CHAPTER 1 ►

Becoming Master Leaders in Healthcare Organizations

LEARNING OBJECTIVES

Students will be able to:

- Contextualize and compare the cost-driven environment of the US healthcare system to other developed countries
- Recognize the economic pressure for reform and the need for a master leader in healthcare organizations
- Understand that the skills needed to manage a healthcare organization are complex, interdependent, and multidimensional
- Identify executive roles and competencies and how they are integrated into important managerial leadership responsibilities
- Analyze the conditions for building strong culture and crafting appropriate message orientations
- Distinguish effective communication strategies for handling internal and external stakeholders

Introduction

Healthcare leaders face unprecedented challenges: a shortage of key workers; millions of first-time recipients of health insurance; an aging population; a need to fortify evidence-based quality systems; technological changes that dramatically influence the nature and exchange of information; emerging treatment modalities that alter how and where medical care is administered, and pressures to contain costs and develop strategic alliances. Healthcare organizations require leaders to have one foot planted in an uncertain future and the other in a present that requires maintenance of operations.

Leadership and management function differently. Management strives for control and predictability. Leadership relies on influence to position the organization for success in a dynamic environment. Rather than striving for permanence and stability, leadership focuses on change and adaptability. Considerable organizational fortitude is required to prevent leadership and management from succumbing to natural tensions between them, particularly as such tensions manifest in healthcare organizations.

These seemingly contradictory orientations are unified in the world of the master leader. The concept of *master leader* represents an integration of the roles and functions associated with preserving order, stability, and control on the one hand, and constructing a vision, directing change, and inspiring a work force on the other. Master leaders possess the capability, flexibility, and dexterity to implement a broad range of communication options to achieve organizational goals. Herein, we identify communication orientations and message construction strategies associated with the responsibilities of the master leader in healthcare organizations.

The competing values framework (CVF) provides the theoretical basis for defining how paradoxically related roles can become compatible in order to address the complex, unprecedented challenges healthcare organizations face.

Changes and Trends in Health Care

Prior to World War II, just 10% of the nation's workers were covered by health insurance provided by their employers. At the time, health insurance was inexpensive, and with wage controls in place during the war, employers began to offer health insurance as a means of enticing prospective employees to join their organizations. By 1950, the number of workers receiving this benefit jumped five fold, to 50%. In 1965, the federal government implemented Medicare and Medicaid, which extended health coverage to the elderly and the poor, respectively. So, in a relatively brief period (less than 20 years), systems were implemented and programs were enacted such that sizable segments of the population—workers, those hovering at or below the poverty line, and senior citizens—would have their healthcare needs paid for by third parties. We became a nation of people covered by health insurance. Not surprisingly, the healthcare industry grew, and it grew at almost exponential velocity during the following decades; indeed, in 1960, national health spending accounted for 5.2% of GDP and escalated to approximately 17% by 2010 (Highlight Health, n.d.).

Interestingly, and in retrospect, we might even say *amazingly*, the insurance system remained largely cost-based for decades to come, just up to the very latter part of the 20th century (Shi & Singh, 2008). Under this arrangement, whatever it cost healthcare providers to take care of people's health needs was reimbursed by a third party. Payers placed little pressure on providers to keep costs down. Not that healthcare organizations or individual practitioners strove to be inefficient, but being inefficient didn't carry the same penalties as in other industries. The cost of inefficiency was simply built into the expense base and passed along to a willing payer.

Moreover, the push to outpatient care did not begin in earnest until the 1990s so competition for patients did not become as intense an issue until then.

The brakes were first applied to the system in 1983 when the federal government instituted prospective payment in the Medicare system (Levine & Abdellah, 1984). For the first time on a large-scale basis, fixed fees were assigned for the treatment of hundreds of diagnoses. In the 1990s, health maintenance organizations (HMOs) and other managed care companies followed suit, determining in advance the amount they would pay to providers for caring for their subscribers. Other trends were taking shape at the same time, in particular, a massive shift to outpatient care that was fueled by a combination of new surgical procedures such as laparoscopy and arthroscopy, as well as by insurance companies that began demanding that care be provided in the least expensive clinical venue possible (Danzon & Pauly, 2001). In short, the world of health care was changing in dramatic fashion.

Prior to the 1990s, we may view the execution of leadership in health care as occurring largely within transactional parameters. Establishing systems of governance, ensuring compliance in a rule-laden industry, and building hierarchical organizational structures to achieve clarity of role and function—these were the hallmarks of leadership for much of the period from the 1960s through the 1990s. Systems were not particularly open; hospitals tended to function cooperatively, though not necessarily interdependently. Leadership in the arena of brokering tended to occur with the medical staff; after all, this was the one stakeholder group that could exercise the most sway with respect to the policies and direction of the hospital. Innovation communication; conceiving and introducing fundamental change—was a commodity that received less organizational emphasis than operational management (Belasen & Rufer, 2014). Capital acquisition, however, was important. It was here that hospitals had no choice—a hospital caught off guard by failing to remain clinically current with the most up-to-date x-ray machine or rehabilitation equipment, risked losing its medical staff to facilities that stayed closer to the leading edge.

A particular synchronicity typified the relationship between leadership and management during these many years. Hierarchies in hospitals were spawned, and with adherence to rules and procedures dominating organizational activity, monitoring and coordinating constituted principal functions.

As we moved into the 1990s, the emerging set of environmental conditions and demands collided with, and made easy dispatch of, the relative simplicity of prior decades. The change had a tsunami-like ferocity and swiftness: reimbursement was now determined as much by the payer as by the provider, hospitals watched as large segments of their customer base migrated to outpatient facilities, and patients were getting older and sicker, consuming more resources and requiring progressively advanced levels of clinical expertise. A dual assault on revenue was unleashed: competition for patients was increasing while payments for providing care were shrinking. The role of leadership was quickly changing, but the rule-governed nature of the industry was not; in fact, the regulatory emphasis was expanding. Moreover, as advances were altering the nature of how care was being provided, it was also altering the nature of how information was acquired, stored, exchanged, and managed.

Leaders who were unable to reposition their role from transactional system administrators to that of transformational change architects were ill equipped to guide their organizations into the complex future that was already whooshing through the entrances of their hospitals. Now open, the system required relationship management across a range of fronts, and leadership needs began to take on the appearance of multiple and interlocking chessboards. Hospital leaders now needed to devote more time to the quest of outmaneuvering rivals in competitive mode while engaging them cooperatively to advance mutual and industry interests. Creative and bold approaches to workforce management involved questioning assumptions about normative workweek patterns and role structures. Bringing their organizations to the attention of the public through channels of advertising demanded new ways of thinking about how communication could be employed in the service of identifying and reaching customer bases. Negotiating contracts with managed care organizations was pivotal in determining revenue flow into the hospital, which panels of physicians could practice at the hospital, and which patients could be served by the institution. Envisioning a service mix that addressed the emerging and future healthcare needs of the communities they served demanded expertise in market analysis and forecasting.

Moreover, the dimensions of the healthcare organization—its very status as an independent organizational entity—were no longer guaranteed. Pooling resources in the quest to achieve economy of scale meant joining forces with others. Who wins in this game? Who determines the culture of the emergent organization? Leaders suddenly found themselves having to confront challenges that seemed distant from the galaxy they recently inhabited. Responding to the interests of the community while simultaneously integrating into a system that served the needs of multiple communities, often with discrepant cultural characteristics and clinical needs, required leadership acumen capable of unifying mutually exclusive forces. A rapid and aggressive shift from transactional to transformational leadership roles was in order. Success now demanded an ability to innovate, to broker, to mentor, and to facilitate.

All the while that demand for paradigmatic change was being foisted on organizational leaders in health care, the need for the institution to maintain operations—to take care of patients and pass muster in the face of intense regulatory scrutiny—was not abating. Managers were fixed in hierarchies that had to remain defined and stable to ensure orderliness in accomplishing the work of the organization. On the other hand, the organization around them was afloat in uncharted waters that, by definition, demanded flexibility and agility.

The Complex and Dynamic Nature of Healthcare Environments

The challenges facing the healthcare industry are unprecedented in scope, number, and magnitude. Organizational realignments have changed the provider landscape and have made the *healthcare system*, rather than the individual

hospital, the dominant entity in the provider industry. Uncertainty about the course and impact of legislation stifles the progress of provider institutions or introduces uncomfortable levels of guesswork into their strategic planning. An aging population calls for clinical protocols and resource configurations that address increasingly acute and prolonged states of illness. Information management technologies are evolving rapidly, increasing diagnostic and clinical capabilities, but also requiring huge investments of capital and, analogous to the electrical grid, linking provider organizations to one another through patient data.

Pressure to establish reliable systems of quality management as well as outcome- and evidence-driven models of care delivery require hospitals to monitor the effects of their work well after patients walk out the door, and demand that hospitals ready themselves for a progressively expansive role in the continuum of care. Similarly, the trend of identifying the impact of environment on health and connecting such knowledge to the provision of patient care is taking root. Clinical advancements are occurring at a rapid rate, changing the skill mix in ways that require human resources forecasting expertise not traditionally common in healthcare organizations. Projected shortages of critical caregivers, especially the key clinical positions of physician and nurse, are expected to continue. Administrative demands are increasing at a rate such that management ranks are expected to require considerable expansion.

As hospitals and other provider institutions continue to coalesce into larger systems, far more integrative and systematic approaches to planning and market development will be necessary to fill beds with patients whose health needs are highly compatible with the mission and orientation of the facility. That means coordinating and collaborating with other facilities in strategic partnerships. It also means reaching into the community and having a well-conceived approach to managing relationships with key stakeholder groups, including physicians, payers and patients. New patients are entering the system through reform, creating both opportunities and challenges. This phenomenon could mean new sources of revenue and market share, but it is not likely to occur without the proper forethought, including the recognition that many of the newly covered patients have little experience with how to engage the system effectively.

While all these trends are occurring, it is still necessary for the institution to be managed properly. This involves ensuring that the appropriate resources are available for patients entering the facility, that those resources are deployed efficiently, and that responsibilities are carried out effectively.

The future is filled with uncertainty, challenge, and change. It is also filled with promise and opportunity. This future is on our doorstep.

Master Leaders: Balancing Act

What is the right balance between management and leadership? How do we evaluate the tradeoffs between behaviors and roles that are both mutually exclusive and collectively exhaustive? How do we account for shifts in behaviors when

organizational leaders and managers grapple with a changing environment? How do we group and differentiate roles and behaviors across hierarchical levels and organizational lines to facilitate internal and external communications?

As discussed in the next section, both transformational qualities and transactional rigor are needed for effective managerial leadership. Master leaders help inspire and energize people to think onward and outward (outside-in) in addition to directing and focusing organizational resources and capabilities inwardly (inside-out) to achieve organizational goals. Master leaders combine vision-setting and high risk tolerance, task-oriented and hands-on coaching, and analyzer and sensitivity skills, which results in energizing employees and setting higher performance targets. They ask "how," not just "why"—they guide rather than find fault. They convert the process of doing into an opportunity for learning. Master leaders are more successful in handling novel or exceptional situations and generally exhibit greater behavioral and cognitive complexity than less effective managers (Belasen & Frank, 2008; Denison, Hooijberg, & Quinn, 1995; Hart & Quinn, 1993).

Competing Values Leadership

The competing values framework (**Figure 1.1**), a tool made of integrated, inevitably bonded paradoxes, helps us understand the triggers and implications of a balanced managerial leadership. The CVF is highlighted in the literature as one of the 40 most important frameworks in the history of business, and the framework

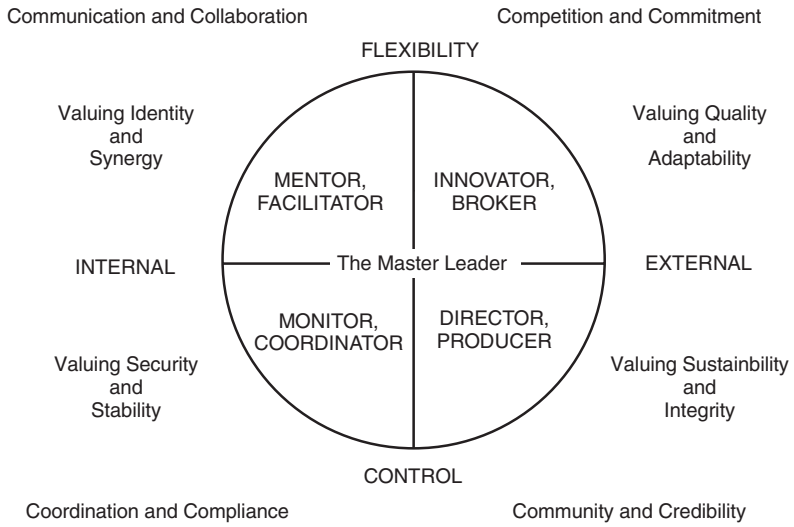

Figure 1.1 Competing Values Framework (CVF): Leadership Roles

Modified from: Quinn, R. E. (1988). *Beyond rational management: Mastering the paradoxes and competing demands of high performance* (p. 48). San Francisco, CA: Jossey Bass. Reproduced with permission of John Wiley & Sons Inc.

has been studied and tested in organizations for more than 25 years (Cameron, Quinn, DeGraff, & Thakor, 2006).

Originated by Quinn and Rohrbaugh (1983) and Quinn (1988), the CVF highlights the contradictory nature inherent in organizational environments and the complexity of choices faced by managers when responding to competing tensions. These responses include a variety of managerial roles differentiated by situational contingencies. The CVF displays the repertoire of leadership roles by aligning pairs of roles with specific domains of action (**Figure 1.2**).

The innovator and broker roles rely on creativity and communication skills to bring about change and to acquire the resources necessary for change management. The monitor and coordinator roles are more relevant for system maintenance and integration and require project management and supervision skills. While the director and producer roles are geared toward goal achievement, the facilitator and mentor roles are aimed at generating a motivated work force driven by commitment and involvement. The upper part of the framework contains transformational roles while the lower part includes transactional roles (Belasen, 2000).

Transformational leadership qualities contribute to greater follower motivation, satisfaction, and results. Transformational leaders are deemed to be altruism oriented and grounded in caring based on benevolence. These factors compel followers to go beyond their self-interest and focus on the organization and

Figure 1.2 Competing Values Framework: Leadership Roles (Top Managers)

Modified from: Hart, S. L., & Quinn R. E. (1993). Roles executives play: CEOs, behavioral complexity, and firm performance. *Human Relations, 46*, 543–574.

the greater community. This generates good will and provides a propensity for positive results. Thus, the transformational leader sparks both an interpersonal dependence with followers and an empowering independence that encourages identification with the organization and its environment.

Transactional managers focus on the orderly accomplishment of tasks and work activities, largely with an immediate or short-term focus. They provide correction when necessary and offer rewards for positive behavior. Compliance, sometimes by coercion, is stressed while creativity and innovation are deemphasized and discouraged because these phenomena represent departures from the status quo. Power is unequal between managers and followers, and communication, when negatively established, is often blocked by uncertainty, fear of reprisal, and mistrust. Simply put, what is most important to the transactional manager is getting things done, whereas the transformational leader focuses on the people who perform the work and the relationship of those people to the work environment.

The key to successful mastery is recognizing the contradictory pressures on the managerial role. Master leaders know how to navigate these roles to balance contradictory demands from diverse constituencies. They are also perceived by others as displaying the eight CVF roles more often than less effective managers (Denison et al., 1995). Gender differences do not change this conclusion: men and women are regarded as equally competent (or incompetent) leaders when assessed objectively by their supervisors, peers, or staff in terms of how well they display the CVF roles (Vilkinas, 2000; Belasen & Frank, 2012).

Master leaders display behavioral complexity that allows them to master contradictory behaviors while maintaining some measure of behavioral integrity and credibility. The concept of paradox reinforces the idea that the structure of this behavioral complexity is not neat, linear, or bipolar, but is instead a more complicated form (Denison et al., 1995). This finding was also supported by other studies that used full-circle assessments to measure the perceptions of leadership roles and their effects on managerial behavior across levels (Belasen, 1998; Hooijberg & Choi, 2000).

Successful organizations benefit from the effective blending of the eight leadership roles—the essence of great *managerial leadership*. Using contemporary management theory, our goal is to demonstrate the organizational benefits of leaders functioning as architects of inspirational change, communicating the vision for their organization, and mobilizing support for that vision while also ensuring that tasks are accomplished, resources are managed effectively, and performance goals are obtained successfully. When leadership and management function interdependently, organizational goals are infinitely more attainable. By tracing the evolving leadership and managerial challenges in the healthcare industry, we provide a window into the critical attributes of master leaders.

Hart and Quinn (1993) developed a model of four archetypal leadership roles that correspond with four domains of action to test the efficacy of the CVF. They also investigated the importance of cognitive and behavioral complexity as the condition for superior leadership performance. These roles (and domains) are depicted in the inner circle of Figure 1.2: taskmaster (performance), vision-setter

(direction), analyzer (conformance), and motivator (inspiration). The outer circle includes the leadership challenges expected of healthcare CEOs. Executives in healthcare organizations are challenged to clarify the strategic vision for their organizations; inspire employees to transform their ways of thinking about patient care and the culture of the organization; employ evidence-based best practices to improve patient quality and safety; and improve the overall efficiency and productivity of the organization.

The results of Hart and Quinn's study (1993) specifically underscored the importance of the vision-setter and motivator roles (which overlap the transformational roles) for business performance. The findings also indicated that the unbalanced playing of the taskmaster and analyzer (which overlap the transactional roles) appears to be detrimental to business performance and organizational effectiveness. Superior performance was achieved by organizations with executives who played all four roles concomitantly. Master leaders spent more time focusing on broad visions for the future while evaluating performance plans. They also paid attention to relational issues while simultaneously addressing tasks and action plans. When managers overemphasize one set of values (or play certain roles extensively without considering the other roles) the organization may become dysfunctional. This sentiment was echoed by Quinn (1988) who labeled this imbalance "the negative zone." The single-minded pursuit of one set of values without paying needed attention to the other values or roles creates conditions of suboptimization that often lead to organizational failure.

Personality Traits and Roles

When a manager plays a particular role, the choice of that role is influenced by personality traits or characteristics. Personality traits and their interrelationships have been documented to affect managerial goals, values, and needs (Herringer, 1998; Sharp & Ramanaiah, 1999) as well as leadership behavior (Hogan, Curphy, & Hogan, 1994). For example, the five factor model (FFM) (Costa, McCrae, & Dembroski, 1989; Digman, 1997) consists of four emotionally stable traits: agreeableness, extroversion, conscientiousness, and openness (Costa & McCrae, 1992) and a fifth trait, emotional stability (at the low end of neuroticism) was found to be related to effective transformation and transactional role behaviors (Belasen & Frank, 2008; Bono & Judge, 2004; Leung & Bozionelos, 2004).

In addition to the relationship between the first four FFM traits, low levels of emotional stability, the fifth trait, would seem to be associated with behavioral extremes indicated by Quinn's (1988) negative zone. Responding appropriately to competing demands requires balanced role strengths along with high levels of emotional stability, whereas lower levels of emotional stability combined with weaker, unbalanced role behaviors, give rise to reactionary, extreme behaviors that often result in ineffective outcomes. Less effective managers who engage in restricted, inflexible modes of thinking find themselves confined to the negative

zone, whereas effective managers, who are able to detect and respond to contradictory signals, reside within the positive zone.

Managers who are able to master the paradoxical behaviors and skills associated with all of the roles have the capacity to use a set of adaptive responses to deal with complexity in a variety of situations. The concept of paradox underscores the importance of developing behavioral flexibility and considering the dynamic interplay across the various roles. By observing the roles and types of messages used by managers across hierarchical levels, we can also obtain a clearer picture of shifts in emphasis in how each level appreciates its roles and expectations in terms of responses to changes in the task environment (Belasen & Frank, 2010).

The CVF is particularly helpful in clarifying expectations during organizational transitions and shifts in importance of organizational goals. Knowing in advance what senior managers communicate and detecting the tone of the messages should also help managers avoid second guessing and, instead, focus attention on messages that are consistent with the expectations of higher-level managers.

Leadership and Management: Not Necessarily Yin and Yang

There is no question that both leadership and management are demanding, challenging, and vital to the successful operation of organizations. But management and leadership have different centralities: management is job centered, whereas leadership is employee centered. Management is responsible for the attainment of organizational goals in an effective and efficient manner through planning, organizing, staffing, directing, and controlling organizational resources. A key word in that definition is *control*. Managers use centralized authority for *controlling* and *directing* the behavior of employees to ensure that organizational stability is maintained. In management, the executive serves an operational role; he or she formally possesses *power*, that is, the *control* over resources and the responsibility for the outcome of the employees' actions. Leadership, on the other hand, is not bound by the hierarchical relations that govern managerial roles and serve as the source for organizational authority. Rather, leadership is a process of influence. While managers use explicit sources of administrative power (e.g., reward, legal action, punishment) to structure the situation, leaders use implicit sources of power to structure attitudes and shape the identity of followers through persuasion and inspiration.

Leadership and management function in dissimilar ways to ensure organizational livelihood; however, because they aim for distinct outcomes it can be very difficult for one to succeed at both leading and managing. Management relies heavily on control, whereas leadership relies on shared authority and the empowerment of subordinates. It is difficult for people to successfully practice

management and leadership simultaneously because management and leadership hold the potential for conflicting agendas and outcomes. Management maintains stability, predictability, and order through a desired *culture of efficiency*; leadership creates change within a *culture of integrity* that helps the organization thrive over the long haul by promoting openness and honesty, positive relationships, and long-term innovation. While management strives for productivity, leadership strives for change (Belasen, 2000). It can be argued that management follows homeostatic processes geared toward equilibrium while leadership employs the forces of morphogenesis, adaptation, and frame breaking. Leadership cannot replace management. In fact, in order for a company or organization to succeed, leadership and management must go hand in hand. The challenge for success in both functions lies in balancing management duties with leadership utilities—the attributes of master leaders.

Although manager and leader are typically considered contrasting roles, and because leadership is not bound by position, in theory anyone in an organization can have a leadership presence, including a manager. The term *manager* indicates a transactional, authoritative position derived from the organizational hierarchy that is concerned with internal consistency, procedures and policies, setting goals for employees, and emphasizing tasks and duties. Conversely, a leader functions transformationally and informally, and the role is often assumed organically, not assigned. Leadership is based on interacting with others to create a shared organizational purpose and reality, influencing and structuring attitudes, helping followers to identify their value systems, and emphasizing people rather than tasks. A transformational leader exhibits behaviors that communicate the mission and vision of the organization, examines new perspectives and creative ideas for solving problems, and develops and mentors employees. One of the main differences between managers and leaders is that managers have subordinates and leaders have followers. However, because of the fluidity of many forms of organizational structure, managers are often leaders and leaders are often managers. This is especially true in healthcare organizations.

The Role of Communication

Communication is the vibrant thread that ties together employee vitality, clarity of direction and purpose, and results and progress. Master leaders use communication as a tool to achieve organizational goals. However, this tool must be used strategically, laser focused to produce results, not merely to fill the airwaves. A plethora of communication does not guarantee vital and engaged employees who are aligned to produce results. In fact, over-communicating can be as destructive as under-communicating. The former can cause confusion, misunderstandings, loss of productivity, and can overwhelm those on the receiving end. The latter can lead to distrust, uncertainty, low morale, and a lack of alignment.

Communication from a transactional perspective is a largely information-based and downward (management to workforce) exchange of information through formal and informal channels. Clear, concise, targeted instructions to subordinates lead to the accomplishment of tasks that fuel results. On the other hand, communication from a transformational perspective is largely vision based and is multidirectional—upward and downward as well as horizontal.

An important question is how managers select the right role in which to communicate different tasks and goals and use the most effective message orientation, or right approach, for each task or goal they encounter. Often managers at different levels see themselves as members of separate constituencies in the same organization rather than as members of the same team. The common language offered by the CVF ameliorates the separateness because it is essentially an organizational language that identifies performance criteria that are common across the hierarchy. Clarifying managerial roles and expectations can help minimize role ambiguity as well as reduce the potential for role conflict. Likewise, interpersonal conflicts associated with turf issues, status, and power can be avoided in favor of developing a constructive dialogue and encouraging positive communication.

Rogers and Hildebrandt (1993) and Belasen (2008) suggested that each quadrant in the CVF represents a different message orientation with significant parallels and polar opposites: relational, hierarchical, promotional, and transformational (**Figure 1.3**). When managers use the mentor and facilitator roles, for example, they use a relational approach to communication, which places emphasis on the insights and feedback of the receivers. A promotional orientation fits the behaviors displayed by the director and producer roles that rely on

Figure 1.3 Competing Values Framework: Message Orientations and Styles

Modified from: Belasen, A. T. (2008). *The theory and practice of corporate communication: A Competing values perspective* (p. 114). Thousand Oaks, CA: Sage.

persuasion strategies to meet functional objectives. A transformational orientation matches the styles and behaviors of the innovator and broker roles that are geared toward selling ideas effectively and meeting future organizational and adaptation goals. Hierarchical message orientations, on the other hand, align with the monitor and coordinator roles, which focus on integrating individuals and groups through work processes and systems of control. Transformational-based messages are aimed at sustaining the ability of the organization to adapt to change. There is a focus on adaptation and change, branding, and reputation management to address interests of external stakeholders (Gotsi & Wilson, 2001). Success is determined by the extent to which the framing of communication is insightful, mind stretching, and visionary.

Promotional messages relate to the mission of the organization to meet external expectations for products, to perform productively to maximize owners' returns on equity, and to enhance performance credibility and organizational accountability (Belasen, 2008). Success is determined by the extent to which the communication is framed in a conclusive, decisive, and action-oriented manner. Hierarchical messages reflect rules of behavior and codified decisions aimed at regularizing interactions between managers and employees. Hierarchical messages characterize the flow and dissemination of formal communications across organizational lines. Success is determined by whether the communication frame seems realistic, practical, and informative. There is a focus on organizational identity, coordination, symbolic convergence, compliance, uniformity, and control (Belasen, 2008; Fairhurst & Putnam, 2004).

Relational messages are aimed at personal relationships, informal interactions, peer communications, and maintaining an awareness of the importance of the role of the individual in completing the organization's mission. There is a focus on social identity, common understanding, commitment, and concerns for human development. These messages maintain the circle of interactions within the organization and stimulate opportunities for revising and realigning social networks with the mission and goals of the organization. Members who constantly seek to improve relationships through constructive cycles of feedback and positive communication are discerning and perceptive of the needs of individuals and groups as important organizational stakeholders.

Competing Frames

Recognizing the existence of competing frames can be used as a personal roadmap for self-improvement (i.e., diagramming personal profiles) or as a tool to help managers understand how well they need to balance the different orientations across the quadrants and the steps they can take for improving oral and written communication. One application (which emphasizes style over content) is diagrammed in Figure 1.3.

In this real-life example, the manager seems to place more weight on relational and hierarchical message styles than on transformational and promotional,

suggesting a preference toward working with individuals within boundaries of trust, structures, and rules. This manager's profile, however, seems to deflect the need for placing importance of equal value on the right side of the framework where messages are aimed at energizing people toward new ideas and commitment to engage in new tasks. When subordinates, peers, and supervisors provide their inputs (often referred to as 360 assessments), this framework can become a powerful tool for guiding improvement efforts based on expectations from others (Belasen, 2008). Under normal conditions the four message orientations or approaches are reflections of administrative responsibilities, with top executives communicating strategic priorities and managers and supervisors translating them into concrete and more practical objectives and tasks that employees accomplish.

The Advantage of Creating Appropriate Messages

Managers reporting to higher levels can gain a number of advantages by using the model of message orientations described in this chapter. Having a strong understanding of the frequency (amount of content), flow (who the message is directed to), and the intensity of the message (power of the message or the source of the message) can help mitigate communication roadblocks as well as clarify organizational directions and expectations. The model is particularly helpful in clarifying expectations during organizational transitions and shifts. This model is relevant for explaining communications and message orientations in healthcare organizations undergoing transition. Knowing in advance what managers communicate, as well as detecting the tone of the messages, should also help managers avoid second guessing objectives and instructions; instead, it will allow them to focus attention on messages that are consistent with the expectations of higher-level managers.

When the lines of communication are clear and the messages reach their target audiences with appropriate orientation, the consistency of organizational communication increases. Creating appropriate messages and choosing the right communication channels to deliver messages can help managers align their goals with the expectations of higher- and lower-level managers, thus increasing vertical alignment across administrative lines. This should also help reduce the opportunity for miscommunication and the potential for conflict between senders and receivers. Knowing that managers at all levels of the organization demonstrate an awareness of the four orientations also provides an additional tool in developing a common language for sharing expectations across administrative levels. Awareness of these differences could help ameliorate unnecessary frustrations and misunderstandings among the managerial levels especially during organizational transitions (Belasen & Frank, 2010).

When paired with the role quadrants of the CVF these message orientations provide an avenue for engaging employees in such a way that optimal

performance becomes possible. The ultimate goal of a for-profit enterprise is to maximize value and profitability for the shareholder, and is accomplished by integrating the transformational and transactional aspects of managerial leadership. Similarly, nonprofit and governmental organizations, whose aim is service in its many facets, rely on a blend of transformational and transactional approaches. As discussed in the following section, the arena of health care provides key insights into the application of high performance leadership and the roles and message orientations used by master leaders.

The Healthcare Industry: A Divergence of Leadership and Management

The healthcare industry has been twisted and turned by a whirlwind of forces since the middle of the 20th century. Finding a balance, that state of homeostasis in which leadership and management cohabit so that healthcare organizations can move forward, has become an increasingly daunting challenge. It is no wonder that since the early part of the 1990s organizational realignments—mergers, acquisitions, reductions in size, expansions, wholesale changes in service offerings, diversifications, and closures—have occurred with resounding speed and frequency (Galloro, 2011). A glimpse into the window of the challenges healthcare managers have faced can help us appreciate the uneasiness of transformational–transactional dynamics and how the balance between them needs to shift as environmental conditions change. The implications for the roles, functions, and definitions of leadership are profound, and shades of these implications are evident in all healthcare institutions across the spectrum of the industry.

The Paradoxical Nature of Change and Stability

What had been for years a relatively noncontentious relationship between the roles and functions of leadership and management, suddenly became a struggle with agendas and purposes that diverged. Leaders had to enter into unfamiliar territory using new tools of navigation; managers, on the other hand, needed to work within the confines of predictable boundaries and reliable processes using tools that had served their needs for quite some time. Strains and stresses between leadership and management are not unique to health care. All industries ebb and flow, and shifts between maintaining stability and envisioning change take place in ways that defy predictability. Moreover, organizations benefit when they have leaders who have the skill and incentive to imagine ways of positioning their organizations for success in the future and managers who are skilled at ensuring that vital processes are followed effectively and efficiently.

Is it inevitable that leading and managing are destined to be bound by a mutually exclusive governing dynamic? Hardly. The competing values framework offers insight into strategies for achieving the right balance between transformational and transactional leadership roles. The concept of *alignment* provides a starting point. We posit that the more alignment that exists in four sets of organizational relationships, the more proximal and synchronous leadership and management will be and the more likely that the integrated force of transformational and transactional roles will be achieved.

Grove Memorial Hospital

Mission and function. A small community hospital of 200 beds, Grove Memorial Hospital has served a working class community just outside of a large metropolitan area for the past 50 years. The hospital recently determined that it could not sustain itself as an independent institution in light of constricted revenue streams. After exploring relationship opportunities, the hospital made a strategic decision to merge into a system comprised of six hospitals (we'll call the system Midwest Elite), all of which were larger than Grove Memorial; the flagship was a state-of-the-art, 550-bed hospital with over 700 physicians on its medical staff. Grove Memorial took pride in being a center of health education for the community and for providing "high touch" acute care basic services. It was homey. Grove Memorial was the type of hospital in which patients and employees were neighbors. The board was composed of local business owners and community residents. Once absorbed into Midwest Elite, Grove Memorial's service menu was forced to change in order to facilitate Midwest Elite's achievement of broader, system-wide goals. The board of Midwest Elite determined that Grove Memorial should focus on specialty care, and in particular on orthopedic surgery (e.g., knee and hip replacements, joint repair). A struggle ensued between the boards of Grove Memorial and Midwest Elite over the mission and function of Grove Memorial. The local board won the battle, but the larger board won the war: the mission of the hospital remained community care, but the function shifted to specialty care. No longer would Grove Memorial serve only residents of the community. Instead, patients from a wider geographical area would be directed there for orthopedic care. The gap between the mission of the organization and the function of the organization created confusion for core stakeholders: employees, consumers, the community, physicians, suppliers of products, and third-party payers. Leadership was exercised on a more transactional than transformational basis. Whether the shift away from a community hospital orientation was good policy and a sound business decision is fodder for debate. But leadership was required to recast the mission of Grove Memorial and to move it in a fundamentally different direction. As such, transformational leadership was essential in order to persuade the array of stakeholders to move in the same direction.

Message orientation and organizational direction. Grove Memorial was caught in a paradox: it sought to capture and communicate two ostensibly contradictory themes in its message orientation. On one hand, it desired to reassure its constituencies, internal and external, that it was not changing. On the other hand, the organization needed to communicate a new direction. Achieving success with one message, by definition, negated the second. Transformational-based messages steer stakeholders to envision opportunities and possibilities for the organization, and such possibilities represent a departure from the status quo. Success is dependent on the extent to which such messages resonate, hold credibility, are motivational, and point the way with clarity. Energizing and mobilizing followers is a hallmark of transformational leadership and communication. On the other hand, hierarchical message orientation is of value in facilitating stakeholder appreciation for steadiness and constancy; it may be employed to provide an understanding of status rather than to chart a new course. Grove Memorial could hardly brand itself as a community hospital when it was now serving the needs of a region. It was disinclined to be perceived exclusively as a "center of excellence"—known principally for a particular medical specialty—for fear of alienating what had always been its core community.

Facing a dilemma of the sort Grove Memorial confronted is not uncommon for organizations. How can communication be organized strategically so that it projects reassurance and, at the same time, newness—comfort *and* enthusiasm—security *and* anticipation—permanence *and* change? All organizations face such challenges. Some fail because of an inability to find a healthy balance—going too far in an attempt to satisfy one drive creates the risk of communicating either staleness or, on the other extreme, instability. The related danger is trying to have it both ways and failing to present them as compatible.

The key is aligning communication strategy and orientation with organizational direction. Grove Memorial could not embark on a successful communication campaign until it resolved the question of its identity and direction. Once accomplished, it could construct messages that could help it explain why and how it was transitioning from what it was to what it planned to be, and why this course of action was desirable or necessary or both. Grove Memorial could employ multiple and highly coordinated message orientations as part of a comprehensive strategy in which its future direction logically evolved from a successful and well-known past.

Culture and external environment. Not surprisingly, organizational culture is resistant to change. Adapting culture to environmental change demands that leaders perform on transformational levels. Cameron and Quinn (1999) developed a model for assisting managers and other change agents to make sense of their organization's culture. The model allows for a comprehensive assessment that maps the cultural profile of the target organization along the lines of four culture types: hierarchy, market, clan, and adhocracy. The predominant cultural type of an organization is identified by surveying employees' attitudes toward

organizational dominant characteristics, leadership, management of employees, core values, strategic emphasis, and criteria for success. Their methodology, which includes a theoretical framework and a validated instrument, allows for the systematic diagnosis of an organization's predominant current and preferred cultures. Systematic cultural diagnosis is a necessary precursor to implementing effective change efforts. Assessments of organizational culture are useful because they help managers and organizations adapt to the demands of external environments and enhance organizational performance. These four types of cultures are consistent with the dimensions and quadrants of the CVF and are depicted in **Figure 1.4**.

The *hierarchy* culture is characterized by a formalized and structured workplace. Rules and procedures govern organization members' actions. Leaders are good coordinators and organizers who help to maintain a smooth running operation. Value is placed on stability, predictability, and efficiency. The organization is oriented toward internal concerns and is kept together by formal rules and policies. The *market* culture is characterized by a focus on the external environment and transactions with external constituencies including investors, business partners, and regulators. The organization is a results-oriented workplace. Leaders are hard-driving producers and competitors. Value is placed on competitive actions and meeting goals and targets. The glue that holds the organization together is an emphasis on winning.

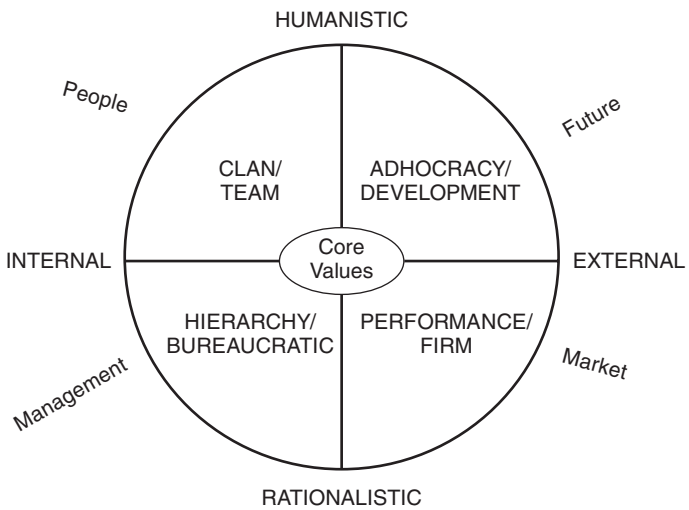

Figure 1.4 Four Types of Cultures

Modified from: Cameron, K.S., & Quinn, R.E. (2011). *Diagnosing and changing organizational culture*. John Wiley & Sons.

The *clan* culture is characterized by a workplace that is supportive and interactive. The organization dominated by a clan culture is like an extended family to its members. Leaders act as and are thought of as mentors and even parental figures. The glue that holds the organization together is loyalty and tradition. Individual development, high cohesion, positive morale, teamwork, and consensus are valued. Success is defined in terms of the internal climate and concern for organizational members. Finally, the *adhocracy* culture is characterized by a dynamic, entrepreneurial, and creative workplace. Organizational members are risk takers. Effective leadership in an adhocracy culture is visionary, innovative, and risk oriented. Commitment to innovation is the glue that holds the organization together. Value is placed on being on the leading edge of knowledge, products and services, being poised for change, and meeting challenges. Success means producing new and original products and services.

Grove Memorial, for the better part of its history, had a predominantly clan–hierarchy culture (**Figure 1.5**). This was quite serviceable because the hospital was highly integrated into the community, and internal communications reaffirmed a particular fraternal orientation in the workforce. The decades-long approach to cost-based reimbursement meant that the financial woes rarely rose to a threshold where job security was threatened. Employment longevity was high. Supervisors, managers, and employees all shopped in the same stores and their children attended the same schools. Work life was an extension of family and community life for the employees of Grove Memorial.

Now, however, a new dynamic was stubbornly chafing at the clan culture that had been deeply entrenched in the social fabric of the hospital. This was the

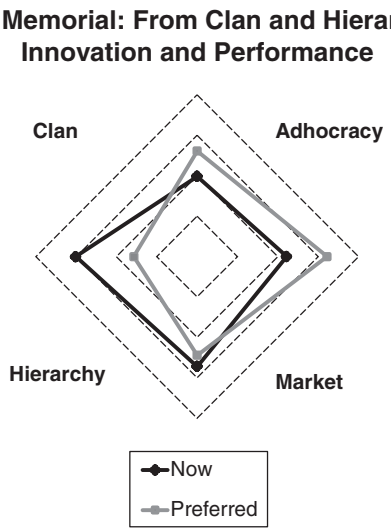

Figure 1.5 Culture in Grove Memorial Hospital

need to become more entrepreneurial, and it was getting increasingly difficult for Grove Memorial to resist its encroachment. More and more, patients were being encouraged to seek treatment in outpatient locations, HMOs and PPOs were becoming stingier when developing payment schedules, and employers were doing all they could to reduce exposure to high premiums, including curtailing the once generous nature of their benefit programs. Hospital administrators began to think about reinvigorating the culture and shifting it from the left to the right side of the CVF (see Figure 1.5).

The hospital had no choice but to examine things like departmental efficiency, employee productivity, and return on investment for its programs and services. Lifetime employment was no longer a guarantee. If the clinical program in which an employee worked closed down, there may not be another place in the hospital for that person. If an employee was less than satisfactorily productive, perhaps the hospital would need to replace that person with someone more capable. This was all new to Grove Memorial, and the impact on culture was swift and startling. When change is inevitable, leaders who remain fixed in transactional approaches to their role are likely to find themselves engaged in damage control. Leaders who seek to align culture with environmental trends are far more likely to help their organizations transition and transform successfully.

Skills and roles. As roles evolve, so too should the skills that enable those roles to mature and actualize with proficiency. Grove Memorial, like thousands of other hospitals across the country, prided itself on a staff with proven technical and clinical skills. Many employees, in fact, had received formal training as a precondition for employment. Hospitals are regimented, hierarchical, and paternalistic environments and, as such, standards of performance tend to be uniform and decision-making latitude is fairly narrow (Longest & Darr, 2008). However, the changes that took root in the 1990s began to dismantle the relatively narrowly defined skill orientation. As reimbursement programs shrank and competition for patients increased, the need for efficiency and a more focused and bold approach to customer service increased.

Many hospitals examined ways to flatten hierarchies to reduce the number of layers through which problems and decisions needed to be communicated. This brought decision-making responsibility closer to the level of the rank-and-file employee as well as reduced the time between problem identification and solution implementation. Moreover, there was a need for customer relations skills, brought about largely by competition, but also by the aging of the population; older patients are often sicker and have reduced capacities for absorbing, processing, and retaining information (McPhee, Winkler, Rabow, Pantilat & Markowitz, 2011). Thus, today we see increasing numbers of employees who possess not only the capabilities required for technical responsibilities, but also increased aptitudes for flexibility, communication, decision making, and teamwork.

The experience of Grove Memorial highlights the need for another skill: tolerance of ambiguity. The more uncertain and unpredictable the organizational future, the greater the need is for employees who can navigate their way through change with minimal stress and burnout. As roles change, organizations are well advised to plan for the impact of that change on employees' skill sets. Employees who do not possess or develop the necessary skills are likely to fail; and if many employees fail, the likelihood is greater that the organization will fail as well.

Leadership in Healthcare Organizations: Transcending Boundaries

We may substitute any industry for the healthcare industry and identify fluid and emerging patterns of needs that call for varying levels and emphases of transformational and transactional orientations. We have examined the healthcare industry not because of its distinctiveness but because of its representativeness. Environmental and organizational forces cause companies in all industries to evolve and adjust in order to succeed. Not all organizations do. The manner by which transformational leadership blends with and complements transactional management will go a long way in determining whether the organization can prosper or fail. Too much of the wrong emphasis at the wrong time will either prevent the organization from moving forward in a changing world or pay short shrift to all of the vital processes that enable the organization to function efficiently.

The CVF offers guidance on the relationship among the critical roles in an organization. The tension to achieve alignment between transactional and transformational roles holds rich potential for energizing an organization in a positive direction or miring an organization in a stuck position or a state of chaos. Master leaders who envision a future filled with possibilities are well served by recognizing the value of managers who oversee vital processes; an organization without order and structure cannot accomplish its work regardless of the genius of its visionaries. On the other hand, an organization lacking an aptitude for adaptation and maturation can fall behind its competitors and lag in its market. After all, processes need to be managed, monitored, and controlled and employees must be inspired if their energy, skill, and dedication are to be maximized and their adaptive potential realized. Alignments function much like a fulcrum, creating balance between transactional and transformational organizational tendencies. Leaders capable of reframing transformational and transactional roles from either/or to both/and—to transcend the boundaries between the two—can employ that reframed perspective to move their organizations forward in a strategic direction. This is the realm of the master leader.

Conclusion

In her book *From Management to Leadership: Strategies for Transforming Health*, Jo Manion (2011) suggested that the study of leadership in healthcare organizations is nonlinear in actual applications because leaders assume nontraditional roles that demand mastery of new and different competencies that match the need to manage complex systems with multiple stakeholders and high levels of interdependence. Manion cites a study by the American Hospital Association (AHA) that identifies administrative pitfalls driving the emerging paradigm of leadership in healthcare organizations. These pitfalls are listed with their parallel CVF quadrants (see **Figure 1.6**):

1. Little or no sense of shared vision and mission within healthcare organizations (*lower right quadrant*)
2. Ineffective communication skills, especially at the executive level (*upper left quadrant*)
3. Unwillingness to abandon hierarchical control structures, particularly at the executive and board levels (*lower left quadrant*)
4. Refusal to let go of the hospital mentality and traditional modes of service (*upper right quadrant*)

Not only does our model (Figure 1.6) address these pitfalls by elaborating on the leadership roles and competencies needed to sustain the goals and capabilities

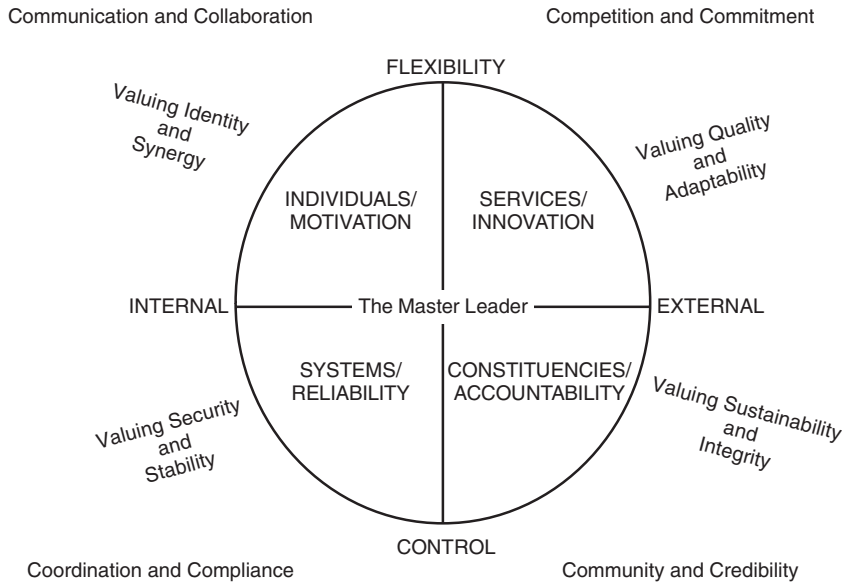

Figure 1.6 Leadership in Healthcare Organizations: Constraints and Opportunities

of healthcare organizations, it also captures the essence of healthcare organizations as complex systems that require transactional and transformational roles along with paradoxical skills essential for effective performance. Note how the framework provides a road map for identifying the main topics of this text and at the same time it charts the critical domains of healthcare organizations and leadership challenges.

In the larger sense, responding to the challenges of leading healthcare organizations through transitions that demand alterations to organizational structure and strategy involves the development of a fundamentally more sophisticated and diverse complement of skills than has previously been in practice. For the majority of the past half century, the skills necessary in health care focused on getting the day's work accomplished. Organizing structures, assigning tasks, constructing systems and policies that could respond to regulatory demands, establishing protocols for accountability—these occupied the bulk of managers' attention. Doing all this within a confined and defined set of means was secondary as long as a willing third-party payer existed.

This context began to change as the last century came to an end. In a sense, the bill came due for the extraordinary expansion of the healthcare system, which occurred in the latter half of the 20th century. For many years, expenses were simply passed along to consumers in the form of higher deductibles, larger copays, and decreased choice of providers. Employers struggled to find ways to contain the rate of premium escalation. Government programs were pressed to contain spending. At the same time, patients continued to get older and sicker, consumers became more adept at discovering information about their health, and technology changed how care was delivered and information was managed. As consumer needs and expectations grew, the ability to pay for it all emerged as an issue of considerable national attention.

For healthcare organizations, yesterday's transactional leadership skills quickly became obsolete, even archaic. Simply, it is no longer enough for a healthcare manager to be a good technocrat, an efficient supervisor, a proficient engineer of operational activity. This is not to suggest that the skills associated with such functions are unimportant or irrelevant, quite the contrary. But they no longer occupy the domain of prominence they did when transactional responsibilities were the hallmark of the administrators' work. Leadership roles can no longer be differentiated along transactional and transformational responsibilities because both are needed. In this chapter we argued in favor of replacing this dichotomy with the more holistic and integrative skill sets represented by the master leader. We contend that this skill composite and the master leader concept represent a fertile area for future study, particularly as it applies to the challenges of the healthcare industry.

Case Study: The Acquisition of Abbott Hospital

Sister Mary Theresa, head of Mt. Mercy Hospital, a 372-bed facility, had received notification of acceptance of her offer to purchase Abbott Hospital, a 108-bed short-term acute general care facility located in a growing city in the Midwest. Abbott was owned by MEDICO, a professional hospital management company and operated as a not-for-profit corporation with no sectarian affiliations.

The eight civilian and military hospitals in the city have a combined bed capacity of 1,500. There are approximately 338 physicians, surgeons, dentists, and dental surgeons operating from these hospitals. The chamber of commerce and the medical community predict that this level of care will not be adequate to service the expansion of the city's population and projected economic growth.

During her tenure as chief administrator of Mt. Mercy, Sister Mary Theresa has become a controversial figure. Her supporters describe her as a strong-willed, articulate, well-organized woman who deserves credit for developing Mt. Mercy into a regional force in both medical care and basic research. Her opponents in the lay and medical communities contend that she is a cold, calculating opportunist who works only for the interests and gains of Mt. Mercy Hospital. Sister Mary Theresa describes herself as a hard worker with little patience for incompetence. Over the years she built a solid core of well-trained, capable physicians who admit primarily to Mt. Mercy Hospital. Both supporters and detractors agree she is persuasive, intelligent, unafraid of confrontation, and a tough competitor.

During Abbott's first year of operation, MEDICO lost over $2 million. Later, MEDICO management fired the administrative staff at Abbott and offered Dr. John Coletti the position of chief administrator. Coletti had been with MEDICO while completing his doctorate in hospital administration. His reputation in the company was based on his experience in several difficult administrative situations. MEDICO management viewed Coletti as a strong, decisive, and self-confident administrator. Coletti spent much of his time during his first months at Abbott staffing departments with people he characterized as strong leaders. Coletti revised the wage and benefits program for employees in order to stabilize what had become an excessive turnover rate. He was extremely pleased when, within 14 months, Abbott was operating at break-even. MEDICO management consequently viewed him as one of their successful administrators.

Both Sister Mary Joseph, director of nursing at Mt. Mercy, and Dr. John Cassler, the Mt. Mercy medical chief of staff, have been strong supporters of Sister Mary Theresa. The three mutually agreed that contacting MEDICO

Courtesy of: Shockley-Zalabak, P. (1994). The acquisition of Abbott Hospital. In *Understanding organizational communication: cases, commentaries, and conversations.* New York: Longman Publishing Group (p. 11–21). Reprinted with permission.

regarding the intent to purchase Abbott might be timely after MEDICO's initial financial losses. Sister Mary Theresa felt that acquisition of Abbott was the best way to pursue the satellite hospital concept outlined in Mt. Mercy's long-range plan. Sister Mary Theresa contacted only select members of the board of directors of Mt. Mercy regarding her decision to approach MEDICO.

Sister Mary Theresa was frustrated when MEDICO management refused to answer her telephone calls. Both Cassler and Sister Mary Joseph also received no response. MEDICO seemingly would not communicate directly with anyone at Mt. Mercy. Sister Mary Theresa, once again with only informal approval of selected board members, hired a consulting firm to act as an intermediary for discussing the purchase of Abbott with MEDICO.

The consultants notified Sister Mary Theresa that MEDICO would entertain an offer somewhere in the vicinity of $30 million. Sister Mary Theresa and Sister Mary Joseph met with financial advisors to the Sisters of the Sacred Heart and determined that an offer of $28 million was in order. The verbal acceptance of the offer by MEDICO made headlines in local newspapers.

Sister Mary Theresa called a board of directors meeting immediately after the story broke and obtained unanimous approval to proceed with the necessary steps to finalize the purchase. Although some members of the Mt. Mercy board felt she was again operating autocratically, they could not fault the results of her efforts. Mt. Mercy staff did not take issue with Sister Mary Theresa's rationale of the multihospital concept, instead their line of questioning centered on determination of the purchase price. They were concerned about the lack of formal assessment of the value of Abbott Hospital. Sister Mary Joseph responded that assessors qualified to evaluate the worth of a hospital were extremely rare, and in any case, MEDICO and Mt. Mercy had mutually agreed on the price. At this point, the staff recommended approval of Sister Mary Theresa's plans.

In order to finalize the Abbott purchase, Sister Mary Theresa began the formal application process for a certificate of public necessity. The state law requires that transfer of ownership of an acute care facility be preceded by obtaining a state certificate of public necessity for construction or modification of acute care facilities from the city's project review board. The procedure to obtain state consent for transfer of ownership involves formal documentation of projected benefits to the community and clients within the service area of the facility. Part of this documentation includes public testimony from hearings held in the local community and at the state level. Mt. Mercy personnel were expected to present and defend their position with regard to the Abbott purchase. Any interested parties from the community or health service field were invited to present information relevant to the proposed transfer of ownership. Timing of the hearings was important to Sister Mary Theresa because the purchase agreement between Mt. Mercy and MEDICO called for an additional $100,000 per month if closing and transfer of ownership did not occur by the agreed upon date.

At the public hearings, Sister Mary Theresa began her formal statement to the group by indicating the significance of changing from a single autonomous institution to a multihospital system. The multihospital system was defined as a

(*Continues*)

combination of distinctly operating institutions under the single ownership and operation of one management unit. Sister Mary Theresa proposed that a multihospital system would achieve economies that could possibly contain or even reduce cost of patient care. She proposed that economies of scale are possible through central management and judicious consolidation of services, equipment, and personnel. She further argued that the smaller institution (Abbott) could improve care by its linkage to the larger comprehensive institution with its greater technology and scope of resources and services. The multihospital system would still be locally operated while effecting cost containments that could not be achieved by the duplication of services necessary for single unit care facilities. Her final argument centered on the advantages of a combined medical staff and administrative services. Sister Mary Theresa submitted a detailed plan of the proposed economies that would substantiate Mt. Mercy's claims of debt service capability through the combined operating revenues of Mt. Mercy and Abbott.

Sister Mary Theresa's written statement confirmed publicly the purchase price of $28 million. An initial $2 million was available from the operating reserves of Mt. Mercy Hospital. The hospital's operating budget would assume associated expenses for acquisition estimated at $500,000. The Monroe Foundation of St. Louis had made a $2 million donation to be applied directly to the purchase price. The balance of $24 million was to be obtained through the issuance of tax-exempt bonds.

Sister Mary Theresa estimated consolidation savings during the first year of acquisition at $673,000. These savings would result from the elimination of the Abbott management contract with MEDICO, using Mt. Mercy's data-processing capabilities, and the combination of maintenance contracts with Mt. Mercy's existing suppliers. Additional revenue economies were projected in laboratory services, purchasing, nursing administration, admitting, and electrocardiography.

Meanwhile, many local doctors went on record opposing the purchase. Among the most vocal was Dr. Martin Leeham, a powerful member of the "old guard" of the medical society. Leeham, noted for having a hot temper and being very outspoken, was considered a fine doctor and surgeon by his colleagues. He was one of the first doctors in the city to perform legalized abortions. During the past 16 years he has not exercised his admitting privileges at Mt. Mercy Hospital, even for cases not expected to run afoul of the Ethical and Religious Directives (ERD) for Catholic Healthcare Organizations (written by the American Conference of Bishops). Leeham also led a group of doctors and businesspersons in the community to approach the city council with a certificate of public necessity to build a 200-bed hospital in the northwest section of Auston. The hospital was to be doctor-owned and administered with no religious affiliation. Sister Mary Theresa and her board were very vocal in their opposition to such a plan and attended all public hearings to voice their objections. The plan for the doctor-owned hospital was defeated and left Leeham with a bitter attitude toward Sister Mary Theresa.

Soon afterward, the second public hearing for approval of the certificate of public necessity was scheduled with the project review board of the Auston

Council of Governments. Publicity from the county medical society meeting had aroused broad community interests. The ERD and the subject of abortions and sterilizations received widespread press coverage.

Abortions and sterilizations constituted 25% of the surgical revenues at Abbott. The ERD prohibits abortions or sterilizations in hospitals under Catholic ownership and operation. Opponents of the acquisition claimed that many of the new doctors locating their offices near Abbott intended to utilize the surgical facility at Abbott for abortions and sterilizations.

Sister Mary Theresa expected the project review board meeting to be emotional with strong opposition to approval of the certificate. During the meeting she refused to answer any questions relating to a description of the ERD. She stated the code would be operational at Abbott and consistently confined her comments to advantages from the multihospital concept and cost economies. The public opposition from the lay and medical community was not well organized and failed to mount any significant counterarguments. The project review board voted to approve the certificate of public necessity, thus clearing the way for a final hearing to be held with the State Department of Health Facilities Advisory Council. Sister Mary Theresa felt pressure to obtain immediate approval to avoid activating the price escalation clause. A delay could cost Mt. Mercy at least $100,000.

Sister Mary Theresa, Dr. John Cassler, Sister Mary Joseph, and Dwight Morris, attorney for Mt. Mercy, attended the meeting. Unlike the previous hearings, Mt. Mercy representatives expected staff of the health facilities advisory council to be well prepared. Sister Mary Theresa repeated her basic remarks about the multihospital concept. The health facilities advisory council staff immediately challenged the validity of her projected economies and raised the issue of closing emergency room services at Abbott. Sister Mary Theresa countered with a flat refusal to consider closing emergency room services without a thorough needs analysis. She supported her figures by asking council staff to specifically indicate areas of possible error in her projections. The council attorney, Jim Redden, launched into a lengthy statement about the power and influence of Mt. Mercy. He questioned community willingness to allow further expansion of that influence, citing newspaper articles following the county medical society meeting. The representatives from Mt. Mercy were somewhat alarmed at what they considered Redden's lack of objectivity. Several days later, a certificate of public necessity was granted by the state to Mt. Mercy for the acquisition of Abbott Hospital. Sister Mary Theresa had won her battle over the opponents of Mt. Mercy's expanding influence in the medical community.

Upon receipt of the certificate, Mt. Mercy retained Kidder, Kidder, and Company to handle a private placement of tax-exempt bonds to finalize the $28 million purchase. Bonds were quickly placed, and combined with operating reserve and foundation monies, the acquisition was completed.

Sister Mary Theresa contacted Dr. John Coletti, Abbott administrator under MEDICO, and asked him to remain. Coletti agreed, feeling the progress he had made at Abbott would continue.

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Early in January 1991, Sister Mary Theresa requested that the Mt. Mercy personnel department interview all Abbott staff members. Staff members were promised continued employment for a three-month probationary period, at the end of which permanent placement would be discussed. Staffs of both hospitals were informed they could be transferred between hospitals at administrative discretion. No seniority and accrued benefits from Abbott would transfer to Mt. Mercy/Abbott staff status. Coletti was not consulted or notified of these actions by the Mt. Mercy personnel department. He complained directly to Sister Mary Theresa and expressed concern that these actions would seriously undermine morale.

Sister Mary Theresa nevertheless directed the personnel department to continue with the interviews. Sister Mary Joseph was instructed by Sister Mary Theresa to advise all Abbott department heads that they were to report directly to their counterparts at Mt. Mercy. Abbott department heads thus became assistant department heads. Coletti was furious and threatened to resign his position immediately unless this policy was altered. Sister Mary Theresa held to her basic reorganization plan, and Coletti submitted his resignation letter immediately. Five department heads from Abbott also resigned.

Amidst turbulent conditions, Abbott Hospital became an operating satellite of Mt. Mercy Hospital. The ERD became the governing code on the Abbott on the same day.

Within two weeks of the Mt. Mercy takeover, six doctors had resigned from the staff of Mt. Mercy at Abbott. They transferred their staff privileges to Memorial, a local hospital that permitted abortions and sterilizations in its surgical facilities.

Sister Mary Theresa took over John Coletti's responsibilities and hired Adam Sampson to become assistant administrator for Mt. Mercy at Abbott. Sister Mary Theresa asked him for monthly reports summarizing the general operating and financial status of the satellite. At his previous position, the hospital's financial problems were dramatically turned around. Sampson had taken the credit for the progress, although reliable sources considered the hospital's staff to be the major change factor. Sampson considered himself an idea man who will work to avoid confrontation if possible. Observers generally described him as a nice person who takes orders well.

During the same month, Sister Mary Theresa formed a Mt. Mercy at Abbott Operational Review Committee comprising Sister Mary Joseph, Dr. John Cassler, and Adam Sampson. The committee was to meet monthly to review all phases of the Abbott operations. Sister Mary Theresa had set a goal for Abbott to break even within 13 months. She intended to make whatever adjustments necessary to facilitate the goal.

During the first few months after the acquisition, revenues for Abbott ran 15% to 20% below projected levels. Revenues from surgery and associated patient care days were the hardest hit, with a decline of 62%. The pediatrics occupancy rate was an unacceptably low 21%. Mt. Mercy staff doctors were not admitting patients to Abbott at a greater rate than before the purchase. Administrative costs were up 6% to 8%, within the anticipated range for the change to Mt. Mercy procedures. Sister Mary Theresa expressed concern about Abbott revenues to Cassler.

She reminded him that cost economies from consolidation were meaningless if she could not keep her operating revenues at a level necessary to service the acquisition debt. Sister Mary Theresa then instructed the operational review committee to look for possible consolidation of services, which would revise the operating structure of Mt. Mercy in order to strongly encourage Mt. Mercy staff doctors to utilize Abbott for all pediatrics and related cases. The beds vacated by pediatrics at Mt. Mercy could accommodate a planned surgical ward expansion.

In a management committee meeting, a somewhat frustrated Sampson indicated he was not getting cooperation from the Abbott staff. Sampson's specific analysis of doctor admissions confirmed Mt. Mercy staff doctors were not increasing their utilization of Abbott facilities. Sampson asked Sister Mary Theresa and the other committee members to consider transfer of Mt. Mercy personnel to Abbott to give him a staff that might be more responsive to his needs for operating information. Furthermore, he was finding it difficult to fill the administrative vacancies that had followed Coletti's resignation. Sampson indicated that while he was impressed with the competency of the Abbott staff he did not feel he was getting helpful input to facilitate correcting the bleak revenue picture. Sister Mary Theresa was opposed to transferring personnel between the two facilities. She proposed immediate reinstatement of accrued benefits from Abbott tenure to all Abbott staff members remaining on the combined staffs. Sister Mary Joseph strongly concurred, emphasizing the linkage between overall staff morale and the high quality of staff–patient relations for which Mt. Mercy and Abbott had been known. Sampson seemed hesitant about their proposal but did not challenge it. Cassler proposed initiation of formal conversations with a number of his colleagues to determine what types of services might attract both new doctors and increased admissions to Abbott from doctors currently exercising staff privileges at Mt. Mercy.

During the meeting, Cassler confirmed Coletti's appointment as director of planning for Memorial Hospital. He further reported Leeham's latest efforts to persuade several new doctors to move their practices to Memorial. Committee members were aware that Memorial had applied for a certificate of public necessity to add 26 additional beds. All committee members agreed a public response to Leeham was inappropriate.

Six months after the acquisition, accrued benefits were reinstated for the original Abbott staff members. Sister Mary Theresa and Sister Mary Joseph had begun plans to relocate all pediatrics services from Mt. Mercy to Abbott. Several staff doctors had expressed mild displeasure to Cassler but did not seem to be contemplating any serious opposition. Cassler also reported success in forming a group of staff doctors to study service needs that could be accommodated specifically at Abbott.

Sister Mary Theresa, without committee or board knowledge, began seeking additional foundation monies for debt service in the event revenues were not sufficient within 13 months to meet the debt service schedule. As she looked ahead, Sister Mary Theresa saw many difficulties but was exhilarated by the challenges of making a multihospital concept work.

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Case Study Review Questions

1. What are the major change issues in this case?
   Organizational change management theory centers on the models developed by Kurt Lewin, who suggested a three-step theory, and John Kotter, who developed a more detailed eight-step theory using Lewin's initial framework. These theories can be mapped to the CVF and the leadership profiles and communication orientation components specifically (see **Table 1.1**). Organizations in transition can be thought of as moving through the CVF framework in a counterclockwise direction keeping an external to internal to external focus. First, a new vision for the organization is established (external), then buy-in is needed from all people involved (internal) and new systems are developed and monitored against goals/vision (internal). Finally, the organization moves back to an external focus based on productivity and long-term planning with an eye toward the competition and marketplace. Likewise, the communication orientations can be mapped to this same sequence, moving from transformational to relational through hierarchical

Table 1.1 Stakeholders and CVF Roles

Lewin's Three-Step Model	Kotter's Eight-Step Model	CVF	Leadership Roles	Message Orientation
Unfreezing—overcome the pressures of individual and group resistance	1. Establish compelling reason for change	Upper right (external)	Innovator Broker	Transformational
	2. Form a powerful coalition to lead change 3. Create a new vision 4. Communicate the vision	Upper left (internal)	Mentor Facilitator	Relational
Movement—promote driving forces (positives) and restrict restraining forces (negatives)	5. Empower others to act on vision 6. Create and reward short-term "wins" 7. Consolidate improvements	Lower left (internal)	Monitor Coordinator	Hierarchical
Refreezing—stabilize new environment by balancing driving and restraining forces	8. Reinforce change by demonstrating relationship between new environment and organizational success	Lower right (external)	Director Producer	Promotional

Figure 1.7 Stakeholders

and finally promotional. The communication mapping is less rigid and less precise, because it is important to implement message orientation according to the situation/environment, the audience, and the communication goal rather than a predetermined path.

2. Map out the key players in the environment of Mt. Mercy.
   The case presented is an opportunity to explore this mapping process and identify the opportunities for effective message orientation based on the importance of the key players and their level of impact on the organization. It also clearly illustrates the communication breakdowns that can occur when a leader refuses to adopt different messages in order to adapt to changing environments and respond effectively to organizational stakeholders. We used the process suggested in Belasen (2008) to identify the stakeholders (**Figure 1.7**) and their relative importance (**Table 1.2**).
3. Evaluate the types of communication used by Sister Mary Theresa.
   It is clear from the way Sister Mary Theresa operates that her managerial style can be found on the lower half of the CVF diagram. She is strongly control focused and competitive and does not venture much into the collaborate (upper left) or create (upper right) quadrants. The words that her supporters use to describe Sister Mary Theresa, "strong-willed, articulate, well-organized," and "unafraid of confrontation and a tough competitor," are the same terms associated with the control quadrant. Thus it is not surprising that Sister Mary Theresa's predominant communication orientation also lies on the lower half of the CVF. The type of messages that Sister Mary Theresa offers are hierarchical and promotional and can be expressed as organized, practical, and action oriented. As **Figure 1.8** shows, Sister Mary Theresa displays strong preference for hierarchical messages in her communications with her staff, the board, and the regulators.

(*Continues*)

Table 1.2 Importance and Influence of Stakeholders

		Importance of Stakeholders			
Acquisition Period	**Stakeholders**	**Unknown**	**Little or No Importance**	**Some Importance**	**Significant Importance**
Influence of Stakeholders	Sisters of the Sacred Heart				X
	Sister Mary Theresa				X
	Sister Mary Joseph and Dr. John Cassler				X
	Mt. Mercy Hospital board of directors			X	
	MEDICO management and shareholders				X
	Area residents (public and customers)			X	X
	Dr. John Coletti				
	City Council of Governments		X	X	
	Community			X	X
	Dr. Martin Leeham		X		
	Abbott's department managers		X		
	Abbott's physicians and staff	X			
	Media			X	

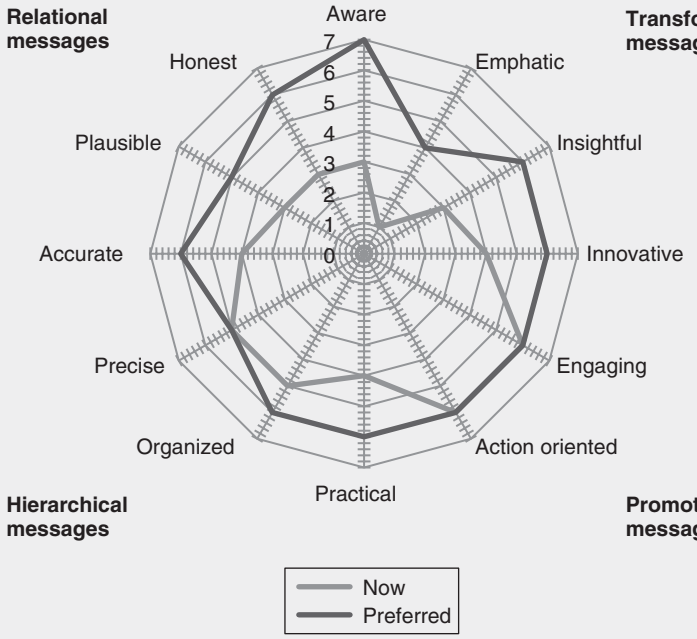

Figure 1.8 Sister Mary Theresa's Message Orientations

Review Questions

1. Discuss current and emerging challenges faced by healthcare leaders.
2. What are the major differences between transactional and transformational forms of leadership? Are these differences reconcilable?
3. What are the tenets of the CVF? How does this framework provide an integrated view of organizational environments?
4. A key to successful mastery is recognizing the contradictory pressures on the managerial job. Explain.
5. What are the strengths of the master leader?
6. Discuss the different types of message orientations, then illustrate each type with examples using a managerial situation.

7. What is the special role of the CVF in facilitating understanding across hierarchical lines?
8. Assume you are a consultant hired by Grove Memorial to help the hospital administrators develop ways to shift the culture from the left side of the CVF to the right side. What do you propose they do?
9. Review the model in Figure 1.8 and discuss the relationships among its quadrants. What tradeoffs should the master leader consider when balancing these quadrants?
10. Trace the leadership roles played by Sister Mary Theresa in the various situations. How effective was she? Should members of her board support her actions without more information? Why or why not?
11. Identity sources of conflict as leaders of Mt. Mercy acquire Abbott.
12. Describe the differing values, interests, and influences in the medical community and at Mt. Mercy. Determine how past events have contributed to the present situation.

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