as cited in Gordon (2002, p. 184), outlines 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.
- *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.

- *Valued Diversity*: The team must recognize each member's expertise and value variety of knowledge, skills, and abilities. In the world of teams, diversity is larger 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*: Positive atmosphere requires that a climate of trust be developed. 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.

I would also add *reflection* and *appreciation inquiry* 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.

SUMMARY

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 17–2**).

Exhibit 17–2 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 he or she lacks the ability to explain his or her analysis effectively to colleagues outside accounting or finance, you'll need to either help him or her 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 his or her 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.

SOURCE: "Project Teams That Get Results," by M. Messmer, 2004. *Strategic Finance, 85*(8), pp. 13–14. Reprinted with permission.

DISCUSSION QUESTIONS

1. Explain why teams and groups are not the same.
2. Describe the various types of teams 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 versus 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 17–1

List and describe the types of teams most commonly used in your organization. What are the purposes of the teams?

EXERCISE 17–2

List the teams of which you are a member. Select one of these teams to analyze. Is this a high-performing team? If yes, why is it? If no, why isn't it? What changes need to be made to increase the probability that it could be changed into a high-performing team?

REFERENCES

Bartunek, J. M. (2011). Intergroup relationships and quality improvement in healthcare. *BMJ Quality and Safety, 20*(Suppl. 1), i62–i66.

Cohen, S. G., & Bailey, D. E. (1997). What makes team work: Group effectiveness research from the shop floor to the executive suite. *Journal of Management, 23*(3), 239–390.

Daft, R., & Marcic, D. (2009). *Understanding management* (6th ed.). Mason, OH: Southwestern Cengage Learning.

Drew, S., & Coulson-Thomas, C. (1996). Transformation through teamwork: The path to the new organization? *Management Decision, 34*(1), 7.

Dunphy, D. (1996). Organizational change in corporate settings. *Human Relations, 49*(5), 541–552.

Gordon, J. (2002). A perspective on team building. *Journal of American Academy of Business, Cambridge, 2*(1), 185–188.

Hackman, J. R. (2011). *Collaborative intelligence: Using teams to solve hard problems*. San Francisco, CA: Berrett-Koehler Publishers.

Katzenbach, J. R., & Smith, D. K. (1993). *The wisdom of teams: Creating the high-performance organization*. Boston, MA: Harvard Business School Press/McKinsey & Co.

Lawler III, E. E. (1999). Employee involvement makes a difference. *Journal of Quality and Participation, 22*(5), 18–20.

Lipnack, J., & Stamps, J. (1997). *Virtual teams reaching across space, time and organizations with technology*. New York, NY: John Wiley & Sons.

Lurey, J. (1998). *A study of best practices in designing and supporting effective virtual teams*. Los Angeles, CA: California School of Professional Psychology.

Margerison, C., & McCann, D. (1989). Managing high-performance teams. *Training & Development Journal, 43*(11), 52–60.

Messmer, M. (2004). Project teams that get results. *Strategic Finance, 85*(8), 13–14.

Oxford Centre for Staff and Learning Development. (2011). Characteristics of a group-cohesiveness. Available at: https://www.brookes.ac.uk/services/ocsld/resources/small-group/sgt107.html

Roebuck, D. B., & Britt, A. C. (2002). Virtual teaming has come to stay—Guidelines and strategies for success. *Southern Business Review, 28*(1), 29–39.

Rothschild, S. K., & Lapidos, S. (2009). Virtual teams that coordinate care for chronically ill geriatric patients reduce emergency department visits and improve medication compliance, referral patterns, and patient outcomes. AHRQ Health Care Innovations Exchange, Available at: http://www.innovations.ahrq.gov/content.aspx?id=2459

Taplin, S. H., Foster, M. K., & Shortell, S. M. (2013). Organizational leadership for building effective health care teams. *Annals of Family Medicine, 11*(3), 279–281.

OTHER SUGGESTED READING

Beich, E. (Ed.) (2001). *The Pfeiffer book of successful team building: Best of the annuals*. San Francisco, CA: Jossey-Bass/Pfeiffer.

Wise, H., Beckhard, R., Rubin, I., & Kyte, A. L. (1974). *Making health teams work*. Cambridge, MA: Ballinger Publishing Co.

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 discussed throughout this textbook. The leader, or change agent, must use his or her knowledge of motivation, leadership, group dynamics, team building, and conflict management, in addition to communication and negotiation skills, to be successful. In Chapter 18, we explain the role of organization development in planned change management. In Chapter 19, we describe the strategies used for successful implementation of change within organizations.

Organization Development

LEARNING OUTCOMES

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

- Understand the role 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 used in the OD process.

OVERVIEW

Health care has been a dynamic industry in recent history. New reimbursement models, escalating costs, and changing regulations have resulted in an environment fraught with survival struggles. In addition to the financial and structural struggles, real and projected staffing shortages have also resulted in retention issues as well as the infiltration of labor unions into the health care industry. These issues have caused health systems to be in a flux of constant change. Health service organizations (HSOs) need the necessary strategies to successfully implement the required changes for future sustainability. As such, 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 HSO.

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 the productivity of workers. The Hawthorne Studies conducted between 1924 and 1933 also played a predominant role in paving the way for understanding organizational behavior-oriented change processes (Ott, 1996). As the nation progressed through the Industrial Age and through the Depression and two world wars,

the emphasis on the way employees were viewed changed as the nation developed a better understanding of employee motivation. In addition, the popularity of labor unions contributed to the organization's motivation for designing a better working environment. The end result of a century of history has been organizations that understand the need to change in order to remain competitive, yet that also recognize that an emphasis on employee satisfaction is critical in meeting organizational goals. The relationship of 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

OD is a field that incorporates a number of characteristics. Most agree that OD is a planned process of change (Beckhard, 1969; Burke, 1982) using behavioral science (Beckhard, 1969; Beer, 1980; Burke, 1982; French & Bell, 1990) in an organization-wide process (Beckhard, 1969) utilizing a systematic approach (Beer, 1980; McLagan, 1989) to problem solving with the goal of improving the effectiveness of the organization. On the basis of these characteristics, OD is not a one-time training program, a quick-fix change, or a "flavor of the month" initiative. Rather, OD is designed to be a planned initiative, which may be based on a needs analysis, and utilizes a strategic approach to implement the change.

Many things that occur in an organization deal with some type of change; however, not all are necessarily 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 impacts 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 that may include the entire organization or a 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 utilizing this new machine, but this training is targeted to new technology and to those specific individuals who will be working with the new equipment.

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 strides are taken 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 understated. 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 within 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 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: (1) OD is supported by multidisciplinary theories; (2) OD views organizations as open systems; (3) OD recognizes that if one part of the organization is impacted by change, an effect will be felt in another part of the organization; (4) OD is based on action research, which is a continuous

examination of the progress of the interventions; and (5) OD is based on data (see **Case Study 18–1**: Doctor's Hospital's Organizational Change).

Case Study 18–1 Doctor's Hospital's Organizational Change

Doctor's Hospital was facing a serious financial hardship as health care costs continued to spiral out of control and reimbursement 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 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 a 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 reemphasize 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 with understanding the linkages between finances, employee morale, and patient satisfaction. After two 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 training 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 that OD practitioners 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 with achieving clarity and understanding, whereas 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 ultimately the client must pave his or her own way to success, so does

the OD practitioner. The OD practitioner provides the foundation for change, but management must pave the organization's way. 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 18–2**: What Went Wrong?).

Case Study 18–2 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 provided Joan with what she thought was an honest assessment of the issues. After two weeks of meetings, she met again with the CEO to review the data and recommend a course of action. The CEO seemed genuinely interested in what she had to say, but disagreed with many of her conclusions and 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 resulting 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 was 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?

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 implemented. Specific expertise in the psychology of change management would be another example of an appropriate expertise.

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, Cotton, & Golembiewski, 1977; Burke, 1982; Gottlieb, 2001), which 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:

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.

OD practitioners are professionals who are employed by the organization, thus serving as an ongoing internal consultant, or organizations may contract for the services of an external consultant. There are pros and cons of each, and the leaders of an 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 in some cases the consultant is too close to the individuals working in the

organization and may not be able, in the eyes of the leadership of the organization, to separate the relationships. Additionally, the internal consultant, if it is someone who has been employed by the organization for a length of time, may be blind to the issues that are creating the organizational symptoms, and thus may suffer a loss of objectivity.

In contrast, an external consultant does not have an established psychological connection with the organization, so he or she may bring the objectivity that might be lacking with the internal consultant. 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 the implementation of the intervention. Another advantage of an external consultant is that a particular skill set may exist with the external consultant that the internal consultant may not possess. For example, if an organization wants to implement Six Sigma, the internal consultant may not have the training or skill set to assist with implementation of this complex process. One disadvantage of an external consultant is that there is not a 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 may, in some cases, hamper the data-collection steps, especially if employees are mistrusting of an outside person. It is interesting, however, that this may also be an advantage to the data-collection initiatives, as often the employees are mistrustful of providing information to an internal person for fear of retaliation.

ACTION RESEARCH

As 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 illustrated in **Figure 18–1**, the Action Research Model contains eight main steps. This model may, in fact, 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 18–1, traditional OD theorists have identified eight steps to the Action Research Model (Burke, 1982; McLean & Sullivan as cited in Rothwell, Sullivan, & McLean, 1995), which has served as the template for OD practitioners to follow. However, other practitioners have recommended that the model be consolidated into a smaller number of identified steps. The two models are compared in **Table 18–1**. A few additional points about each of the major steps are worth noting.

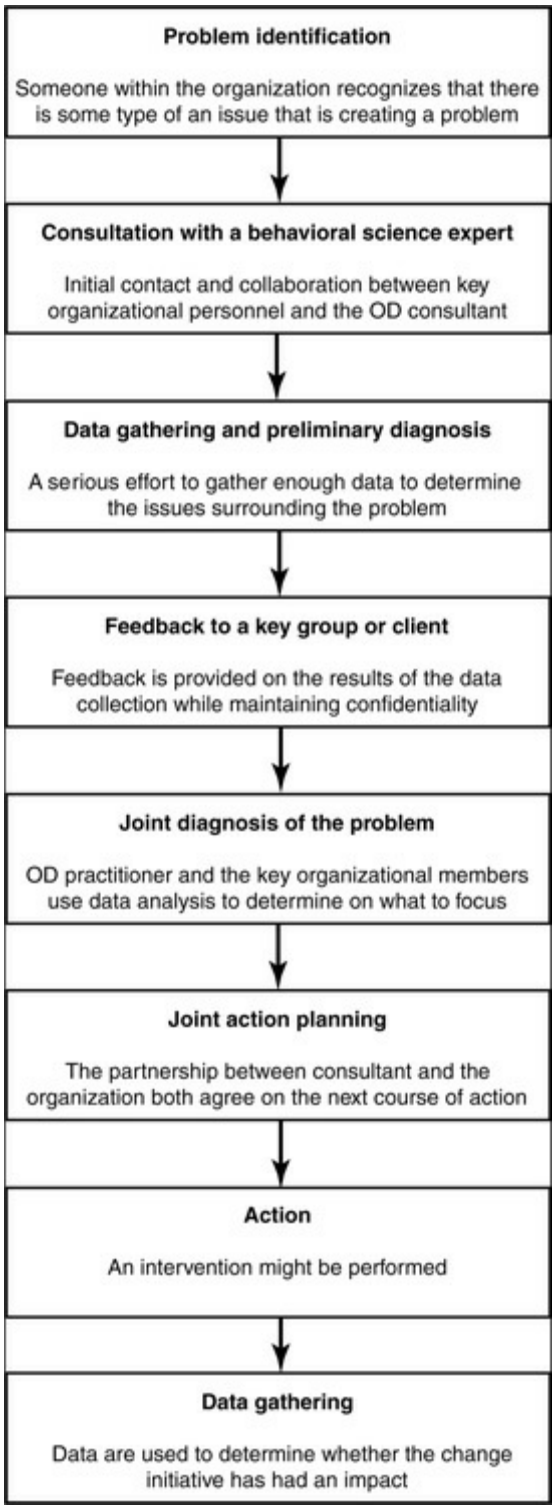

Figure 18–1 Action Research Model

Reproduced from Cummings, T. G., & Worley, C. G. (1997). Organization development and change (6th ed.). Cincinnati, OH: South-Western College Publishing, pp. 29–30.

Table 18–1 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 employed.
4. Action planning		Steps are taken to work with the organization to ensure 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 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 just listed. The plan is implemented and carried out. The process of managing change is implemented, and steps 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.

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 outcomes expected, such as greater employee satisfaction, increased revenues, lower turnover; length of the engagement; and communication and reporting expectations—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 (whether that is an expectation), and how to terminate the engagement if there are concerns or issues from either party (Cummings & Worley, 1997; Rothwell, Sullivan, & McLean, 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, with the choice being largely determined by efficiency, sample size, and type of information that is needed. The most commonly used methods include questionnaires, interviews, observations, and unobtrusive methods.

Questionnaires are often the first method used for collecting information from an organization (Cummings & Worley, 1997). Questionnaires are often utilized because of their relative ease of administration and ability to collect information from large groups of people and to provide some response anonymity. Additionally, questionnaires, if developed correctly, enable an efficient means to quantify and analyze 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, one must work to ensure that there is some validity to any questionnaire that is used in an organization and that it does not seemingly 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 is going to complete it. It is likely that you have received many satisfaction surveys at home, only to throw them in the trash or forget to complete them. 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 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 the questionnaire. 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 identified. However, coding of responses is a hurdle for analyzing the results of the interview. Additionally, the interviewer may hear the responses that the interviewee wants to be heard. This response bias may make it difficult to obtain valid results, but this 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 for data collection is that of observation (Cummings & Worley, 1997). An 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 with the lack of teamwork among a group of employees, and questionnaire data collection revealed a variety of potential reasons for these issues. Because the results were somewhat ambiguous, the OD practitioner might decide to go in and actually 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 within the process because they are so accustomed to performing those tasks regularly. Therefore, it is obvious that there are some distinct advantages to the observation method of data collection. However, as with all data-collection techniques, there are also some pitfalls. The most apparent is that employees behave differently simply because they are 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 ultimately the goal for many employees is job security, it is probable that in some cases the employees may in fact 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 their 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.

Finally, one additional type of data collection frequently utilized by OD practitioners is that of 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 of this 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 type of data is that they are relatively easy to utilize once they are obtained, although in some organizations the information systems or mechanisms by which organizations collect information are either cumbersome or in some cases nonexistent. A second advantage of these data is that they are typically free of biases that may be introduced as a result of other data-collection strategies.

Planning and Implementing Change

An enormous variety of interventions are utilized by OD practitioners. 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:

1. *Strategic Interventions*: Strategic interventions deal with large-scale

organizational strategic issues, such as ensuring the organization maintains a competitive advantage, and marketing strategies, as well as other organizational performance issues. Assessing the organizational environment and external factors impacting performance may identify an intervention whereby a diversification in products or change in geographic location may be identified as 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 impacting on 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 history between employees, or perhaps ineffective leadership. In these interventions the data might point to a problem involving fundamental communication processes, and, therefore, the recommended intervention might be a strategy to assist the group with improving interpersonal relationships. An intervention such as communication training involving the Johari Window (a model used to improve communication between individuals; see 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 typical human resource issues. Interventions in this arena 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 a way 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 predetermined 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 with that ensure that the proper steps have been taken to implant the new strategy into the fabric of the organization.

ORGANIZATION DEVELOPMENT INTERVENTIONS

Listed below 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, from providing assessments to team members, team-building workshops, or in-depth group analysis. Regardless of the strategy 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 the way an individual may 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 tools that the team is trained to use are Pareto diagrams, cause-and-effect diagrams, brainstorming, and flowcharts, as well as a host of other tools. Team members are trained on these techniques. 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 impacts on team dynamics and provides opportunities for employee involvement.
4. *Work Redesign*: The work of Hackman and Oldman (1980) suggests

that there is a significant relationship 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). The relationships between these 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 mentioned earlier, it is possible to change the organizational structure if it is determined that the current structure is ineffective. Changing the structure essentially changes reporting relationships, which is designed to streamline and improve quality outcomes.
6. *Training*: Training is often seen as the only intervention needed. Often organizations fall into the trap that a training program will be the panacea that addresses and solves all of its organizational issues. This is clearly not the case; however, training is considered to be a very effective intervention when conducted with the right 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 is composed of goal setting, appraisal, and reward systems. Some organizations have none of the components in place; some have one or two components, or all. This intervention may involve designing a performance-management system within an organization where none exists or the redesign of one in an organization with an ineffective system in place. 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). Where the action research process is primarily deficit based—focusing on the organization's problems and how they can be solved so 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 the 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 guided change process by an OD practitioner adept at maneuvering through the maze of possibilities that might be exposed through the positive issues identified (see **Case Study 18–3**: Creating Positive Conversations around Exceptional Healthcare Dining Services). The OD practitioner essentially helps the organization see the future and then sets the organization on a path to make that visualization a reality (Cummings & Worley, 2001).

AI is often explained using the five Ds: Define, Discover, Dream, Design, and Deliver. This approach is described in the five steps below (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/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.

Case Study 18–3 Creating Positive Conversations around Exceptional Healthcare 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 healthcare facilities.

Client Organization: UHF Purchasing is a group purchasing organization that provides prime vendor contracts, product supply contracts and services to healthcare 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

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SUMMARY

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, with this analysis based on a thorough analysis of data. The partnership with the organization is critical, and the OD practitioner must work to ensure that ultimately the organization understands and accepts that the responsibility for the success of any intervention lies with management.

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 18–4 Gateway Hospital

Gateway Hospital is a 500-bed tertiary-care hospital located in a busy metropolitan area. A recent employee satisfaction survey scored well below the national norms on most scales. The hospital has been facing 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 if one is new; 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 impacting 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 be a normal occurrence. Several leaders have been let go in an effort to address issues.

The leadership of Gateway Hospital is extremely concerned about the organizational 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. The time frame on fixing the financial issues is one of a critical need; since the environment is rapidly changing, 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 is 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, as well as the breakdown in teamwork and communication.

The data collection is discussed with leadership; after a series of discussions, leadership admits that many of the financial pressures have created a "knee-jerk" reaction to staffing issues, often cutting back dramatically on employee hours. This would create a crisis mode and the need to ask employees to work harder. This cycle 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 and the leadership agree that in order to fix the "people" issues of the organization, there will need to be a culture shift of 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 practitioner will need in order to be effective in this organization?
4. What type of a timeline would you establish if you were this consultant?

Case Study 18–5 City Hospital

City Hospital is a growing hospital in a large metropolitan city. The hospital is currently experiencing an issue that many other organizations are also facing, that of the multigenerational workforce. The senior leadership of this hospital is the typical "baby boom" generation, but the population of employees is slowly growing into one of a younger workforce. The leadership is struggling to deal with issues such as iPods at work, cell phone use, Internet use, tattoos, body piercing, and so on. Equally troublesome is a different perceived commitment to the job and breakdowns in communication. Leadership has decided to hire an outside consultant to help the organization understand the impact of the multigenerational workforce and to try 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 this situation?
4. What other interpersonal issues exist in organizations besides generational that may create a need for an OD intervention?

REFERENCES

Argyris, C. (1970). *Intervention theory and method*. Reading, MA: Addison-Wesley.

Beckhard, R. (1969). *Organization development: Strategies and models*. Reading, MA: Addison-Wesley.

Beer, M. (1980). *Organization change and development: A systems view*. Santa Monica, CA: Goodyear Publishing.

Block, P. (1981). *Flawless consulting*. San Diego, CA: University Associates.

Browne, P. J., Cotton, C. C., & Golembiewski, R. T. (1977). Marginality and the OD practitioner. *Journal of Applied Behavioral Science, 13*(4), 493–506.

Burke, W. W. (1982). *Organization development principles and practices*. Glenview, IL: Scott, Foresman.

Church, A. H., Hurley, R. F., & Burke, W. W. (1992). Evolution or revolution in the values of organization development: Commentary on the state of the field. *Journal of Organization Change Management, 5*(4), 6–23.

Cooperrider, D., & Srivastva, S. (1987). Appreciative inquiry in organizational life. In W. A. Pasmore & R. W. Woodman (Eds.), *Research in organizational change and development* (pp. 129–169). Greenwich, CT: JAI Press.

Cummings, T. G., & Worley, C. G. (1997). *Organization development and change* (6th ed.). Cincinnati, OH: South-Western College Publishing.

Cummings, T. G., & Worley, C. G. (2001). *Organization development and change* (7th ed.). Cincinnati, OH: South-Western College Publishing.

Cummings, T. G., & Worley, C. G. (2009). *Organization development and change* (9th ed.). Cincinnati, OH: South-Western College Publishing.

Fitzgerald, S. P., Murrell, K. L., & Newman, H. L. (2002). Appreciative inquiry: The new frontier. In J. Waclawski & A. H. Church (Eds.), *Organization development: A data-driven approach to organizational change* (pp. 203–221). San Francisco, CA: Jossey-Bass.

French, W., & Bell, C., Jr. (1990). *Organization development* (4th ed.). Englewood Cliffs, NJ: Prentice Hall.

Gottlieb, J. Z. (2001). An exploration of organization development practitioners' role concept. *Consulting Psychology Journal: Practice and Research, 53*(1), 35–51.

Hackman, J., & Oldman, G. (1980). *Work redesign*. Reading, MA: Addison-Wesley.

Hanson, H., Moir, M. J., & Wolf, J. A. (2011). Organization development in health care: The dialogue continues. In J. A. Wolf, H. Hanson, & M. J. Moir (Eds.), *Organization development in health care: High impact practices for a complex and changing environment* (pp. 273–279). Charlotte, NC: Information Age Publishing.

Homans, G. C. (1950). *The human group*. New York, NY: Harcourt, Brace and Company.

Luft, J. (1984). *Group processes: An introduction to group dynamics* (3rd ed.). Palo Alto, CA: Mayfield.

McLagan, P. (1989). *Models for HRD practice*. Alexandria, VA: American Society for Training and Development.

Ott, J. S. (1996). *Classic readings in organizational behavior* (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Roethlisberger, F. J., & Dickson, W. J. (1939). *Management and the worker*. Cambridge, MA: Harvard University Press.

Rothwell, W. J., Sullivan, R., & McLean, G. N. (1995). *Practicing organization development, a guide for consultants*. San Diego, CA: Pfeiffer and Company.

Waclawski, J., & Church, A. H. (2002). *Organization development: A data-driven approach to organizational change*. San Francisco, CA: Jossey-Bass.

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Managing Resistance to Change

Jeffrey Ritter, DBA

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, for example, sudden shifts in the marketplace accompanied by reduced product/service demand, emergence of more competitive products/services, changes in technology, depressive 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 administration staff. Resistance may also be expressed by middle managers and senior executives. As such, it is a top priority for managers to understand the factors involved with change management. By understanding these factors, employees' readiness for

change can be increased, causing a reduction in their resistance to organizational change.

DRIVERS OF CHANGE

Organizations function within three identifiable environments: external/social, industry/task, and internal (see **Figure 19–1**).

The primary forces creating the need for change originate in an organization's external and industry environments. Change becomes the organization's attempt to respond and adapt to new operating requirements generated by demands from these environments.

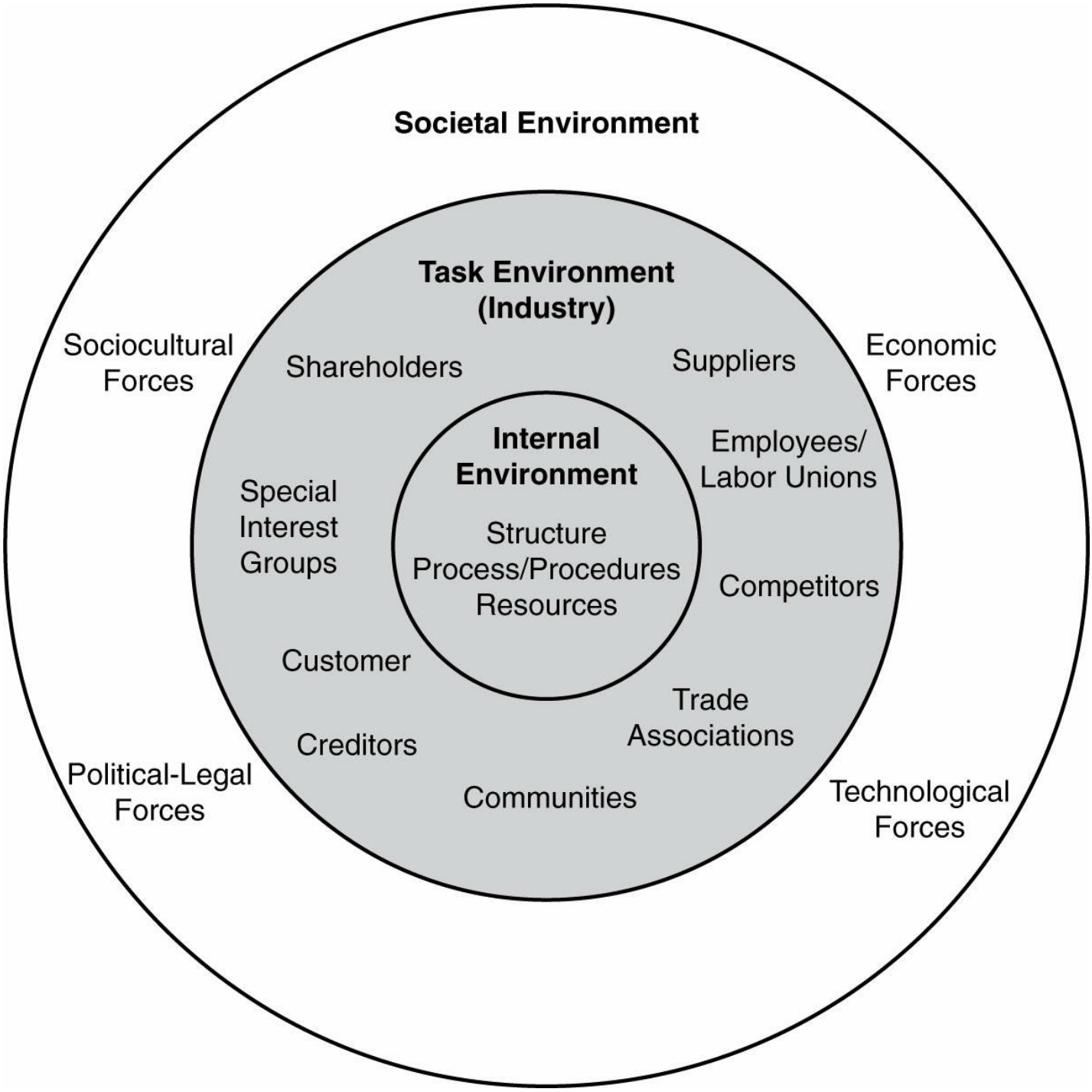

Figure 19–1 Environments

Source: Strategic Managementand Business Policy (6th ed., p. 10), by T. L. Wheelan and J. D. Hunger, 1997, Upper Saddle River, NJ: Addison-Wesley. Used with permission.

Today's organizations are facing many challenges. For example, war and terrorism are viewed as powerful political/legal forces impacting organizations worldwide. Economic forces include other countries' economic threats of inflation, deflation, and recession and the resulting general

weakening of the U.S. dollar. Advances in technology and "big data" availability are major forces affecting today's businesses. The Internet has dramatically empowered consumers and 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. Although these external forces affect all organizations, they have had a direct impact on changes within the health care industry. For example, patients have become informed consumers of health care services' value and costs; stem cell research and cloning capabilities have challenged an organization's ethical practices; special interest groups, such as insurance companies and employer-sponsored health consortiums, have directly impacted the way health services organizations do business; and the increase in union representation of not only nonlicensed employees but also professional groups, such as nurses and physicians, has had a direct impact on the health care industry. The government, with its changing health policies, has had a direct and major impact on the industry, with the implementation of the Prospective Payment System in the 1980s; the Balanced Budget Act and the Health Insurance Portability and Accountability Act (HIPAA) in the 1990s; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and most recently, the Patient Protection and Affordable Care Act (PPACA) of 2010. The PPACA represents the most significant regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965.

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, health services organizations (HSOs) are experiencing decreasing reimbursements and increasing costs, resulting in smaller profit margins. In addition, they are being challenged to deliver patient-centered care with value-based outcomes. As a result, HSOs are considering and engaging in redesign to include more alignment and inclusion across systems (Fischer, Berwick, & Davis, 2009). Whatever the reasons that create a need for change, a planned response must be developed and implemented by management to ensure future organizational effectiveness.

RESISTANCE TO CHANGE

Although resistance to change is a deeply embedded concept in change management, there are situations in which individuals will embrace it.

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 physicial 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 change agent, (2) inadequate finances and/or capacity, (3) poor leadership and resistance to change by senior management, (4) lack of the necessary technology, (5) time restraints, or (6) poor market conditions. Overcoming organizational barriers to change may be beyond the control of the manager and is usually a topic within 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 may feel about the change, the cognitive component is how the employee thinks about the change, and the behavioral component is what the employee does when confronted with the need to change (Palmer, Dunford, & Akin, 2009). For a majority of individuals, it is contextual factors that determine how they will react (Bareil, Savoie, & Meunier, 2007).

The famous Hawthorne Studies that discovered that employees behave differently simply because they are being observed. Roethlisberger (1941) proposed that an individual's attitudes affect his or her response to change. In other words, how a person feels about a change determines his or her response. Feelings are not random. Feelings and/or attitudes toward an object are based on the collective experience of one's life; thus, each

employee may well be affected in a different fashion when changes are introduced in the workplace.

As illustrated in **Figure 19–2**, Roethlisberger's X model suggests, on the basis of his work at the Hawthorne plant, 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, Dunford, and Akin (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

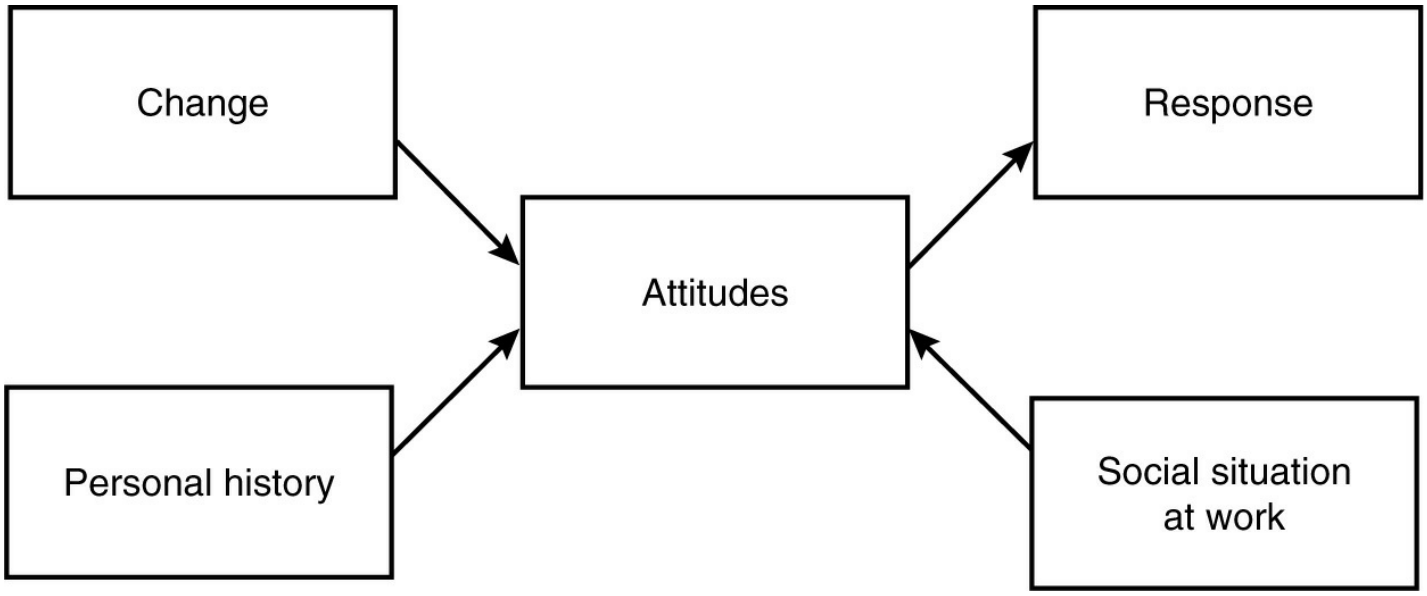

Figure 19–2 Roethlisberger's X Chart (Model for Change)

Reproduced from Management and morale (p. 21), by F. J. Roethlisberger, 1941. Cambridge, MA: Harvard University Press.

Discomfort with Uncertainty

Employees require a stable psychological condition in the workplace. In instances where 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 internal adjustments. Management's failure to furnish realistic information in a timely fashion further adds to an employee's uncertainty. This uncertainty often results in lower morale, increased absenteeism, and reductions in both 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 Negative Effects on Interests

Employees form beliefs as to the nature of the reciprocal relationships between them and their employers—that is, a "psychological contract." Change often leads to a disruption of employee expectations. The employee–employer psychological contract becomes unbalanced; historical feelings of trust and perceptions of honest relationships become questionable.

Lack of Clarity as to What Is Expected

Resistance to change may be due to management's lack of providing a clear message of the behavior expected of employees at the organizational level. 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 is when an organization is pursing several change initiatives simutaneously and employees perceive them as unrelated or in conflict. The second form occurs when the organization is introducing numerous change projects before others are 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 is a way that managers may act to prevent or minimize the likelihood of resistance to change (Armenakis, Harris, & Mossholder, 1993). Readiness for change refers to organizational members' shared determination to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy) (Weiner, 2009). Armenakis, Harris, and Mossholder (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 infrasctructure (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 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 desiring change may well be offset by forces and interests striving to maintain the status quo (see **Figure 19–3**).

For implementation of change, there must be an increase in the strength of the force for change (i.e., driving forces); 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

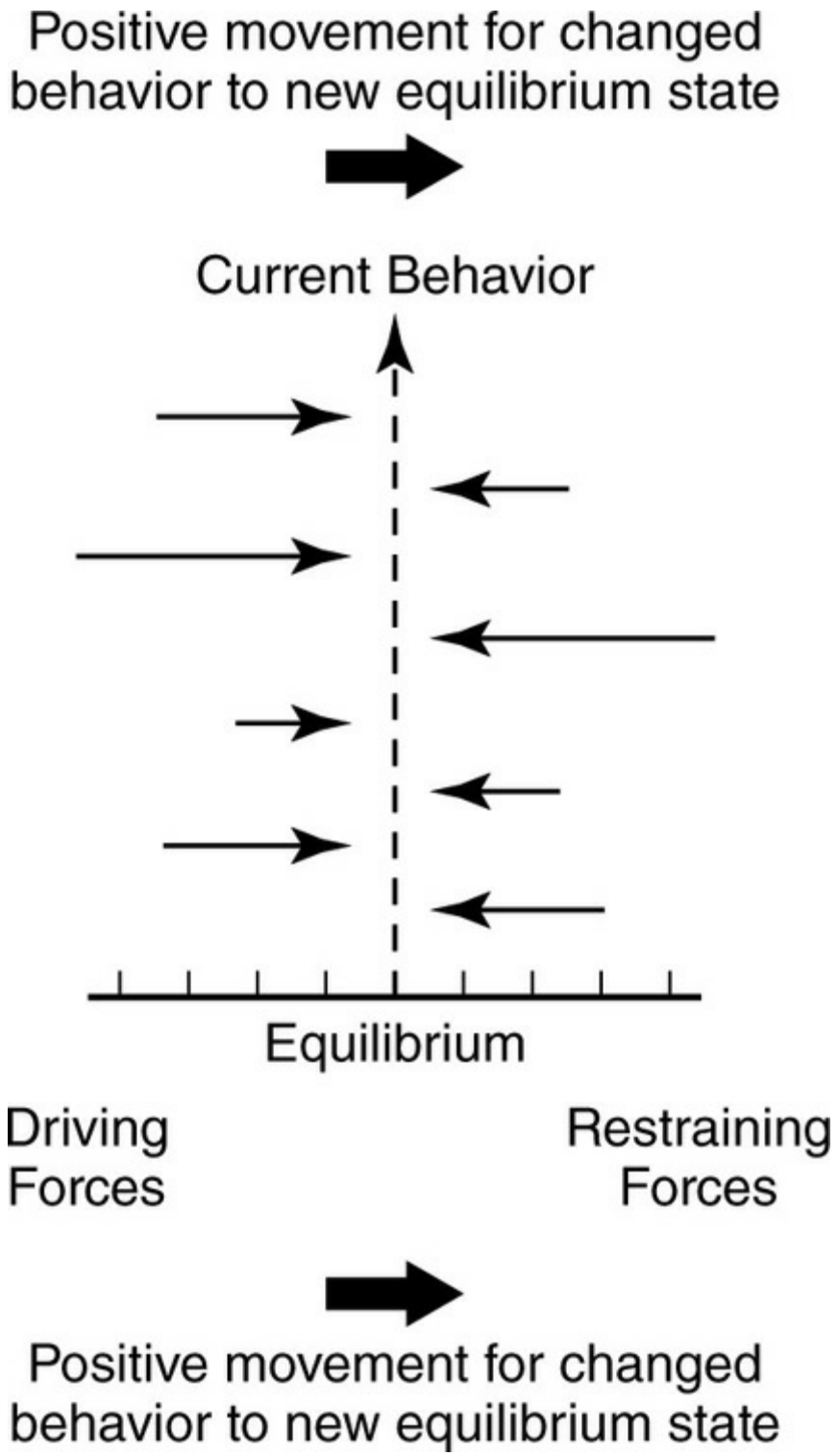

Figure 19–3 Lewin's Force Field Analysis

According to Lewin (1947), change can be enacted in one or 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 regarding physicians' nonacceptance of clinical practice guidelines (CPGs)

into their medical practice illustrates the application of Lewin's Force Field Analysis in the change process. CPGs are viewed as important tools to reduce variances of medical services received by patients and to improve quality of care by establishing "best practices." As such, there is great concern as to why CPGs have been remarkably unsuccessful in influencing physician practice patterns. Borkowski and Allen suggested that the driving forces for acceptance and implementation of CPGs 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 19–1**).

By understanding these forces or variances, a realistic approach to planning change can be undertaken. As reflected in **Figure 19–4**, Lewin provides us with a three-step process for implementing planned change:

1. *Unfreeze*: Workers involved in perpetuating resistance acquire an understanding of variances that exist between current practices and behavior and desired activities and behavior. Using the CPG 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. Again, using the CPG example, Borkowski and Allen (2002) found that physician participation (whether directly or indirectly) in the development of a CPG does increase the acceptance of a CPG, as measured by hospitals' reduced length of stays and inpatient costs.
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. Regarding the implementation of CPGs, Borkowski and Allen (2002) found that audit of and feedback on physicians' practice patterns were the most common reinforcements used by managers.

Table 19–1 Suggested Driving and Restraining Forces Regarding Physicians' Acceptance of Clinical Practice Guidelines

Driving Forces	*Restraining Forces*
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

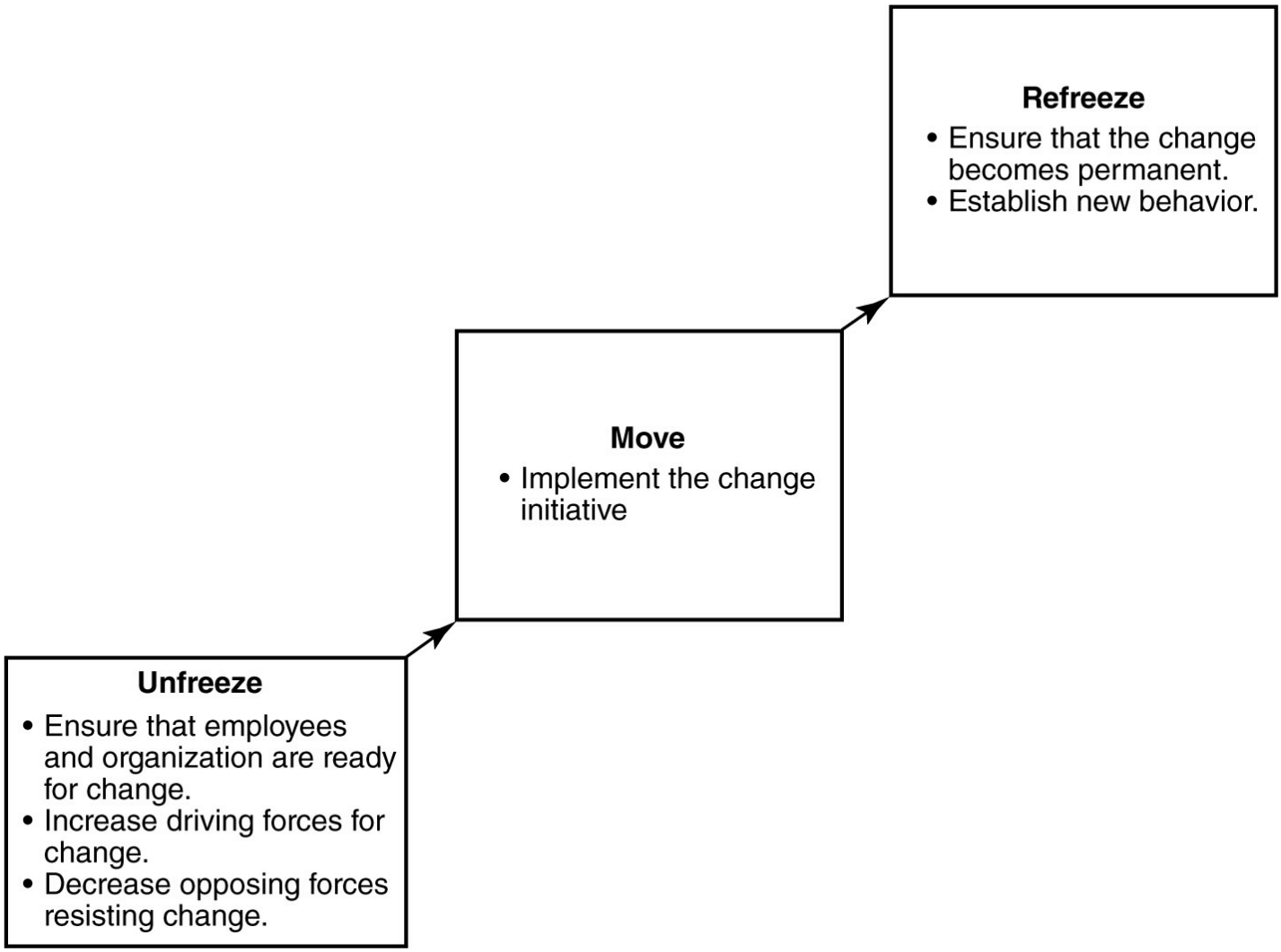

Figure 19–4 Lewin's Three Step Change Process

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 as follows:

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., new desired state). Managers need to raise the feeling of urgency (i.e., 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, they 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.
5. *Empower Others to Act on the Vision*: Management must eliminate barriers to change, and they must encourage risk taking and creative problem solving. They 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.
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.

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 and colleagues (2007) examined twelve health care systems that either were participants in the Robert Wood Johnson Foundation's Pursuing Perfection program, or have existing reputations for 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 19–5**):

1. *Strong impetus to change*: Impetus to change can be external or internal to the organization. In most cases, external pressure for change is the strongest (i.e., regulatory, changes in reimbursement schemes, and so on).
2. *Leadership commitment to quality*: Leadership is a critical element for organizational transformation. Leaders must demonstrate authentic passion for and commitment to quality and 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 around objective, meaningful, urgent problems (i.e., eliminating never events and reducing 30-day 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. As such, changes need to be consistent with 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 boundaries to improve coordination and continuity of care (i.e., 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.

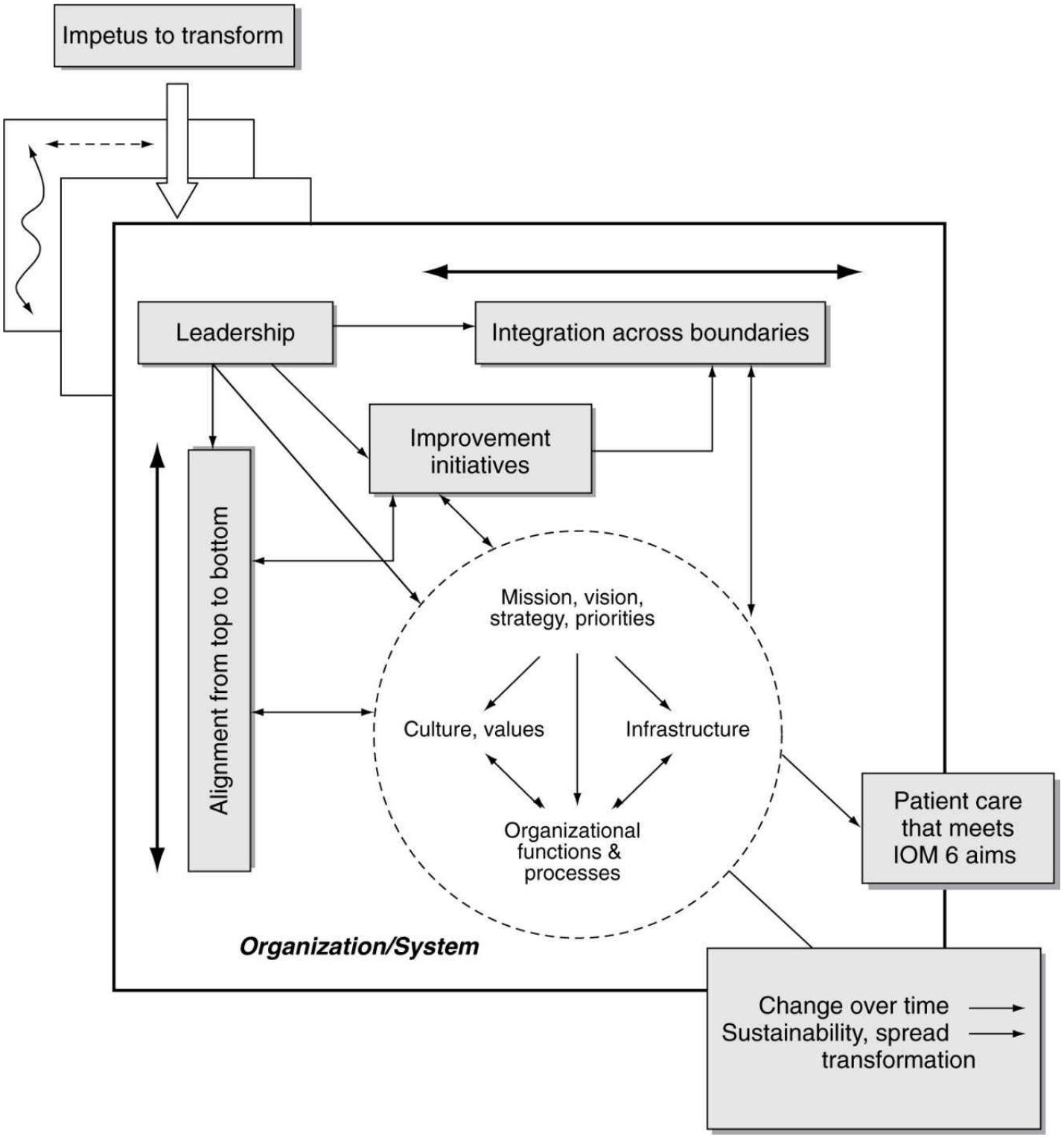

Figure 19–5 Key Elements of Organizational Transformation to Deliver High-Quality Patient Care

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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 will 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 STUDIES AND EXERCISES

Case Study 19–1 Organizational and Cultural Change for Providing Safe Patient Care

The chairperson of the Department of Medicine (DoM) in an urban academic medical center was concerned. During the past two years, events had occurred in which patients had needlessly suffered serious harm. Although the events were few and far between, the chairperson's view of patient care safety meant that there was no place for such incidents. After all, the medical center had a quality improvement department, a process improvement oversight committee, and a risk management department. Nevertheless, despite the considerable efforts of all of these well-intentioned groups, medical errors were still occurring. This could be attributable to the constant competitive pressure to do more with less, but everyone still understood that improvements in efficiency had to be made within the boundaries of safe patient care delivery. Didn't they?

Because the physicians in the DoM were at the center of decision making in the patient care process, the chairperson felt the responsibility not only to continue his support of the medical center's efforts to improve patient safety, but also to address the issue more directly. His perception was that the medical center's current mechanisms for dealing with patient safety matters focused

more on broad policy issues, as in the institutional patient safety committee (PSC). The organization's culture did not allow for an open exchange of ideas, which was needed to improve patient care in such a complex environment. Actual and potential patient safety problems were reported to risk managers, who determined the root causes and assigned blame. In addition, the medical center was in a high medical malpractice award area, which also promoted a closed, defensive attitude toward patient safety issues.

Although the DoM already had its own quality-assurance committee, the chairperson wanted to emphasize safe patient care, so he created a PSC. The PSC was going to have to deal with a number of barriers before reaching its goals. First, physicians resist changing their practice patterns unless they are supplied with hard evidence that the change will be beneficial to their patients; second, many of the solutions to patient safety problems would cross departmental boundaries; and third, many of the solutions to patient safety problems would involve the medical center's patient care information systems.

Recognizing that resident practice patterns might have to change to solve patient safety problems, the DoM chairperson appointed the associate director of the medical resident education program as a co-chairperson of the PSC. Furthermore, he appointed the associate chief of the section of medical informatics, an outgoing medical researcher and educator with a positive attitude, the second co-chairperson of the PSC.

The DoM chairperson and the PSC co-chairpersons felt strongly that safer patient care would not be readily achieved within a culture of blame. They wanted to promote a culture of collaboration, group learning, and prevention. The PSC co-chairpersons decided that the PSC meetings would be relatively informal and open to all interested parties. This would provide an atmosphere conducive to discussion and a forum for anyone who wanted to talk about patient care safety issues. PSC committee members were recruited from the chief residents, medical informatics, nursing, pharmacy, and utilization management to ensure that all aspects of patient care safety issues could be addressed in the PSC discussions.

In examining the balance of the forces that would facilitate or hinder these changes, the DoM chairperson concluded that the driving forces were adequate. Caregivers want to be effective and do well by the patient, take pride in their work, avoid the waste of scarce medical resources by providing efficient care, compete successfully in the local health care marketplace on the basis of effective and efficient care, and avoid malpractice (i.e., another waste of scarce medical resources). However, the DoM chairperson also knew that there were restraining forces that had to be dealt with, such as the desire to remain in one's comfort zone and avoid change, the tendency to seek scapegoats and assign blame, and the defensive attitude developed in response to the legal environment.

The change agents were skillful and up to the task. The DoM's chairperson had decades of management experience and was politically and culturally savvy. He would provide the necessary organizational support of the PSC's work. The PSC co-chairpersons were respected medical educators. In addition, one of the co-chairpersons possessed extensive research experience and understood the value and necessity of evidence in the improvement of patient care processes.

These change agents knew that they would need resources to bring about patient care safety changes. Original cost estimates included the salaries of the PSC members and programming changes to the medical center's clinical and management information systems. Fortunately, the medical center was among the most wired in the nation, so the infrastructure to support e-mail, data storage, and so on in the patient care (i.e., clinical) information systems already existed. Nevertheless, the PSC would need approximately $300,000 annually to develop and implement patient safety initiatives.

The very announcement of the formation of the PSC served to unfreeze the previously existing environment. The DoM chairperson communicated his support of the PSC's efforts by way of discussions with colleagues, as well as his support of discussions with management and staff within and without the DoM. He also remarked on the dangerous lapses in patient care safety and expressed his dissatisfaction with the current state of affairs. These communications served to

strengthen the driving forces. Critics of the efforts viewed the PSC as duplicating the efforts of existing departments and committees (**Figure 19–6**). However, the critics of the PSC were soon convinced that it was performing a worthwhile activity when the committee undertook the project of creating protocols to avoid potassium overdosing; when administered incorrectly, potassium may result in a patient's death.

The PSC's initial charge was to examine lapses and problems in the delivery of safe patient care and identify trends and clusters that merited action. The responsibility of the PSC was subsequently broadened to include the development of protocols for improving patient care. The participatory style of the PSC's leadership allowed all members and their respective departments to participate in the development and implementation of the agreed-upon new practices and procedures. The efforts of the PSC were communicated through educational events and status reports at its frequent meetings.

For example, the activities of the PSC involved providing objective data regarding the current level of patient care before beginning a project and then providing periodic follow-up measurements. The original data and project results were presented by PSC committee members at medical conferences, patient safety seminars, quality fairs, and research forums. These communications reinforced the positive effects of the changes and served to reinforce acceptance as successful operating practices, thus promoting the refreezing of the operating environment with the new practices in place.

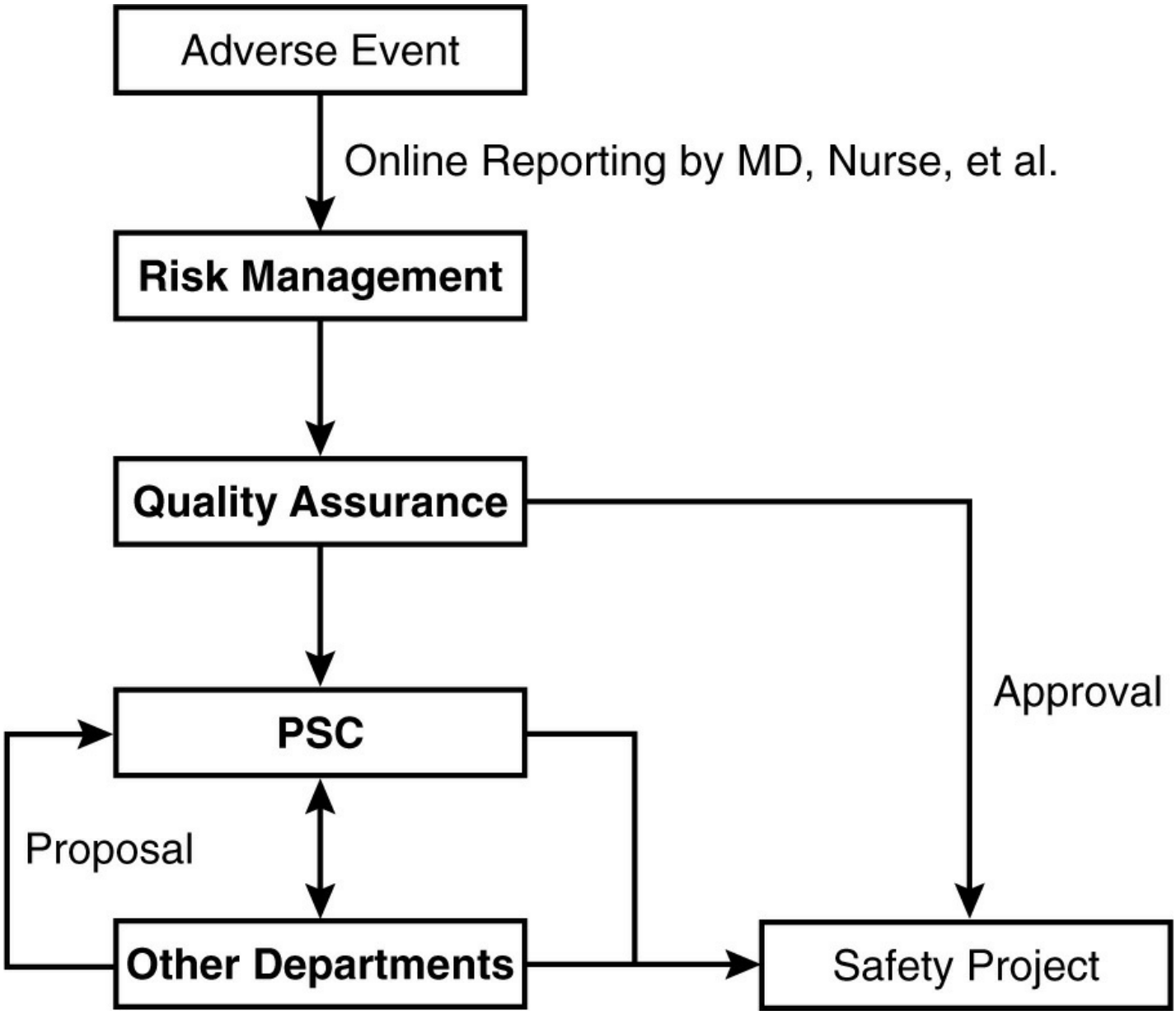

Figure 19–6 Adverse Event Work Flow

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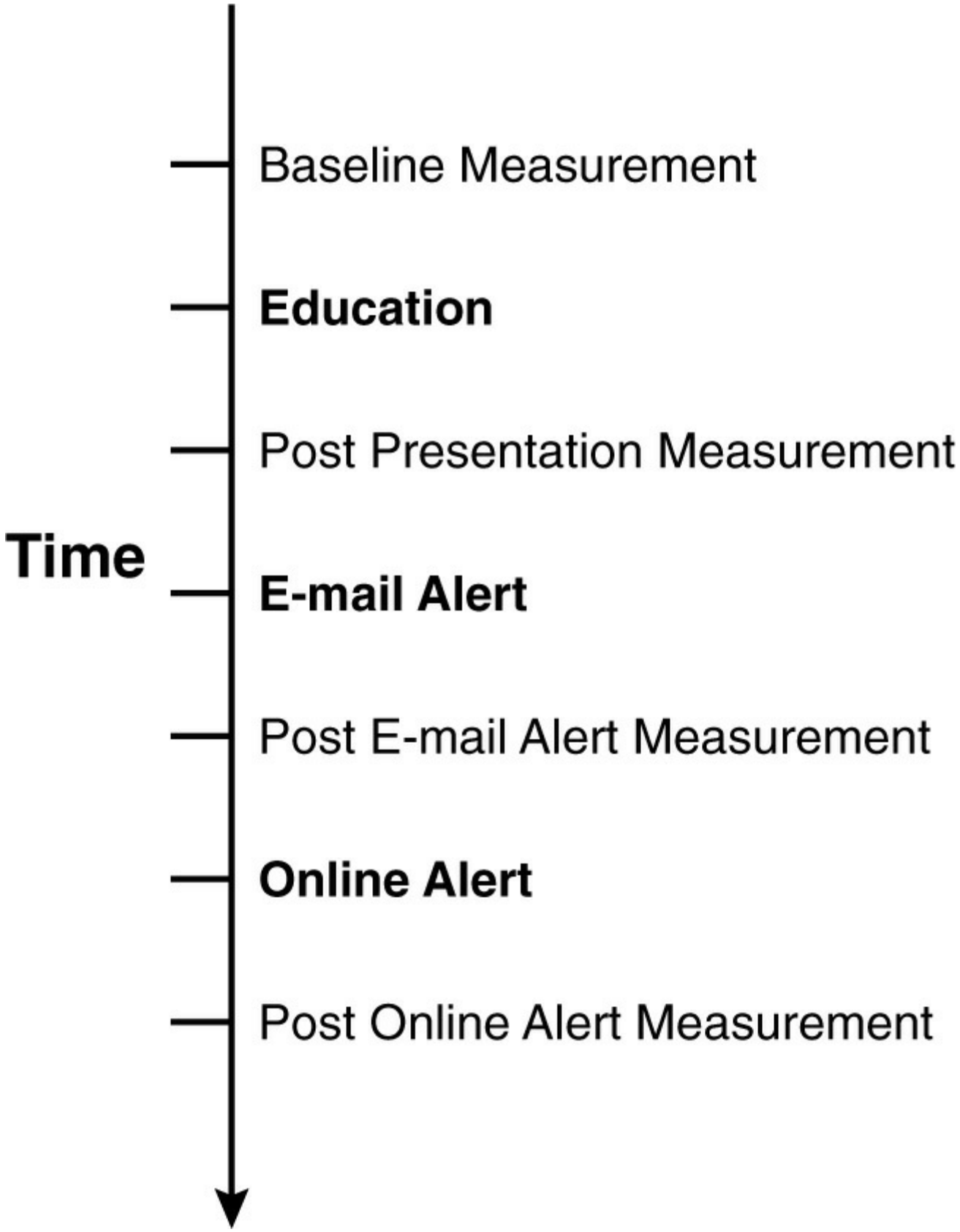

Figure 19–7 Intervention Model

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The PSC was intended as a means to the goal of safer patient care delivery. It provided an environment that welcomed problem reporting and patient safety initiatives. The PSC was the catalyst for developing and implementing projects to promote safer patient care. The number of projects and the quality of their results served as judge of the PSC's success. Projects successfully completed by the PSC include:

- Development and implementation of an online adverse-event reporting system.
- Development of a model for designing three-stage interventions to address patient safety problems (**Figure 19–7**).
- Reduction of the use of potassium and magnesium supplements.
- Development of an online narcotic conversion calculator and its deployment in clinical systems.
- Elimination of sliding-scale orders for insulin therapy.
- Reduction of use of serum amylase orders for diagnosis of pancreatitis.

Senior management support of a culture of learning and prevention and an organizational structure that promotes collaboration have provided an environment in which patient safety initiatives can flourish.

Identify and discuss Kotter's eight-step approach for successful organizational change in this case study.

Case developed by Richard Odwazny, Assistant Professor, and Robert McNutt, MD, FACP, Professor, Department of Health Systems Management, Rush University, Chicago, IL. Reprinted with permission.

Exercise 19–1 Individual Readiness Assessment

INTRODUCTION

The Individual Readiness Assessment is an analysis of readiness for the change and potential sources of resistance and one component of the overall approach.

INDIVIDUAL READINESS ASSESSMENT

Resistance to change is natural and inevitable. A thorough analysis of the specific reasons why and how you will resist the change project is critical to increasing the probability of implementation success. Strategies and tactics can be developed to anticipate likely barriers and successfully manage the implementation project toward the accomplishment of important business objectives. Valuable information can be obtained by having this resistance assessment tool completed by Sponsors, Change Agents, and/or Targets and comparing the different results. In this manner, different Frames of Reference about the change can be surfaced and effectively managed.

INSTRUCTIONS

Each of the items on the following pages is to be rated on a scale from 1 to 5, with "1" meaning that you "strongly disagree" with the statement. A "5" indicates that you "strongly agree" with the statement. To the left of each item, place the number that represents your assessment of how you will react to your specific change. Your answers will be more accurate to the extent they reflect your perspective about the change.

1	2	3	4	5
Strongly Disagree	Disagree	Neither Strongly Agree or Disagree	Agree	Strongly Agree

_____ 1. I am very clear about WHY the change is being implemented.
_____ 2. I believe that there is a strong need for the change.
_____ 3. I can easily see how this change can directly solve a problem for me.
_____ 4. I do NOT believe this change implies I have performed poorly in the past.
_____ 5. I see this change as having a LOW personal cost to myself.
_____ 6. This change has HIGH compatibility with the values and "unwritten rules" of the organization.
_____ 7. I see this change as having HIGH compatibility with my personal values.
_____ 8. I think there is a HIGH reward for successfully accomplishing this change.
_____ 9. I believe there will be no disruption of stable personal relationships after this change is implemented.
_____ 10. This change will have a positive impact on my job characteristics, such as status and/or salary.
_____ 11. Important habits and routine procedures are NOT disrupted by this change.
_____ 12. I feel the confidence necessary to accomplish this change.
_____ 13. I do NOT tend to focus on the old way of doing things.
_____ 14. I believe this change will have a positive impact on my power or the power of people important to me in the organization.
_____ 15. I see the change as reversible if it does not prove effective once it is implemented.
_____ 16. I do NOT believe this change will lead to less control over key aspects of my job.
_____ 17. I am very clear about what is specifically expected from me as a result of the change.
_____ 18. Generally this change will NOT cause a great deal of disruption in my work life.
_____ 19. I feel very involved in this change.
_____ 20. I believe that adequate organizational support and resources are provided to accomplish this change.
_____ 21. I think that adequate time is provided to accomplish this change.
_____ 22. I believe that the organization has been consistently successful in past implementations.
_____ 23. I am NOT experiencing a significant amount of work pressure and stress.
_____ 24. I believe that this change project will be implemented successfully.
_____ 25. Important Sponsors and Change Agents have a HIGH level of credibility with me.

INDIVIDUAL READINESS SCORE

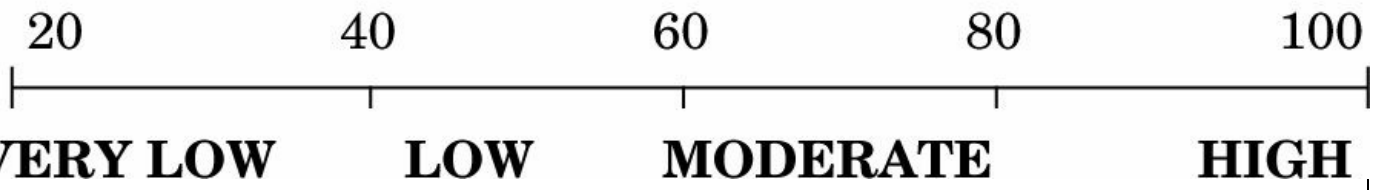
1. Total your answers to all items.
   (Page 3 Total + Page 4 Total = Total Score)
2. Calculate your Average Item Score.
   (Total Score ÷ 25 = Average Item Score)

   _____/25 = _____

   Total Score Average Item Score
3. Calculate your Individual Readiness Score.

   _____ × 20 = _____

   Average Item Score Individual Readiness Score
4. Plot your Individual Readiness Score.
   Probability of Implementation Success



RESULTS

Your Individual Readiness Score represents the probability of implementation success for your current change project on the basis of your assessment of the level of Individual Readiness. Scores in the high range indicate a strong likelihood that you will be successful in this change as long as you continue to manage important sources of resistance. Scores in other ranges mean that you must develop strategies to eliminate or minimize significant sources of Target resistance to avoid the real costs of implementation failure and achieve strategic business objectives.

INDIVIDUAL READINESS PROFILE

	1 Very Low	2 Low	3 Moderate	4 High	5 Very High
1. Purpose	o	o	o	o	o
2. Need	o	o	o	o	o
3. Solve Problems	o	o	o	o	o
4. Imply Past Performance	o	o	o	o	o
5. Personal Cost	o	o	o	o	o
6. Organizational Compatibility	o	o	o	o	o
7. Personal Compatibility	o	o	o	o	o
8. Reward	o	o	o	o	o
9. Social Relations	o	o	o	o	o
10. Job Characteristics	o	o	o	o	o
11. Habits	o	o	o	o	o
12. Confidence	o	o	o	o	o
13. Old Ways	o	o	o	o	o
14. Shift Power	o	o	o	o	o
15. Reversibility	o	o	o	o	o
16. Loss of Control	o	o	o	o	o
17. Clear Expectations	o	o	o	o	o
18. Disruption	o	o	o	o	o
19. Involvement	o	o	o	o	o
20. Resources	o	o	o	o	o
21. Time	o	o	o	o	o
22. Past Implementations	o	o	o	o	o
23. Work Stress	o	o	o	o	o
24. Success	o	o	o	o	o
25. Credibility	o	o	o	o	o
Probability of Implementation Success	Very Low	Low	Moderate	High	Very High

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Case Study 19–2 Healthy Lives: A Cost-Effective, User-Friendly Way to Improve Health and Productivity in Targeted Chronically Ill Workers

St. Mary's Health System, headquartered in Evansville, Indiana, is part of the Ascension Health National System. The system is composed of multiple entities, including a 450-bed medical center with more than 3,000 employees. The average age of employees is 44, the workforce is predominantly female, and the average tenure is 11 years.

St. Mary's Medical Center has a wellness center called Health Matters, which has performed health screenings on employees and spouses since 1993. The system also has a preferred provider network, SelectHealth, which has more than 1,800 providers in a three-state area. The network has been accredited in Health Network and Health Utilization Management since 1999 by the Utilization Review Accreditation Commission (URAC).

St. Mary's Health System was experiencing annual, double-digit increases of more than 18–20 percent in medical claims costs for its health plan. Through analysis of this expenditure, modifiable

lifestyle-related conditions such as diabetes, hypertension, obesity, and hyperlipidemia were targeted as an opportunity for improvement. This presentation shows how St. Mary's successfully triaged and educated about 75 percent of its employees and offered health promotion and disease prevention/management programs to 5 percent of its benefit-eligible population. This 5 percent of employees committed to modifying lifestyles to optimize health and to minimize costs for individuals with hypertension, obesity, diabetes, and hyperlipidemia. These conditions were selected because: (1) efforts can be concentrated on selected, measurable conditions, (2) these conditions occur frequently in high-dollar medical cases, and (3) individuals can minimize the effects of chronic illness on productivity and quality of life by making a commitment to learn and better care for themselves.

Results after 18 months showed significant improvements in financial, productivity, and clinical indices, which had been measured over the course of the program.

Historical Perspective/Cultural Assessment

Before the inception of Healthy Lives, St. Mary's had a wellness screening program from 1993 to 2001 named HealthStyle Plus! This program included basic laboratory tests and physical assessments. Participating employees and spouses received counseling on their results.

To encourage good health, the hospital used the clinical results to categorize participants as low, mid, or high risk for purposes of health insurance premiums paid for benefits. Employees participating in HealthStyle Plus! received "credits" to offset insurance premiums in accord with their risk level. For example, if an employee smoked, was obese (defined as having a body mass index of 30 or more), or had high lipids or high blood pressure, he or she would be classified as high risk and get the minimal reward. If married, the spouse had to participate, or the employee would automatically be placed in the high-risk category.

This old system had several problems. One, it rewarded individuals with good health and discouraged those with poor health from participating. Two, the program made the medical center vulnerable by motivating results rather than participation, once the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. Three, employees worried about how poor health would affect their careers. Four, the wellness program and the externally managed health plan worked in silos, limiting the possibilities of optimizing the health and medical resources used by the St. Mary's population. Five, healthy employees, rather than the individuals driving health plan costs and productivity, were targeted by HealthStyles Plus!

Communicating the Message for the Paradigm Change

The Plan

1. Data mine the wellness screening, medical claims, pharmacy claims, and productivity statistics to find the 20 percent driving health costs (Pareto principle applies).
2. Identify the chronic health conditions that can be modified by lifestyle changes, and target those individuals who are ready to change.
3. Hold individuals accountable, not for health status but for behaviors within their control that influence health, performance, and medical costs.
4. Convince senior management and then the employees that this is a sound approach that will reward them with lower health plan costs and better productivity in their peers.
5. Use a systematic approach in triaging the health plan population, intervening and providing resources, measuring outcomes, and rewarding commitment to personal health.
6. Use the quality improvement process to identify systematic issues in benefit design, claims management, use of insurance, medical treatment, and educational or communication needs, and prioritize and implement changes to address issues.
7. Provide feedback to the employer, physicians, and employees.
8. Market the program to other employers.

The Message

1. Employees who are chronically ill don't do their share of work, causing more overtime, poor morale, lower customer satisfaction, disability, turnover, and lost dollars through absenteeism and presenteeism. That is why health costs are only about 25 percent of what the chronically ill cost us.
2. Health is more than the absence of disease. It is about being the best that you can be. Healthy people have energy, endurance, strength, confidence, optimism, and a sense of well-being. Everyone deserves to feel this good.
3. Chronically ill people have problems because of bad genes or bad luck. The bad luck is in the form of inherited conditions, preventable illness, and complications, as well as lack of self-care, emotional problems, or accidents.
4. Chronic illness is insidious and silent. Many people don't know they have a health problem, don't take needed medications, and don't take care of the problem because they think they feel fine, they are in denial, or they believe they cannot afford treatment and medication. Only when they start getting healthy do they realize how badly they once felt and the risk that they were taking.
5. Chronically ill people are often stressed, uninformed, and caught up in a vicious cycle, where they never budget time or money to care for themselves. They require a personalized approach to understanding their health needs, obstacles, and resources and help in creating and implementing their own health plan.
6. Good health is its own reward. Let's put our money to use where we will get the most benefit; that is, in helping the chronically ill health plan members learn about their health and take responsibility for improving it.
7. Make the reward within reach of all benefit-eligible employees and spouses on the health plan who commit to taking personal responsibility for their health.
8. Keep results confidential. Release only aggregate results to management or to other publics. Include a confidentiality statement that binds the wellness and health plan to these standards.

The Culture

The system was recently redesigned to integrate the purchase of another hospital in the city and to compete with large national health plans in attracting employers to the SelectHealth network in the tri-state area of Southern Indiana, Southeastern Illinois, and Western Kentucky. The hospital merger with all its issues of integration was a great factor. At the same time, insurance premiums increased dramatically in 2003, and health plan management was contracted to SelectHealth to improve the system's experience and reduce medical costs.

The incidence of obesity, hypertension, hyperlipidemia, and diabetes was increasing annually in the employees who were screened. In summary, medical costs were soaring and the system was in major flux, making the timing ripe for introducing a change that could correct the problem. (Major historical works on change process indicate that change is most readily accepted when a system is in flux)

Assessment of Forces

In most situations, there are conflicting forces that drive and restrain the change process. A major problem for this program was that an integrated wellness/health promotion and disease management program needed to be developed, marketed, and implemented within three calendar months. The plan for the program is outlined in **Table 19–2**.

Table 19–2 Driving and Restraining Forces to Healthy Lives

Factor	*Driving Forces*	*Restraining Forces*
Model	1. Develop a simple model, targeting lifestyle illnesses that will reduce health costs for everyone.	1. Communicate a paradigm flip to employees. 2. Well people want to be rewarded. 3. Employees wonder why people with poor

	2. Make the participant accountable. 3. Reward commitment to personal health. 4. Leadership wants change that will improve health and pro-ductivity.	lifestyles get rewarded. 4. What if program can't be measured? 5. What if program doesn't work? 6. What if no one voluntarily participates?
Resources	1. Chronically ill will be able to afford medical care. 2. Money already budgeted. 3. Wellness and managed care staffs are experienced in program development, screening, and disease management. 4. Staff committed to work with available resources.	1. Fear that employees will say, "I counted on the money to reduce my health insurance premiums." 2. "Program isn't fair." 3. Must work with accounting to reallocate funds. 4. Need to create new program and integrate staffs from two different departments to develop and implement plan in three months. 5. Actual budget for new program unknown.
Infrastructure	1. Program leaders are well organized. 2. Employees accustomed to annual health screenings. 3. System needs to measure absenteeism and presenteeism that was complicated by the introduction of a Paid Time Off (PTO) system.	1. Need to develop database. 2. Establish baseline. 3. Create participant report cards. 4. Set up new program and reporting mechanism. 5. Need to find a reliable and valid tool for measuring absenteeism and presenteeism.
Leadership	1. System is in flux from merger. 2. System needs to stop the annual 18 to 20 percent increases in medical claims costs. 3. Leadership wants to make positive changes now. 4. This program could reduce health plan costs. 5. Some cheerleaders have been identified in different work areas.	1. Need to educate and get top- down support. 2. Must educate/convince leaders to participate and be resources for their employees. 3. Need employees to volunteer. 4. Need to report de-identified success stories. 5. What if physicians don't support the program or refuse to change practices?
Physicians	1. Physicians will do what is best for the patient if included in the plan and educated. 2. Medical Director and Physician Advisory Group for health plan are supportive. 3. Physicians will have more resources to achieve their goals with patients. 4. Medical Director is well respected by the medical staff and has strong communication with them.	1. Physicians need education to be part of the team. 2. Safety and follow-up issues with current, serious health issues. 3. Physicians must give permission for employees to participate in disease management program.
Project Design/Outcomes Measurement	1. Commercial health risk analysis tool identified that minimizes scoring time and gives participants real time results. 2. Willing, salaried staff that have good relationship. 3. Staff is knowledgeable and experienced. 4. Consultant hired to expedite project.	1. No time or money for new information systems. 2. Three months to identify key measures, set up system to track improvements. 3. Need to accurately select baseline measurements and benchmarks. 4. Actual staff needs unknown.
Savings Potential	1. Improved health will translate into higher productivity, reduced absenteeism and presenteeism. 2. Medical costs will be reduced. 3. Healthy Lives participants will have improved health.	1. Database needs to be developed to capture clinical data. 2. Systematic method needed to track relevant medical costs through claims data. 3. Most health plans complain about inability to track actual costs. 4. What if baseline cannot be measured properly prior to intervention?
Communication	1. Consultant MD is experienced in writing a complex program in simple terms. 2. Consultant has charisma and experience. 3. Leaders in medical management and	1. Logistics of reaching physicians, leaders, and employees and convincing them to participate in three months. 2. Challenge of using multimedia. 3. Need to send a message that encourages

	wellness have credibility with employees. 4. Program staff is entrepreneurial; able to handle change.	participation. 4. Challenge of reaching all parties. 5. Way to keep track of responses.
Personal Response	1. Participants will learn and be pleased with the experience. 2. Participants have time with health professional tailored to their needs. 3. Participants will be able to see actual results from their efforts.	1. There will be no volunteers. 2. Employees will not trust the program. 3. The proposed program might not work. 4. The new program might be disorganized. 5. All factors may not have been considered in development.
Health System Future	1. This program is innovative, and will distinguish our system for its excellence and leadership in addressing lifestyle problems that have become a national health crisis. 2. System needs to model wellness and disease management program before it is sold to other employers. 3. Employers want to see results and get relief from high medical costs. 4. Successful health systems attract commercial business.	1. System needs to be implemented successfully. 2. Results may not be positive; program may not work. 3. Difficult to measure "soft results"; i.e., how does a lower blood pressure save money that falls to the bottom line this year? 4. Employers want to see bottom line savings. 5. Employers want to understand what they are receiving for their investment and how the health plan is improving the lives of their employees; few systems know how to show results in dollars.

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Implementation Plan

The leaders at the system level recognized the need for innovative changes in how employee health issues were identified and managed. They also wanted to stop the annual 18 to 20 percent increases in paid medical claims costs. The system hired a consultant who worked with the Healthy Lives team to develop the program. The sequence for major objectives was as follows:

1. Develop program and PowerPoint explaining program, including rationale.
2. August—Show senior management, accept input, and make changes.
3. August—Present program to leadership team of all managers at monthly meeting.
4. September—Revise employee handbook to include Healthy Lives program.
5. September—Develop forms and program methodology. Present design to senior management, including goals.
6. October—Present jointly with human resources at open enrollment meetings so that employees learn about the changes in health screening, the new disease management program, and the incentives. Have a sign-up booth at open enrollment meetings to answer questions and enroll volunteers into disease management programs. Provide participants with handouts. Enroll participants in November wellness screening sessions.
7. November—Perform health screening, and coach all disease management participants. Explain what participants must do for their particular health conditions.
8. December—Present baseline statistics to system management team.
9. January—Provide incentives to those who participated in screening, coaching, and education.
10. February—Receive first quarterly reports, submitted by disease management participants.
11. February—Reward participants who completed online education programs.
12. March—Send incentives to first-quarter participants. Present first-quarter results to management team in relation to goals for hypertension and diabetes.
13. May—Analyze second-quarter reports.
14. June—Send second-quarter incentives. Present two quarters of results to senior management team.

15. August—Receive third-quarter reports.
16. September—Reward third-quarter participants. Report results to senior management.
17. October—Announce 2004 program of hypertension, diabetes, lipids, and obesity, and enroll participants.
18. November—Year-end screening for 2003 participants and 2004 screening for year two programs. Turn in fourth-quarter disease management reports.
19. December—Receive fourth-quarter incentive.
20. January—Start the cycle again. Report full-year results.
21. July—Report financial results of plan for 2003, and productivity and progress for current participants.

Healthy Lives Program—Making the Changes

Healthy Lives is a corporate-wide health promotion and disease prevention program that emphasizes hands-on assessment, education, personalized commitment, goal setting, and coaching for all employees and their spouses. The initial health assessment process allows population screening and early identification, as well as intervention opportunities. Additionally, individuals with diabetes, obesity, hypertension, and hyperlipidemia are invited to participate in an intensive, personalized program to live a healthy lifestyle. The program is an on-site health initiative that blends health promotion with disease and case management to achieve remarkable results for participants.

This "case study" presentation reviews the steps and interventions that resolved problems.

The ActivHealth health assessment tool and online educational Personal Health Development programs that were developed by Duke University were licensed for use in Healthy Lives. Results of health screenings were available in an access database from which queries could be generated by the vendor and by St. Mary's. Claims and pharmacy data were available to the health plan. An access database was developed to store clinical information, according to the critical measurements identified. The Work Limitations Questionnaire (WLQ) from Tufts–New England Medical Center was the tool selected to monitor absenteeism and presenteeism.

Management and human resources had feedback in the form of aggregate data compared with national benchmarks. The year two 2004 program included hands-on quarterly coaching, where participants were being evaluated and coached on current progress in relation to pre-set goals. More exercise and nutrition classes were added at Health Matters, and pharmacists attended exercise classes to educate participants on disease-specific medications. Fitness and nutritional analysis was added in 2004, at the request of participants.

This program has been very successful in improving the clinical and financial performance of Healthy Lives participants. The program was presented at the Ninth Annual Disease Management Congress in Boston in September 2004 and has been successfully sold to other area employers.

Healthy Lives Results

Diabetes Program Results: Clinical results from year one were impressive. For example, at the end of the first year, 69 percent of diabetics achieved glycolated hemoglobin (HbA1c) levels of less than 7.0, compared with 43 percent at the beginning of the year. Statistically significant improvements in blood pressure, weight reduction, and compliance with national guidelines for monitoring the urine, eyes, and feet were also noted.

Hypertensive Results: At the beginning of the project, 57 percent of the hypertensive participants had blood pressure readings of less than 140/90. (Results are available in more detail and in graphics displays.) Seventy-five percent or more of participants in the hypertensive program achieved blood pressures of less than 140/90 for 9 of 12 months. They also had significantly improved results in other clinical measures.

In year two, beginning in November 2003, participants began to be measured using the WLQ, a Tufts-New England Medical Center productivity tool, to better assess the total costs of having a chronic health condition (see **Table 19–3**).

Table 19–3 Managing the Change Process

Process	*Issues*	*Resolution*
Outlining the Program and Developing Forms, Processes, and Baseline Measures (August)	1. Process took more hours than anticipated. 2. Everyone had different ideas. 3. Search of literature showed congruence on major lifestyle health conditions; paucity of actual measures. 4. Medical claims database massive and time-consuming to analyze. 5. Outcome measures needed to be simple, focused.	1. Consultant served as facilitator in driving work. Both the director of health promotion, the medical manager, and the medical director had experience in change process. The team worked well together, split tasks, and spent extensive overtime to meet deadlines. 2. Use physician consultant and medical director to get support of senior management.
Selecting the Health Conditions	1. Conditions needed to be modifiable by lifestyle changes and quantifiable.	1. The MD consultant and medical director helped with the literature review. The Physician Advisory Council reviewed information and advised Healthy Lives staff.
Open Enrollment Presentation and Employee Handbook Changes	1. Educate senior management, leadership team, and human resources prior to open enrollment. 2. Response to programs was overwhelming and much greater than anticipated. 3. This totally new approach was hard to understand.	1. Accommodate those who meet criteria, assuming that some will not follow through with program requirements. Healthy Lives leaders had to prioritize time and arrange additional meetings to meet with participants to explain how the program works.
Health Screening	1. Participants were at all socioeconomic levels; some were barely literate, and others were educated but in denial. 2. It took longer to take the computerized assessment than planned. 3. Many had limited computer skills.	1. Healthy Lives staff had to make adjustments as needed.
Structure	1. Some participants stated they could not progress without structure. 2. Many wanted to change, but did not know how. 3. Physician's releases needed.	1. Need for structure and hands-on help led to special exercise class for diabetics and hypertensives that followed American College of Sports Medicine guidelines. 2. Staff had to assist participants in getting releases and had to budget time/be available in classes as resources. 3. Additional needs for structure will have to be addressed in year two program.
Reporting	1. Database needed to be built for clinical information. 2. Data entry for health plan medical management needed to be streamlined, accurate, and complete. 3. Medical and pharmacy claims needed to be mined to determine health plan costs.	1. The medical director and medical manager wrote a letter explaining the program to physicians and presented the program initially and when results were available at a medical staff luncheon. Case managers worked with physicians to resolve individual participant problems.

Incentives	1. Changes in the budget caused the accountants to have problems in paying incentives. 2. Incentives were taxed.	1. The team was expanded to include other health plan professionals with experience in database design, projects, and claims analysis.
Physicians	1. Patients had to be educated about their health and screening results, so that they could discuss them with their physicians. 2. Written materials and formal education were needed.	1. This took member education and multiple meetings with finance. Rules had to be set to encourage compliance with rules, while not discouraging the newly motivated.
Telling the Story	1. The program was multifaceted and complex. 2. Pressure to get results that can be marketed to other employers. 3. Measurement needs to be relevant and simple.	1. Access database allowed multiple sorts to identify outliers needing special attention. It also enabled rapid analysis of results. 2. Financial results were delayed for seven months to incorporate data on 2003 claims.
Measuring Productivity	1. The PTO system does not track the reasons for days off. 2. The system does not track presenteeism.	1. The health promotions director and the medical manager attended the 2003 Annual Institute of Productivity Management conference and were able to identify a tool, connect with the author, and secure permission to use this reliable and valid tool.

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In year two, second-year participants had consistently higher results than the new program participants. For example, results in the hypertension program were as follows:

- Hypertensive patients in Healthy Lives cost the plan one-half as much as nonparticipants.
- Diabetics in Healthy Lives cost the health plan one-third less than nonparticipants.

Summary and Application of Healthy Lives Programs to Other Work Settings

The Healthy Lives Program has been very successful. This case study has focused on introducing a major change into a large health system. Results were successfully measured, but a presentation of these outcomes is beyond the scope of this case study.

General principles learned from this project are as follows:

A. Disease management is a continuation of the employer's commitment to workplace wellness promotion.

B. Disease prevention/management involves the following steps:

1. Analyze the claims experience to identify the chronic health conditions that are most prevalent in the work population.
2. Determine which conditions can be most effectively modified by lifestyle changes or modifications in work patterns.
3. Further narrow the list by identifying the cost/benefit of implementing each program.
4. Design a high-touch program that is result-oriented, simple, and based on self-responsibility and continuous learning in collaboration with the physician's plan of care for participants.
5. Invite participants, and think of creative, tangible programs and incentives to keep them interested.
6. Emphasize education and coaching, supported by helpful ideas and resources to make

essential life changes.

7. Capture the spirit of the culture and strive to recruit company leaders to set the example.
8. Infuse a measure of fun and provide special one-to-one attention for individuals who are not progressing.
9. Measure the outcomes quarterly, using these results as a springboard for fine-tuning the approach to individual participants.
10. Add a productivity measure so that the full impact of illness can be calculated on absenteeism and presenteeism.
11. Evaluate self-concept and changes in health status, along with financial, clinical, and productivity measures to assess impact.
12. Identify and discuss the 12 steps for implementing and monitoring a change management program.

Principal Project Managers

Kishor R. Bhatt, MD, Medical Director, St. Mary's Managed Care Services

Dr. Bhatt completed medical school in India at M.P. Shah Medical College, where he also did a rotating internship. He then went to Metropolitan Medical Center in Minneapolis for a second rotating internship. From there he moved to the Bronx, where he became chief resident in pediatrics at Misericordia-Fordham in New York. After working in private practice in the Bronx, he moved to Southern Indiana, where he was director of the Pediatric Clinic and later chairman of pediatrics at St. Mary's Medical Center. He also served as chief of staff at St. Mary's Warrick Hospital. Dr. Bhatt is board certified in pediatrics, serves as chief of pediatrics at St. Mary's Medical Center, has expertise in quality and utilization management, is currently in private practice, and works as the medical director for SelectHealth Network. He also has several systemwide appointments, where he serves as an advocate for health care quality, a peer educator in managed care, and a member of the hospital patient care evaluation committee and the managed care executive team.

Barbara E. Rutkowski, EdD, MN, Medical Manager, St. Mary's Managed Care Services

Ms. Rutkowski earned her bachelor's and master's degrees in nursing from the University of Florida and received her doctoral degree in higher education and administration from Indiana University. She has authored four books (two were named *American Journal of Nursing* Book of the Year) and multiple professional articles and book chapters, and she has published two national employment and labor law newsletters with her attorney husband for the past 19 years. Over the past 10 years, she has created and currently manages credentialing, quality, site visits, utilization, clinical risk, and case/disease management programs for St. Mary's Managed Care Services. The network spans the Illinois, Kentucky, and Indiana tri-state area and has full URAC Health Network and Utilization Management Accreditation. Dr. Rutkowski has been active in community affairs and has spoken at conferences conducted by the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services. She has recently served on a Joint Commission advisory group in managed care and is on the advisory board for the *Journal of Nursing Risk Management*. She has also presented hundreds of management workshops across the country.

Cynthia Williams, RN, BSN, Director of Health Promotion, St. Mary's Medical Center

Ms. Williams graduated from the University of Evansville with a bachelor's degree in nursing. For the past 20 years she has been in health promotion. In 1992, she was promoted to director of health promotion for St. Mary's Medical Center. In addition to overseeing the wellness program for employees, she has developed and implemented numerous creative wellness programs in business and industry throughout the tri-state area. Ms. Williams regularly does formal presentations at seminars, at company retreats, and at other businesses. Together with Ms. Rutkowski, she has created and beta-tested the Healthy Lives program.

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REFERENCES

Armenakis, A. A., Harris, S. G., & Mossholder, K. W. (1993). Creating readiness for organizational change. *Human Relations, 46*(6), 681–704.

Bareil, C., Savoie, A., & Meunier, C. (2007). Patterns of discomfort with organizational change. *Journal of Change Management, 7*(1), 13–20.

Borkowski, N., & Allen, W. (2002). Using organizational behavior theories to manage clinical practice guideline implementation. *Journal of American Academy of Business, 1*(2), 365–370.

Carroll, L. (1865). *Alice's adventures in wonderland*. New York, NY: Penguin Putnam.

Fischer, E., Berwick, D., & Davis, K. (2009). Achieving health care reform: How physicians can help. *New England Journal of Medicine, 360*(24), 2495–2497.

Gadiesh, O., & Gilbert, J. L. (2001). Transforming corner-office strategy into frontline action. *Harvard Business Review, 79* (5), 73–79.

Kirkpatrick, D.L. (2001). *Managing change effectively: approaches, methods and case examples*. New York, NY: Routledge

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review, 73*(2), 59–67.

Kotter, J. P. (1996). *Leading change*. Boston, MA: Harvard Business School Press.

Kotter, J. P., & Cohen, D. S. (2002). *The heart of change*. Boston, MA: Harvard Business Review Press.

Lewin, K. (1947). Frontiers in group dynamics. *Human Relations, 1*(1), 5–41.

Lippitt, G. L. (1973). *Visualizing change: Model building and the change process*. La Jolla, CA: University Associates.

Palmer, I., Dunford, R., & Akin, G. (2009). *Managing organizational change: A multiple perspective approach*. New York, NY: McGraw-Hill Irwin.

Roethlisberger, F. J. (1941). *Management and morale*. Cambridge, MA: Harvard University Press.

Senge, P. M. (1990). *The fifth discipline*. New York, NY: Doubleday.

VanDeusen Lukas, C., Holmes, S. K., Cohen, A. B., Restuccia, J., Cramer, I. E., Shwartz, M., & Charns, M. P. (2007). Transformational change in

health care systems: An organizational model. *Health Care Management Review, 32*(4), 309–320.
Weiner, B. J. (2009). A theory of organizational readiness for change. *Implementation Science, 4*, 67. doi:10.1186/1748-5908-4-67
Wheelen, T. L., & Hunger, J. D. (1998). *Strategic management and business policy* (6th ed.). Upper Saddle River, NJ: Addison Wesley.

OTHER SUGGESTED READING

Bardwick, J. M. (1991). *Danger in the comfort zone*. New York, NY: AMACOM.
Burke, W. W. (1987). *Organization development: A normative view*. Upper Saddle River, NJ: Addison-Wesley.
Lewin, K. (1951). *Field theory in social science*. New York, NY: Harper & Row.
Mone, M. A., McKinley, W., & Barker, V. L. (1998). Organizational decline and innovation: A contingency framework. *Academy of Management Review, 23*, 115–132.
Riggio, R. E. (2003). *Industrial/organizational psychology* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
Sheehy, G. (1991). *New passages: Mapping your life across time*. New York, NY: Random House.
Tomasko, R. M. (1987). *Downsizing*. New York, NY: AMACOM.
Zand, D. E. (1995). Force field analysis. In N. Nicholson (Ed.), *Blackwell encyclopedic dictionary of organizational behavior*. Oxford, U.K.: Blackwell.

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