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WORKSHOP IN HEALTH ADMINISTRATION STUDIES

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"Lessons from the Hospital Leadership Project"

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HEALTH SERVICES RESEARCH AND MANAGEMENT WORKSHOP

April 19, 1990

"LESSONS FROM THE HOSPITAL LEADERSHIP PROJECT"

by

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TO SERVE AND TO LEAD

A DEVELOPMENT WORKSHOP FOR LEADERS OF HOSPITALS AND HEALTHCARE ORGANIZATIONS

Participant's Workbook

Foundation of the American College of Healthcare Executives
The Hospital Research and Educational Trust
Chicago, Illinois 1990

CONTENTS

INTRODUCTION

"To Serve and To Lead" is an original short play created expressly to develop more effective hospital leadership. The performance you will see was video recorded so that groups of hospital and healthcare leaders—trustees, physicians and other caregivers, executives—would be able to sit together and view the dramatization as an experience in common. As will become clear, the behavior depicted in the video is not intended to be viewed as behavior to emulate!

The video and supporting materials were developed as an integrated package that would give hospitals a framework on which to build their own leadership development workshops. The intent of such workshops is to enable leaders to explore together conflict-related issues such as trust, understanding the importance of hospital leaders' roles and responsibilities, and the importance of sharing values and objectives. By doing so, the participants should gain insights that will make their subsequent dealings with actual conflicts more understandable and manageable.

An important premise of this development program is that effective hospital and healthcare leadership must be collaborative. Such leadership involves unique but interrelated contributions of effort by trustees, physicians, and management.

Any resemblance in this material to actual individuals, institutions, or communities is unintentional and coincidental.

WORKSHOP OBJECTIVES

As a result of participating in this program, the audience should:

1. recognize the personal attributes associated with effective leadership;

2. develop an appreciation for the importance of trust in achieving effective collaboration and an understanding of the origin of threats to the preservation of trust; and

3. comprehend the potential for conflict in a competitive healthcare setting and be familiar with ways to optimize relations among parties that have both common and divergent interests.

DOCUMENT TWO

HISTORY OF THE COMMUNITY HOSPITAL OF MILL CREEK

Mill Creek was founded in 1839 by lumbermen. It grew slowly—first in lumber harvesting, then as a farm community. Following the Civil War, the population of Mill Creek grew rapidly. The community inherited its share of Reconstruction Era problems, among them the needs of widows and orphans. Through the concerted efforts of the community's largest religious congregation, the First Avenue Baptist Church of Mill Creek, the Mill Creek Home for Destitute Women and Children was established in 1871. By the turn of the century it had become a hospital and home for the infirm. Throughout its early history, the Home relied principally on the community's Baptist congregation for support. Once it took on a medical mission, however, the institution's financial needs quickly outstripped the congregation's philanthropic resources.

Following World War I, the First Avenue Baptist Church sought to divest itself of the financial burden of the hospital and home. Working with civic leaders, the church elders arranged to transfer ownership of the facility to the Hospital Association of Mill Creek. In consideration for the $1.00 sale price, the Association agreed to retain the chief pastor of the church as a "member of the hospital and home executive board in perpetuity." The institution became known as the Community Hospital of Mill Creek. The home for the infirm was demolished and its role assumed by the county home.

The 1950s were a time of growth for the community and the hospital. In 1954 the original facility was replaced by a 240-bed edifice, with the assistance of the Hill-Burton program. The city experienced suburbanization, particularly on the east side of the river. In 1958, a rift occurred in the First Avenue Baptist Church that had two results. The more traditional faction decamped and relocated to the new Timber Ridge subdivision on the east side of the river. The parishioners who remained were unable to afford their independence. In 1960, they sold their building and property to the community's largest black congregation. In 1961, that congregation rededicated the sanctuary as the home of the First Avenue Ebenezer Baptist Church of Mill Creek. In 1962 the chief pastor asserted his historical claim to be seated on the executive committee of the Community Hospital of Mill Creek. In 1964, the court upheld his claim.

With the advent of Medicare and Medicaid, healthcare became an expanding sector of the Mill Creek economy. From the mid-1960s to the mid-1970s, the Community Hospital of Mill Creek dedicated itself to being a full-service medical center. Many physicians on the faculty of the Craig State University School of Medicine made the Mill Creek area their vacation home. Consequently, the hospital enjoyed an unusually large number of specialists on its medical staff, both as consultants and active members. Their influence was evident: The hospital was among the first in the region to offer ICU, CCU, and CT scanning services.

The late 1960s also heralded the addition of two newer but smaller hospitals in the eastern part of the county in what had been the fastest growing segment of Community Hospital's primary service area. In 1966, Mill Creek Memorial Hospital opened. In 1969, the Mills Falls Osteopathic Medical Center opened in that community on the eastern border of the county.

From the late 1970s through the mid-1980s, Community Hospital doggedly pursued the status quo. While hospital administrator Fletcher Fisher provided a friendly and paternal presence, board chair Douglass Newberry provided vision for the hospital until his death in 1985. Mr. Fisher took an early retirement in 1987. Francis Whitson served as interim administrator until he was replaced by Jim McAddamms, the present hospital CEO.

DOCUMENT FIVE

THE PLAYERS

(in order of appearance)

Melvin Walanek. Vice chair of the board and member of the Executive Committee. One of the state's leading insurance brokers. In the 17 years he has lived in Mill Creek, Melvin has earned the respect of the community through business success and his service to many civic and service organizations. He has a perfect attendance record for hospital board and committee meetings.

Margaret Wellington. Administrative secretary for Jim McAddamms, the hospital's CEO. Known to all as Peggy, the hospital is the only place she has ever worked. Prior to being promoted by Mr. McAddamms, Peggy worked in Pediatrics, the Newberry Clinic, and in medical staff relations.

Alicia Newberry. Widow of industrialist/philanthropist Douglass Newberry, a past board chair of the hospital. She joined the board five years ago and was suggested for the Executive Committee by the previous CEO (who knew she was an active participant in her husband's commercial success).

Karen Farrington. Chair of the hospital board and executive vice president of the Mill Creek State Bank, which her family has owned for three generations. Since she is the only one of the Farrington children with an interest in the family business, her father is mentoring her. She has a prestige MBA and worked briefly with an investment bank's mergers/acquisitions department. The youngest person ever selected to the hospital board, she headed the Finance Committee before becoming the first woman to chair the board.

Reverend Gerald Thompson. Head pastor of the First Avenue Ebenezer Baptist Church, the community's largest congregation. He was born in Mill Creek and has lived there all his life. He is *the* black leader in Mill Creek and has served on the boards of virtually every major service organization. Owing to the church's role in the founding of the hospital, his position on the Committee is mandated in the hospital's charter.

Jim McAddamms. Chief executive officer of the Community Hospital of Mill Creek for about 11 months. An MBA with a healthcare specialization, he is the first in his graduating class to make it to the top. The hospital bylaws, enacted under Douglass Newberry's chairship, made the CEO an ex officio member of the Executive Committee without a vote.

Dr. Stuart Magrini. President of the medical staff. He came to the Community Hospital of Mill Creek after completing his internship over 23 years ago. He has been president of the staff before and has also headed the county and state medical societies. He, too, is an ex officio member of the Committee without a vote.

Fred Jones. Treasurer of the board and member of the Executive Committee. He is also chair of the board planning committee and president of Mill Creek Steel Specialty Company. He was named the Mill Creek "Entrepreneur of the Year" twice in this decade. Fred is the first member of his family to be management, not union.

TOPIC ONE

LEADERSHIP

While "To Serve and To Lead" contains several issues important for hospital leaders to consider, the suggested starting point is the topic of leadership. Without an understanding of what is expected of contemporary leaders, especially hospital and healthcare leaders, meeting those expectations is virtually impossible.

The resource material section highlights the attributes of effective leaders of large-scale organizations. It also notes the behaviors and functions a leader needs to get the most out of a small group of decision makers. Sources that consider the importance of collaboration in leadership are found in Section Four.

UNDERSTANDING LEADERSHIP

Understanding leadership is a prerequisite to becoming an effective leader. Two often relied upon approaches for conveying an understanding of leadership are examining the attributes of effective leaders and enumerating the functions of leaders.

A subtle problem with examining the attributes of effective leaders becomes evident when one considers the question, "Effective when?" The style of leadership that works in one situation—say, a time of organizational crisis—may not be effective in a different circumstance, such as a period of organizational opportunity. In "Good Managers and Good Leaders," Warren Bennis reports the common traits he found among the nation's most successful leaders during an ebb in national leadership and commitment.[1] Healthcare may be in similar straits as it confronts a turbulent environment. In looking for effective leadership, Dr. Bennis took care not to contaminate his results. His focus was on good leaders, people who do the right thing. It was *not* on good managers, people who do things right. He found four competencies in common:

1. They have a vision or agenda and communicate their commitment to it so well that others are attracted to its pursuit.

2. They succeed by communicating their vision with such effectiveness that their message permeates the layers of their organization.

3. They engender trust through their constancy and reliability.

4. They foster an environment that supports risk taking, based on a belief in individuals' competence (especially their own) and the ability to learn from mistakes.

Leadership can be said to occur when the functions of leadership are fulfilled. The functions of leadership should not be confused with a list of responsibilities associated with a

[1]Warren Bennis, "Good Managers and Good Leaders," *Across the Board* (October 1984): 7–11.

specific organization. They can be more readily understood when thought of as helpful ways to play one's real life role. In *Group Process for the Health Professions*, Ed Sampson and Marya Marthas cite a list of leadership functions developed by Lippet:

1. Help the group decide on its purpose and goals.
2. Help the group focus on how to work together effectively to avoid becoming trapped by faulty problem solving and decision making.
3. Help the group become aware of its own resources and how best to use them.
4. Help the group be receptive to new or different ideas without becoming immobilized by conflict.
5. Help the group evaluate its progress and development.
6. Help the group learn from its failures and frustrations as well as from its successes.[2]

By thus playing the role of group member, anyone can carry out leadership functions. In fact, for a group facing the complex challenges of a hospital executive committee, it may be impossible for a single individual to perform all these functions. Leadership behavior from any committee member would represent an important contribution to the group's effectiveness.

Differences of opinion are a reality of our personal and professional lives. Since diverse perspectives often produce better solutions to group problems, effective leadership creates an environment that permits constructive disagreement, but that does not allow degeneration into destructive conflict.

Citing the research of Maier, Sampson and Marthas offer the following list of leadership behaviors needed to optimize the existence of diverse opinions:

1. The leader is open to accepting disagreements rather than denying their presence.
2. The leader helps the group focus on its mutual interests rather than emphasizing conflict; the leader helps the group realize that its mutual interests can be served through the open expression of disagreement, as long as the long-range goals are kept clearly in mind.
3. The leader adopts a permissive attitude, one that allows members to express diverse opinions without fear of ridicule or rejection.
4. The leader structures the sessions to keep the group focused on issues and goals, and not become lost in conflict or side issues.
5. The leader helps the group avoid a rushed decision, so that a fuller discussion can be generated and disagreements explored.
6. The leader structures the sessions so that idea generation is separate from idea evaluation.

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[2]Edward Sampson and Marya Marthas, *Group Process for the Health Professions*, 2nd ed. (New York: John Wiley & Sons, 1981).

TOPIC TWO

TRUST AND COLLABORATION

Today more than ever, hospital and healthcare leaders find themselves dependent on one another just to survive in the changing environment. With threats arising from competition and regulation, leaders must often move more quickly than they would prefer. In such situations, trust becomes extraordinarily important. Where trust exists, collaboration may flourish. In its absence, the potential for destructive conflict is ever present.

The resource material for this section examines several factors related to effective collaboration. Trust and communication, attributes ascribed to effective leaders, receive attention. So does the issue of "turf invasion," insofar as board–executive relations are concerned. Some material suggests how to do what is right. Equally important is the material that discusses the challenge of achieving effective collaboration.

TRUST AND COLLABORATION

In today's turbulent healthcare environment, making timely, effective decisions is critically important. For hospital leaders, crucial decisions increasingly involve collaboration between physicians and the hospital. Achieving effective partnerships demands effective communication, understanding, and trust. There are significant hurdles to overcome if hospitals and physicians are to collaborate for their mutual advantage and survival.

In "Five Roadblocks to Effective Partnerships in a Competitive Health Care Environment," Sandra Gill and Spence Meighan outline the barriers to collaboration.[1] First, whether right or wrong, many physicians feel betrayed by the changes occurring in healthcare. The intensity of their feelings may vary by age and specialty, but virtually all practitioners feel threatened. Like anyone who feels threatened and angry, they become more difficult to work with.

Fear, the second barrier, afflicts doctors, administrators, and board members. At risk are the success of medical practices, the executive's employment, and a potential financial liability for trustees (who bear a fiduciary responsibility for the hospital). Fear produces a number of divisive consequences: unconscious collusion to attack an innovation perceived as threatening; pervasive pessimism that saps organizational energy; and, aggravation of the adversarial aspects of relationships, so that "win-lose" problem solving operates to the exclusion of collaborative approaches. Worst of all may be fear's impact on trust.

Gill and Meighan cite a model of trust composed of predictability, dependability, and faith. In this model, predictability indicates the ability to foretell how someone will behave. While we need predictability for complete trust to exist, it alone is not sufficient: People are sometimes predictably selfish, uncooperative, or deceitful. Dependability indicates that one will act in a partner's best interest even when not face-to-face. This develops through successive positive interactions where one partner could not realize goals without

[1]Sandra Gill and Spence Meighan, "Five Roadblocks to Effective Partnerships in a Competitive Health Care Environment," *Hospital & Health Services Administration* (Winter 1988): 505–16.

the cooperation of the other. Faith means belief in a partner's trustworthiness. As a belief, it may be based more in emotion than logic. With faith, a high-trust relationship is possible; without it, only a low level of trust can be achieved.

Misplaced belief in the efficacy of new organizational arrangements is a third barrier to effective partnerships. An example is putting all one's eggs in the basket of restructured governance to solve relationship problems. Increasing physician membership on a board is an example of a structural approach, often undertaken without regard to process concerns. If the physician board member serves as a representative of the medical staff, he or she may maintain the ideal balance between business concerns and clinical priorities. When the physician board member becomes an advocate for the medical staff, his or her role is in forcefully presenting the staff's collective thinking on governance issues. Unless assumptions regarding physician board member roles are examined, individual physician board members may not see collaboration as a goal. Often, peer pressure may dictate advocating solely for the economic interests of physicians.

A fourth barrier is the lack of understanding, preparation, or acceptance of leadership roles and responsibilities. When a partnership requires collaboration in role performance, the absence of a critical part may leave a nonfunctoinal "whole."

The fifth barrier is underdeveloped group process skills. The intent to be good leaders can be undermined by problems that commonly afflict task groups: conflict, self-centeredness, "group think," and the inability to be forgiving.

Unless hospital leaders acknowledge that environmental change produces interprofessional strains, they will be unlikely to remove the identified barriers. If the barriers remain, effective collaboration cannot be achieved.

TOPIC THREE

CONFLICT

Although conflict is endemic in organizational life, individuals tend to have such an aversion to it that they let conflict manage them instead of managing the conflict. Accepting the inevitability of conflict is the first step toward building relationships that permit collaborative leadership to flourish. Optimizing conflict is the problem-solving strategy that may allow hospitals and physicians to coexist in a turbulent competitive environment.

The resource material in this section defines conflict situations, and common approaches to dealing with conflict. While there is no way to eliminate conflicts entirely, preserving and building trust may reduce the number and intensity of conflicts that do arise.

ON CONFLICT

Paul Preston defines conflict as a situation where two or more parties have objectives that are, or at least appear to be, in opposition.[1] At a more advanced stage, solutions to conflicts are or appear to be mutually exclusive. In either case, the contending parties must have some ability or power to go ahead with an action that upsets the existing situation. Otherwise, we have a difference of opinion without the ability to resist the prevailing side and, hence, no conflict.

Preston observes that even though conflict is an almost daily experience in management, most people have a one-sided view: conflict is a step down the road to aggression, hostility, and other unpleasant, unproductive behaviors, and is to be avoided. Few people realize that conflict can be managed. Fewer still know that, managed properly, conflict can lead to creative, positive outcomes. This enlightened minority does not include those people who believe that when an immediate conflict situation is defused, it is no longer a concern. Disregard for the aftermath of a conflict-ending arrangement can plant the seeds for even more bitter conflicts or invite sabotage of a one-sided "settlement."

Preston outlines three of the most common approaches for dealing with conflict. One is *conflict suppression*. Suppressors either ignore the conflict or they acknowledge it by attempting to prevent "conflict behavior" from being acted out. When conflict is ignored or suppressed, the contending interests become frustrated, so whatever "peace" is created must be regarded as temporary, at best.

Conflict resolution, a second approach, does acknowledge that a conflict exists. Would-be resolvers try to eliminate the conflict by getting rid of the source or by exposing the conflict to open and public examination. This approach may work, but only on rare occasions. What limits such efforts is the episodic nature of conflict in organizations: Today's conflict is causally connected to previous conflicts and to conflicts yet to occur. Before expecting unrealistically good results from efforts at resolution, it is important to recognize how little

[1]Paul Preston, Ph.D., "Productive Conflict Management," *Administrative Radiology* (June 1988): 26–30; and, "Optimizing Conflict Through Problem Solving," *Administrative Radiology* (July 1988): 34–37.

can be achieved in the short run when major forces outside our control establish the basis for future conflicts.

Conflict management is a third approach. Its practitioners adopt the long-term view in which peace is not regarded as an end to conflict. Instead, they see peace as a way of successfully living with conflict. Their objective when working with conflict is to create a good working relationship for the future. Conflict managers can choose among a number of *passive* and *active* strategies. Avoidance, doing nothing about the conflict, is an obvious passive strategy. This short-run approach may make sense when passions are running so high that trying to find a solution now may result in a divisiveness so great that the relationship becomes permanently damaged. It also applies in those situations where each of a number of conflicts requires full attention. Avoidance then becomes a way of prioritizing.

Smoothing is another passive approach with short-run applicability. Those who would smooth over a conflict often emphasize the contending parties' common interests in order to cool down heated rhetoric. Here, its practitioners count on the situational factors changing so that the causes of conflict go away. Then, a long-run solution may become possible. This time-buying measure may backfire, however, if those in conflict feel their concerns are being ignored or sense they are being patronized.

Among the active conflict management strategies, competing only for one party's self-interest at the expense of others is the approach with the highest potential for a serious negative aftermath. Making such a "win-lose" strategy work depends on the winner having enough power to compel the loser to accept the so-called solution. There are several drawbacks to managing a conflict in a "win-lose" mode:

- Creativity is stifled. There is no need to consider alternatives when power can compel one solution.
- If the power is not sufficient to compel a solution, parties react to all or nothing offers by hardening their positions.
- The hostility engendered may make working together impossible, even on nonconflict related matters.
- The loser may engage in sabotage.

Another active conflict management strategy is compromise. Here, the conflicting parties reach an agreement by splitting the differences dividing them. While politicians may consider compromise art of the highest form, in organizational life it must be regarded much more modestly. Often, compromise cannot be reached in the absence of a high degree of trust between the parties. An outside party with the power to enforce a deal sometimes can substitute for trust, but, at the governance leadership level, finding such a powerful outside force is highly unlikely. Even when contentious parties strike a compromise, there is no guarantee that they will be happy with the result and not move on to a further round of conflict.

Problem solving is the most challenging and most promising active strategy for managing conflicts. It requires the participants to seek common points of agreement while focusing on mutual problems. For problem solving to work, the parties must shift their focus from assigning blame to discovering an *overall remedy*. They can achieve a "win-win" solution, wherein all parties commit to an optimal settlement rather than grudgingly agree to a

compromise that leaves an "us versus them" attitude. A solution is not optimal if it leaves hidden agendas, the basis for future conflicts.

What makes problem solving or optimizing challenging are the steps involved. Many are contrary to individual human nature, although quite consistent with harmonious group behavior:

- Opposing parties must face each other and approach each other's ideas and feelings head on. Hidden agendas and personality clashes *are* germane. Unless they are addressed, these issues may interfere with problem solving and leave the potential for future conflicts.

- Forget about fixing blame, which can become an end in itself. If that occurs, the real basis for the conflict may go undiscovered and any settlement may be ineffective.

- Don't rush a commitment to a specific solution. Not only does being rigid make negotiating more difficult, it makes it harder to discover an optimal solution that will avoid future conflicts.

- Identify areas of agreement and mutual benefit early on. When all parties are committed to a larger goal, reaching the goal becomes the objective—not emerging as the winner.

- Communicate carefully. How you express yourself may be as important as what you say. Don't use language that makes others defensive, and don't overgeneralize or exaggerate or you will not be perceived as credible.

- Do work to build coalitions for handling future conflicts. A coalition can be the foundation for greater trust. Greater trust may lead to fewer or less serious conflicts.

SECTION FOUR

ADDITIONAL REFERENCES

TOPIC ONE

LEADERSHIP

"Five Leadership Patterns for Contemporary Healthcare Systems" by Andre L. Delbecq. In *Emerging Issues in Healthcare,* edited by Gill and Gallagher. Englewood, Colorado: Estes Park Institute, 1986.

Delbecq reaches back over 50 years to trace the outlines of leadership behavior developed by researchers and analysts. An early concept was the heroic leader. Such individuals possessed the right stuff if they were tall, handsome, masculine, and charismatic. Their leadership was "one man" leadership. In the following era, charisma gave way to humanistic management which involved working with people to accomplish goals. Today, the leader is a culture builder who creates shared expectations and evokes commitment to the organization's philosophy and/or values.

Delbecq found five enduring leadership behavior patterns spanning these eras of leadership. Through *visioning,* leaders provide a sharp sense of the organization's direction. By means of *communicating,* a leader celebrates individual achievements that make the organization succeed and builds integrity by matching his or her deeds to words. Also, leaders use strategic internal and external communication networks to stay current and to appropriately involve formal and informal opinion leaders.

Leaders *inspire* others by focusing on them as the key to success. They see organizations as their personal team.

Leaders *endure* by focusing their scarce energy on a few key issues and delegating less strategic matters. They are physically healthy and keep growing through their outside interests and new challenges.

Leaders manage their environment so that it *fosters innovation* and encourages the *associated risk taking* to reap desired returns on investments.

"Identifying the Right Leader for the Right Situation" by Carl A. Rodrigues. *Personnel* (September 1988): 43–46.

Professor Rodrigues offers the view that organizations in a dynamic environment—such as today's hospitals—go through three stages of change, and that for each stage the most effective leader will utilize different traits and abilities.

Stage one is problem awareness. Here, innovators would be the most effective leaders because such individuals can identify and "sell" new ideas. Stage two is the implementation-of-solution stage. Here the right leader would be the implementator, one who uses his or her need to control and influence situations to establish a systematic program of accomplishment. When the organization's activity subsides into a stable state, the right leader is a pacifier. Such individuals create a friendly, decentralized decision-making atmosphere. This lets members of the organization feel that they can use their competence with

little direction from above. Professor Rodrigues provides a questionnaire to measure what type of leader a manager might be.

"Leadership: Implications of the Literature for Health Services Administration Research" by Richard Kurz and Cynthia Carter Haddock. *Medical Care Review* 46:1 (Spring 1989): 75–94.

This article is most helpful to scholars and researchers who want to organize their thinking before they start an investigation of leadership. The article itself is organized and far-reaching; the bibliography is extensive. It is of value for those with more casual interests as well.

Kurz and Haddock base their discussion on how the analyst decides to approach the concept of leadership. One perspective is the rational system; another is the natural system. They compare bureaucracy and the rational system in which leadership is based on position. The natural system is more akin to ancient feudal traditions; leadership is based on the personal relationship between leader and follower. One view focuses on organizing to achieve goals efficiently. The other view considers effective leadership a matter of being able to relate well.

Under the rational approach, the organization is a tool through which predetermined goals are accomplished. Concern is with structures, not individuals.

In the natural system approach, organizations are not instruments; they are social groups attempting to survive within a particular set of conditions. When the natural system is closed, emphasis is on the individual and the informal structures that develop as a result of diverse individual interests and abilities: power, status, communication, friendship.

If the natural system is open and relating to its external environment, then the concern is with the interdependency of organizations and the distribution of power. Here, leadership can evolve through the ongoing activities of group members. Leaders are individuals distinguished by their ability to satisfy individual needs or to accomplish group goals, or both. The most widely recognized leadership characteristics are consideration (behaviors indicative of friendship, mutual trust, respect, and warmth) and initiative (behavior that organizes roles, communications, and ways of getting jobs done).

"Entrepreneurship Reconsidered: The Team as Hero" by Robert B. Reich. *Harvard Business Review* (May-June 1987): 77–81.

Robert Reich places before the reader two choices regarding the future of American entrepreneurship. The good, old, maybe even patriotic notion is the triumphant individual hero. The new and mysterious notion is collective entrepreneurship which provides economic success through the "talent, energy and commitment of a team." Reich contends that America will be ill-served by continuing to celebrate the myth of the entrepreneurial hero. To compete successfully, we need to honor teams more and our old-fashioned genius-heroes less.

The myth as discussed by Reich holds that there are two sets of actors in business: entrepreneurial heroes and industrial drones. Its appeal was the noble ideal that imagination

and effort bring their just reward. Examples seem plentiful: Rockefeller, Carnegie, Ford, Iacocca, and Ueberroth. They hold center stage while the "drones" labor anonymously, valued for their reliability, pliability, and interchangeability.

Reich considers the myth obsolete because the economy that gave it validity no longer exists. Today, an entrepreneur's vision or bright idea is quickly snatched by foreign competitors. Technology moves overseas and into the hands of often less expensive and more productive labor quickly. Some competitors, especially Japan, have created integrated teams that have done away with the hero-drone distinction. The result is that "our" big ideas go overseas quickly, get produced for less, and undergo continuous improvement. Meanwhile, back at the ranch, we bog down "somewhere between invention (the hero's domain) and production (the drone's domain)."

Reich contends we have two ways to become effective competitors: (1) match the low wages and productive discipline of overseas workers (in a period of labor shortage?) or (2) compete by quickly transforming ideas into incrementally better products. Option two, however, will work only when innovation and refinement become continuous and collective and spread throughout the organization. In such entrepreneurial organizations each advance builds on a previous advance and everyone has the opportunity to participate.

In an entrepreneurial organization there cease to be clear borders to the market for goods and services. Growth is tied to the creative and adaptive capacity of the workers, not to the changes in the market. The organization is constantly reinvented. Coordination and communication replace command and control. The quality of work is often more important than the quantity.

TOPIC TWO

TRUST AND COLLABORATION

"Charting the Territory of Nonprofit Boards" by Richard P. Chait and Barbara E. Taylor. *Harvard Business Review* (January-February 1989): 44–54.

The authors begin with the assumption that a nonprofit organization's board has one responsibility—governing. That means monitoring quality and seeing that the mission is fulfilled. Sometimes, however, boards get into the staff's realm of operations and ignore life-or-death governance issues. Chait and Taylor identify transient and persistent reasons for trustees to delve into operations and management. Transient reasons include temporary need for the trustees' professional expertise, such as finance or real estate, or trustees assuming managerial responsibilities during a crisis. Examples of persistent reasons are the trustee-business executive's propensity to act, not delegate, or the trustee's "pet project" (e.g., a cancer center or family health center), where donations create a special relationship. When trustees dive from the high board of governance into the muck and mire of managing, organizational harm can occur. The damage may be that the trustees lose their objectivity and so the organization becomes captive to special interests. Other examples are loss of vitality, as first trustees (bored with neglecting policy for minutiae) and then administrators (feeling undermined by meddling) resign.

Chait and Taylor cite a spectrum of policy matters (major, secondary, functional, minor, standard operating procedures, rules) and a four-phase policy development process (establishing policy objectives, formulating a policy statement, implementation, and evaluation). Collaboration will be enhanced when trustees and management know and understand their roles in the process. In general, trustees should expend their time and attention on higher-level policy objectives and statements. Then they should *selectively* focus on executing and monitoring higher-level policy. They might devote peripheral attention to developing mid-level policy objectives and statements, but spend little energy on implementation. They should devote almost no attention to any phase of lower-level policy development.

The authors also discuss the need for trustees to be informed with the right information in the right amount. When trustees get management information, instead of governance information the natural tendency is to delve into management. They recommend a governance information system, and suggest that such a system include feedback on trustee performance.

"Communicate" from *Leadership is An Art* by Max DePree. East Lansing, Michigan: Michigan State University Press, 1987, pp. 95–103

In this section of his book, Max DePree, CEO and chair of Herman Miller, Inc., reflects on the importance of good communication in maintaining the common bond of interdependence and mutual interest found in almost all healthy, vibrant organizations. He states that relationships within corporations improve when information is shared accurately and freely. Good communication is an ethical matter in that it means respect for individuals.

DePree suggests that behavior is the best way to communicate the organization's common bonds and values. This means, in part, that communication is more than sending and receiving or mechanically exchanging acts. Good communication forces you to listen.

DePree considers communication skills among a leader's most familiar and trusted skills, but he asserts that a number of obligations must accompany good communications. Leaders must understand that access to pertinent information is essential to getting a job done. Even though information is power, "it is pointless power if hoarded"; power must be shared if an organization is to work.

Communication can help an organization work by performing two functions—educating and liberating. Good communication educates us in what to expect from each other. It liberates when it sets a standard, so that individuals know the right way to respond to the demands placed on them. Especially as organizations grow older and more complex, good communication becomes more crucial. It plays a critical role in passing on basic organizational values to new members and reaffirming those values to old hands.

"Can Doctors and Administrators Work Together" by Sandra Gill. *Physician Executive* (September-October 1987): 11–16.

A tough problem faces complex organizations when they adapt for survival in a competitive environment. Internally, they become more differentiated as their components respond to different market demands and technological breakthroughs. This can create the basis for internal fragmentation. To respond to external threats, however, means the organization needs the collaboration or integration of its special interests to meet competitive challenges.

For hospitals, this is especially difficult as physicians bring with them influence and other traits that make them unlike other healthcare organization members. First, the physician culture has a powerful base in advocating the best care for the patient, period. This not only means that an individual doctor may perceive that management costs come at the expense of patient care, but this perception very likely will receive support from the doctor's colleagues.

Second, tradition and perhaps clinical necessity have conferred considerable authority on the physician in dealing with other healthcare professionals. Behavior that must be tolerated in a doctor's own office may be intolerable when "inflicted" on the cadre of health professionals essential to a hospital. Efforts to harmonize health team interdependence may threaten some physicians' feelings of power and authority, thereby producing alienation from the hospital.

Third, physicians approach their work differently than administrators. Doctors tend to make rapid diagnoses and provide prescriptive instructions that others carry out. Administrators, in contrast, regularly work through committee deliberations. Implementation of committee decisions often is protracted and requires "winning support"; this may involve compromise. Finally, a doctor's clinical effectiveness may depend on almost endless attention to detail. Administrators who delegate all but their highest priorities may be regarded as slackers by the physician whose patients' well-being requires virtual round-the-clock personal attention.

Overcoming these "cultural differences" is made especially difficult as physicians tend to identify more with their profession, particularly their specialities, than with the many organizations to which they belong. A common bond between physician and hospital, for example, is not going to develop quickly or easily. Again, since administrators and trustees typically do not have such strong multiple allegiances, they *do* develop institutional loyalty and commitment quickly. Until and unless all three parties *develop* some common bond, there is room for doubt and distrust.

Gill points out two techniques that may promote integration in a competitive and turbulent environment. Responding to an external common enemy may produce short-run collaboration. If, however, the common enemy is a hollow threat, allegiances can shift rapidly, and then the prospect for enduring collaboration is as unlikely as a long-lived truce in the Middle East.

Developing a common vision is a time-consuming technique that can have enduring impact. Gill presents a dozen steps that aid in building a common vision and cohesive relationships. One is to recognize that a new beginning—a joint venture, for example—is also an ending for a previous set of relationships. Another key is that acknowledging past assumptions may not be relevant in a new environment. Specifically, consensus decision-making among physicians may not be feasible when rapid action is needed.

Consequently, medical staff leaders may need to support controversial action in advance of achieving consensus among their peers. Finally, developing trust takes time. Time spent together leads to really knowing one another and so predictability and confidence in each other's intentions can supplant negative stereotypes.

TOPIC THREE

CONFLICT

Conflict in Organizations **by Steve Turner and Frank Weed. Englewood Cliffs, New Jersey: Prentice Hall, 1983.**

Much of this short book deals with finding solutions for conflicts at or below the middle-management level. Its introductory pages, however, provide a concise overview of common conflict-prone situations and individuals' characteristic styles of response to conflict. Weed and Turner illuminate how individuals' conflict response patterns can exacerbate or ameliorate relations in a variety of typical organizational conflict situations. They are persuasive in illustrating how blaming becomes an impediment for all types of response patterns (avoiders, communicators, confronters) in all types of situations.

Creative Negotiating **by Gordon F. Shea. Boston, Massachusetts: CBI Publishing, Inc., 1983.**

This book deals with the concept of creative negotiating, that is, "using the full mental resources of all parties to a conflict to develop the best possible solution for everyone, so that all parties will be committed to making the agreement work." Shea works at a general level of analysis that accommodates the need to resolve differences between people, groups, or even nations. He identifies and critiques common patterns of response to conflict, the most fruitful of which he terms "synergistic collaboration." For Shea, conflict is the mainspring of negotiations. What people often overlook is a focus on each other's needs as a starting point. Instead, those with conflicts often jump ahead by focusing on their own solution that takes care of their own needs. Shea briefly explores barriers to negotiations, then thoroughly examines the important aspects of establishing and concluding fruitful creative negotiations. He makes an important distinction between bargaining (coming to terms over what is given and received in a transaction) and the broader concept of negotiation which transcends mere price and value considerations. He offers admonitions concerning the application of power to create win-lose "solutions," whether conflict is inevitable or not.

Power in Management **by John P. Kotter. New York, New York: AMACOM, 1979.**

This short book is valuable for two main reasons. First, power is an important consideration in whether conflicts will be addressed and how they may be resolved. Second, very little else has been written that objectively and dispassionately examines power as fact and factor of organizational life. Kotter distinguishes among power (a measure of one's potential to get others to do what he or she desires or to avoid being compelled), power-oriented behavior (actions to acquire or use power), and power dynamics (interpersonal interactions involving power-oriented behavior). Kotter offers an important insight to the emergence of power dynamics. They develop because the *dependence* inherent in managerial jobs is greater than the power or control given to the people in those jobs. Dependence is present

because managerial work (accomplishing results through others) involves ceaseless dependence on the activities of a variety of other people. Kotter discusses methods for acquiring and holding power, and basic methods of using power to influence others. He also examines the misuse of power in instances involving personal integrity or a mismatch between a manager's level of dependence and level of power skills. This latter illustration is particularly important to hospitals and health organizations where a manager's job-related dependence is so great that power acquisition and maintenance may consume 80 to 90 percent of a chief executive's day. A plant manager, in contrast, may devote only one-third the time to the same activities.