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The human face of organisational change

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The Human Face of Organisational Change

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Abstract

This current study investigated a possible extension to existing transformational leadership models used during organisational change programs. Researching the literature provided some preliminary evidence there was a need to include a potential extension to transformational leadership models.

The original models of transformational leadership involved looking at the staff members from an organisational perspective, whereas the potential extension, concerns the human aspects of organisational change. The potential new extension consists of four components: communication, team building, stress and coping and inter-group conflict. This possible extension to the transformational leadership models appeared to be an exciting addition as it addresses important human resource issues experienced during organisational change. The present study sought to further investigate whether these four components indeed were warranted and whether its components actually contributed to successful organisational change.

The research methodology was exploratory, qualitative and based on a grounded theory approach (Glaser & Strauss 1967). Using an embedded case study method, in-depth convergent interviews were undertaken in four hospitals undergoing considerable organisational change. Twenty-six managers, executives and staff were interviewed.

It was found that the change managers themselves were enthusiastic about implementing change but were unable to offer effective support for staff. Staff and managers said that communication within the hospitals during the period of change was poor. Similarly there was a paucity of accurate information being disseminated. Managers and staff also revealed that they had experienced considerable stress during the period of change and they needed help in order to cope effectively. Varying levels of inter-group conflict were reported in all the hospitals studied and managers reported that changes were not being implemented appropriately. However, efforts at team building were non-existent in two of the hospitals studied.

These findings provide strong support for managers and leaders to pay increased attention to communication, team building, dealing with conflict and managing stress during times of increased change. This study suggests that a potential extension of the four components could be added to, and thereby strengthen, the transformational leadership models of organisational change.

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DECLARATION

I certify that the work presented in this thesis is to the best of my knowledge and belief, original, except as acknowledged in the text and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I also certify that to the best of my knowledge any help received in preparing this thesis, and all sources used have been acknowledged in this thesis.

_____ 5th July 2006

Camille R.A. Jackson

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This thesis has been completed with incredible support and guidance from numerous people. The research and writing has been challenging and exciting. The experience has been valuable and I have grown as a writer and a researcher.

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The most profound thank you must go to my parents Ruth and Peter Jackson. At the commencement of this thesis my mother Ruth was diagnosed with Breast Cancer. Throughout her surgery, radiation and recovery she has provided unfailing strength, support, stamina and love. She is now a Breast Cancer Survivor and a thesis survivor as well. I cannot say in words how much I love and admire her strength at this incredibly difficult time. She has always been there for me with this thesis.

My father Peter has also seen me through many different thoughts, ideas and discussions and has always supported and guided me. He has been an incredible support to me through my mothers ordeal and through the completion of my thesis. My parents have added valuable contributions to the development and finalisation of the thesis. With their love, support and continual encouragement the thesis has been completed.

Thank you.

CHAPTER 1
Thesis Overview

1.0 Introduction

The principle aim of this current study was to investigate transformational leadership models used during organisational change. Specifically, previous research had suggested the possibility that many transformational leadership change models neglect to consider the management of the effects of change on humans. This research used an embedded case study method involving four hospitals in Queensland, Australia that had recently undergone considerable organisational change. A qualitative, exploratory approach based on grounded theory (Glaser & Strauss 1967) was used.

This chapter first provides the background to the current study and the research problems and questions derived from the literature. A justification for the current study and an explanation of the research methodology are provided. The current study and the results are discussed and, finally, the key assumptions and limitations are described.

1.1 Background and justification for the study

There are a number of change models that provide specific guidelines on how change should be led by applying distinct steps to change or challenges (Mintzberg 1973; Kotter 1996; Bass and Avolio 1994); Kouzes and Posner 1995; and Kanter, Stein and Jick 1992). One of the advantages of these transformational leadership frameworks has been their value as a checklist to highlight the underlying aspects of change that needed to be taken into consideration. It appeared, as discussed in Chapter 2, that these models did not adequately address the issue of how leaders deal with the effects of change on people.

Managers and leaders of organisations operate in environments that exert considerable pressure for change because of globalisation, improved communications and rapid technological innovation. (Finegold & Schechter 1995). In response to these challenges,

managers and leaders drive changes to organisational structures and work practices essential for increasing efficiency and competitiveness. Strong leadership has been noted as central to successful change (Miller 2002). Thus, successful leadership behaviour appears to be dependent on the leader's own personal level of change adaptability, including their built-in coping mechanisms and the beliefs they hold about the drivers that make change successful. This study was specifically concerned with this element of transformational leadership in a change environment.

This current study involved four hospitals in Queensland where the health system had undergone major changes over the past few years. The four hospitals investigated in this study had thus been through major change, with two hospitals moving from a religious-based organisation to a business enterprise, while the other two public hospitals were amalgamated into a single, district-based unit. Consequently, these hospitals were in a fascinating and suitable position to investigate organisational change and the role of leaders during the process.

In summary, this present study aimed to contribute to both theory and practice and described three major frameworks that guided the understanding of the behaviour of leaders of change, especially transformational leaders. Each framework (Bass & Avolio 1994; Kotter 1990a, Kouzes & Posner 1995) provided a useful guide to the current research.

1.2 Statement of the research questions

A number of research questions were derived from the literature:

1. What communication skills do transformational leaders use in the organisational change process?
2. How do transformational leaders foster change in the organisation through team building?
3. How do transformational leaders manage the high levels of stress and coping that occur during organisational change?

4. What do transformational leaders do to manage inter-group conflict during organisational change?
5. Are there other components that need to be added to the transformational leadership models not previously identified?

The following section briefly describes the methodology used to answer these research questions.

1.3 Research methodology

This present study was based on a grounded theory (Glaser & Strauss 1967) approach and used in-depth interviews with the executives, managers and staff of the four hospitals that had undergone organisational change. Grounded theory is particularly useful in generating theory where little is already known, and to provide fresh views on existing knowledge. Specifically, an approach to grounded theory proposed by Strauss and Corbin (1990) was used to inductively derive theory about leadership during change.

Qualitative research methods are widely accepted as an appropriate methodology for exploring the management and leadership of change. Recent examples of qualitative studies that have informed theory development in this field include the change models of Dunphy and Stace (1991), the stages of change leadership by Kotter (1996), and the work of Kanter and her colleagues on corporate change (Kanter, Stein & Jick 1992).

Qualitative methods, according to Conger (1998) offer the study of leadership several distinct advantages and provided opportunities to explore the leadership phenomena in significant depth. The conclusions emerging from qualitative research are impressionistic rather than definitive. Accordingly, the qualitative method was judged as the most appropriate for this study.

Qualitative studies, such as case study research, allow the researcher an opportunity to obtain accurate and detailed information (Gorden 1975). Within the case study environment, the use

of the interview technique provides the means to understand respondents' interpretation of the questions and allows greater flexibility in questioning respondents. This research involved in-depth interviews that facilitated control over the interview situation and provided a better chance to evaluate the validity of the information by observing the respondents' verbal and non-verbal behaviour (King 1994).

Chapter Three provides a comprehensive analysis of the research methodology used in this study and details how the methodology was applied to answer the research questions.

1.4 Limitations and delimitations

This was an embedded case study that focused on four hospitals in Queensland and hence the findings have limited generalisability to other organisations and contexts. However, the study did provide an opportunity to investigate transformational leadership in great detail and devise models that might be tested at a later time.

1.5 Outline of the thesis

This current thesis, entitled *The Human Face of Organisational Change*, is organised into six chapters.

Chapter 1 provides a brief overview of the study, its background, purpose and objectives, the research questions, and the methodology undertaken.

Chapter 2 is a detailed review of the existing literature pertaining to transformational leadership, organisational change, and the role of leadership during an organisational change program.

Chapter 3 describes the methodological approach used in the study. A justification for the use of qualitative research, especially the use of grounded theory, is provided.

Chapter 4 presents a detailed description of the changes within the researched hospitals, and analyses how and why the hospitals undertook that change. It also sets the scene for Chapter 5, where the changes and their impact on staff are addressed and analysed

Chapter 5 discusses the findings in light of the previously presented literature and consolidates the results to provide specific comments to each of the research questions.

The sixth and final chapter summarises the major conceptual and applied outcomes of this project. The shortcomings of the study are indicated and proposed future research directions described.

1.6 Conclusion

It can be seen from the background above that this current study provided a potentially exciting opportunity to examine transformational leadership in a climate of change. Specifically, it aimed to examine, using a case study analysis of four hospitals, the extent to which the effects of change on people needs to be included in models of transformational change.

The next chapter, Chapter 2, examines the literature in relation to change management and leadership, and discusses the gaps in the literature underpinning this research.

CHAPTER 2
Literature Review

2.0 Introduction

This chapter analyses and identifies gaps in the literature of leadership, particularly transformational leadership, and several organisational change models. This analysis provides the basis for the current research, which is based on several transformational leadership models of organisational change.

The literature review indicated that organisations reacted to continuous change in a number of key ways as encountered by Rieley and Clarkson (2001) with the constant movement of people in and out of organisations undergoing corporate change resulted in relative chaos, reducing options for accountability, organisational effectiveness, and a cohesive organisational vision – it also, increased the levels of stress among those affected by the change. Organisational design according to Starbuck and Nystrom (1981) created problems which lead to job accidents, high turnover of staff and poor product quality. To redesign organisations through change programs the leaders should not imitate other successful organisations but must design their own organisations so they were different from present organisation and from other successful organisation. Starbuck and Nystrom (1981) believed organisational design was an essential element to understanding the modern organisation and the role of leaders in the organisation. Consequently, Miller (2002) believed strong leadership was central to successful change, and successful behaviour in leaders depended on: i) their personal adaptability to change, and their built-in coping mechanisms; and ii) the set of beliefs they held about what makes change successful.

This literature review considered relevant leadership theories of change (Bass & Avolio 1994; Kotter 1990a, b; Mintzberg 1971; Kouzes & Posner 1987, 1995) beginning with a broad overview of the theories leading through to several leadership and change models. Specifically, the efficacy of these transformational leadership models was reviewed and the research (Jackson 1999; Jackson & Callan 2001) suggested that there may be some

components missing from these models that may have an impact during the change process. These components were:

- communication
- team building
- stress and coping
- inter-group conflict.

This chapter provides a general description of the building blocks of good leadership and an overview of the models of leadership styles (Bass & Avolio 1994; Kotter 1990a, 1996; Kouzes & Posner 1987, 1993, 1995) required to complete successful organisational change. The review of these leadership models has highlighted the relevance of the four components to organisational change in the 21st Century. The following section discusses the roles of managers and leaders with a comparison of management and leadership during organisational change.

2.1 Comparison of Managers and Leaders undertaking organisational change

The following section examines and contrasts the roles of leaders and managers within organisations, especially during periods of organisational change.

2.1.1 What do managers do?.

Several conceptual frameworks and managerial typologies defined the major roles of managers. In one of the earliest typologies, Fayol (1949) believed that a manager's role was categorised as a planner, organiser, commander, coordinator and controller. Later, Mintzberg (1971) identified ten major managerial roles: figurehead, leader, liaison, monitor, disseminator, spokesperson, entrepreneur, disturbance handler, resource allocator and negotiator. Moreover, in contrast to Fayol's (1949) assertions of order and control, Mintzberg (1971) described the managerial lifestyle as reactive, political and extremely hectic (see also: Hill 1992).

Overall, these frameworks (Fayol 1949; Mintzberg 1971) divided managerial functions into four general processes. First, managers developed and maintained relationships; second, they obtained and gave information; third, they made decisions; and finally, they influenced people. Higher-level managers, according to Katz and Kahn (1978), were usually concerned with formulating long-range plans and policy, modifying the organisational structure and initiating new ways of achieving results. Lower-level managers were more concerned with interpreting and implementing policies and programs (Mintzberg 1973; Nealy & Fiedler 1968). Similarly, Daft (1999) stated that a traditional model of management could be defined as the attainment of organisational goals in an effective and efficient manner through planning, organising, staffing, directing and controlling organisational resources.

Studies of managerial behaviour (Kotter 1990a, 1999a; Mintzberg 1971) revealed a lifestyle that was more dynamic, complex and reactive than initially described by Fayol (1949). A manager's life was demanding – being concentrated on communication and action – and there were high levels of fragmentation (see Hill 1992; Luthans 1988; Mintzberg 1971). Managers were geared to action, and the pace of the action could be unrelenting, especially in keeping up with new information (Hill 1992). These models (Kotter 1996; Mintzberg 1971) revealed that the manager's job was not one of a reflective planner but to be reactive to emerging situations with managers heavily relied on their own feelings about what was appropriate action (Mintzberg 1973). Many of a manager's decisions were based on actions that were practical and time efficient, however, despite their desire to control their time, many managers were reluctant to delegate (Luthans 1988) and often became overburdened with jobs and tasks that should be performed by others in the workplace (Hill 1992; Luthans 1988).

Investigations into the responsibilities of leaders and managers within organisations, found that leaders performed different functions, undertook different decision-making roles and had specific leadership objectives that differed to those of managers. The literature analysis above shows that mangers are limited to undertaking the implementation and day-to-day functions of organisational change. They are not equipped with the tools, abilities or leadership skills to inspire and develop the agenda for change.

2.1.2 What do leaders do?.

To be a leader, one has to make a difference to an organisational change program and facilitate positive change (DuBrin 1998). The common characteristic of leaders was their ability to inspire and stimulate others to achieve worthwhile goals (Hughes, Ginnett & Curphy 1993). An important understanding in leadership was that there would be a long-term relationship, or partnership, between the organisation and the employees (DuBrin 1998). A partnership occurred when, in a move from authoritarianism to shared decision-making, control shifted from the leader to group members. According to DuBrin (1998), for a valid partnership to exist: the leader undertook an exchange of purpose; employees had the right to say "no"; there was a joint accountability between leaders and followers; and finally, there was absolute honesty between leaders and followers.

According to Kotter (1999a), leadership was usually about setting new directions. Leaders clarified the vision, helped people understand the new direction and, despite sacrifices and difficulties, motivated within them the desire to make it happen. Yukl (1989) stated that leadership established direction and developed a vision for the future with the strategies to achieve it. Leadership was about aligning people and communicating the direction, through words and deeds, to all those involved (Bass 1990). It was also about influencing the creation of teams and coalitions who understood the vision and accepted their roles its implementation (Bennis 1989a). Leadership was about motivating, inspiring and energising people to overcome major political, bureaucratic and resource barriers to change by satisfying basic, unfulfilled needs and produced useful change in an organisation that was often dramatic (Kotter 1999a). As well Kolb, Rubin and McIntyre (1971) believed if leaders wanted to have a really far reaching influence, they must make followers feel powerful and able to accomplish things on their own. For a group to feel truly strong, the leader must continually consult them and be aware of their wishes and desires.

According to Sosik and Megerian (1999), the leader of an organisation undergoing change needed to maintain five components: self-awareness; emotional control; motivation; empathy; and social skills. To be effective in organisations Kolb, Rubin and McIntrye (1971) stated leaders must be educators. They lead staff by helping set goals, communicating those goals

widely throughout the organisation, taking the initiative in formulating means of achieving the goals and finally inspiring members of the organisation to feel strong enough to work hard for those goals. As well leaders needed to be attuned to their own feelings and those of others and used their understanding to enhance the organisation (Weisinger 1998). The research (DuBrin 1998; Kotter 1999a) showed the necessity for a leader to be visionary and transformational when undertaking organisational change.

To attempt to be a visionary leader when a change process was undertaken, Kotter (1999a:17) believed that there were four functions for leading from the top down:

i) setting a vision that is consistent with the market (and other external realities) and strategies for achieving that visions;
ii) aligning people by communicating the vision both inside and outside the organisation;
iii) inspiring action by motivating and influencing people and removing large obstacles (like bureaucracy and poor compensation); and
iv) succeeding by focusing on strategically appropriate goals that help the enterprise to leap ahead and excel.

Overall, Kotter (1999b:15) believed that in high-performance organisations with strong direction, leaders created internal change processes that coped with external change. Strong leaders were perceived to have eight abilities that created a high-performance organisation (Kotter 1999b:15):

1) They set a greater sense of urgency by seriously examining the market and competitive realities, identifying and discussing real or potential crises and major opportunities.
2) They created the guiding coalition by assembling a group with enough power to lead the change and getting them to work as a team.
3) They developed a vision and strategies to help direct the change effort.
4) They constantly communicated the change vision using all means, and modelled the behaviour needed by the guiding coalition.

5) They empowered others to act by changing systems and structures that blocked or seriously undermined the change vision, and by encouraging risk taking, non-traditional ideas, activities and actions.
6) They created short-term wins by planning for visible performance improvements, then recognising and rewarding those who made the wins possible.
7) They consolidated gains (and produced even more change) using their increased credibility to alter incongruent systems, structures and policies to fit the transformation vision. By hiring, promoting and developing people to implement the vision, they reinvigorated the process with new projects and themes, and did not prematurely declare victory;
8) They established a greater sense of urgency by creating better performance through: customer and productivity-oriented behaviour; superior leadership; more effective management; articulating the connections between new behaviour and the firm's success; and ensuring leadership development and succession.

This current research study was based on the transformational leader qualities identified by Kotter (1999a) and other leadership models. Managers attempting significant organisational change would struggle to succeed if they did not have the necessary disposition to be visionary and inspirational. An organisation undergoing change had a significantly higher chance of success with a leader possessing the attributes mentioned above.

2.1.3 Summary.

As the previous analysis showed, managers and leaders assume different roles and functions within an organisation, especially when undergoing change. Leaders provide a vision, guide the change, inspire staff and establish a sense of urgency about the change; while managers undertake the detailed work of developing policies, planning, and following procedures as directed by the leaders. The literature established an interesting pattern of differences between managers and leaders that is analysed in the next section.

The literature demonstrated that a combination of skills enhanced a leader's ability to move an organisation through a change process, and showed the followers that the principal in charge

was not simply a manager, but a true leader (Jackson & Callan 2001). Leadership can have a positive impact on organisations by: helping employees grow and learn; creating a sense of purpose and meaning; instilling unity and team spirit; and building relationships of trust and respect that allowed employees to take risks and fully contribute to the organisation (Kotter 1990a, 1999b).

The next section presents a comparative study of leaders and managers to develop an understanding of the need for a leader rather than a manager to implement a change program. The following analysis shows that an organisational change program should be based on a number of aspects, including charismatic leadership (Bass 1985; Conger & Kanungo 1988) and transformational leadership (Hater & Bass 1988; Yukl 1971, 1989).

2.1.4 Managing versus leading.

Kotter (1990a, 1999a, b) suggested that management and leadership were different: management involved planning, budgeting, organising, staffing, controlling and problem solving while leadership was about the establishment of direction, aligning people and inspiring managers to achieve a vision (Bennis 1989a, b). Vision occurred among those people who intentionally desired significant changes that reflected the purposes shared by leaders and followers (Smith, Peterson & Jyuji 1994).

These views led to the belief that leadership and management were two distinctive and complementary systems of action (Kotter 1990b, 1999b). The challenge for today's managers was to provide both strong leadership and strong management (Zaleznik 1983). However, managers were caught between contradictory demands and pressures: they experienced ethical problems; they ran the risk of dismissal; they were *victims* (as well as perpetrators) of discourses and practices that unnecessarily constrained their ways of thinking and acting (Alvesson & Willmott 1992). Kotter (1999a) stated that leadership was different to management and was the primary force behind successful change. Without leadership, the probability of mistakes during a change program greatly increased and the probability of success significantly decreased (Mintzberg 1994).

Kotter (1990b) stated, managers and leaders needed to accomplish three functions that were achieved in different ways. First, management focused on dealing with complexity by planning and budgeting: leadership dealt with complexity by setting a direction and developing a vision of the future. Second, management provided the capacity to achieve plans and budgets by organising and staffing: leadership was about aligning people and communicating the new direction to those who created powerful and guiding coalitions. Third, management ensured success by encouraging control and problem-solving behaviour: leadership focused on motivating and inspiring others to complete the plan (Bennis 1989; Kotter 1990b).

Despite differences between management and leadership, Zaleznik (1974, 1983) believed there were clearly high levels of overlap and both involved deciding what needed to be done and creating networks of people and relationships to accomplish the agenda. Despite these similarities, Bass (1979) argued that the differences far outweighed the similarities. The planning and budgeting processes of management tended to focus on timeframes, ranging from a few months to a few years. While, leadership processes tended to encompass longer timeframes, with big-picture strategies involving a series of calculated risks (Bennis 1989b). Leadership and management also differed in primary function (Bennis & Nanus 1985), for example, strong management discouraged the risk-taking and enthusiasm needed for leadership, while strong leadership disrupted orderly planning and undermined the management hierarchy. The challenge was to combine strong management and leadership and to balance each other (Kotter 1990b).

Zaleznik (1997) believed that our predisposition for bureaucracy had a tendency to develop managers rather than leaders. He believed that managers were perceived as merely problem solvers, concerned with rationality and control, not necessarily relying on imagination, creativity or ethical behaviour to guide the destiny of an enterprise. This view was supported by Selznick (1984) who believed that roles were differentiated by the manager's exclusive domain to become an expert preoccupied with *routine* decisions. Terry (1995) also felt that the key difference between them was that managers were "routine problem solvers", while leaders were "creative problem finders".

According to Zaleznik (1997), leaders faced situations actively rather than passively; they overcame and transformed conditions and not simply reacted to them. In addition, Bennis and Nanus (1985) argued that leadership with a vision and a capacity to inspire followers must replace management. They also maintained that to be successful, a leader needed the ability to communicate meaning and cultivate trust through positioning and must have a positive and adaptable self. More recently, Parry (1996) asserted that a leader charged followers with enthusiasm and engendered an aura of action and vision that bound the organisation together. Australian leaders that Parry (1996) interviewed were successful in generating a willingness in others to follow their lead.

Those in managerial jobs (Yukl 1989) were thought of as people who created agendas with both plans and budgets (the management part) and visions and strategies (the leadership part). They were people who developed networks to implement change through both hierarchy (management) and a complex web of aligned relationships (leadership) – and they executed both through controls (management) and inspiration (leadership) (Kotter 1999a). The proportion of planning versus creating vision, organising the hierarchy versus aligning the web of relations, and controlling versus inspiring varied with the individual and the organisation. The higher a person rises in an organisation, the more they needed to be involved in the role of leadership (Kotter 1999b) and leadership, according to Kotter (1999a), was a growing aspect of a managerial role and was an important shift in the nature of *managerial* work.

Since management, unlike leadership, tended to work through a formal hierarchy, and as organisational change demanded more leadership, managerial positions were placing people in more complex webs of relationships (Bass 1990; Bennis & Nanus 1985). In a changing world where leadership was necessary, more individuals outside one's chain of command took on added importance. Managerial work was increasingly a leadership task, becoming a game of informal dependence on others rather than just formal power over them (Kotter 1990a, b, 1999a, b). Increasingly, managerial work involved actively dealing with dependence on superiors, subordinates, peers and often outside people as well. The current research showed

that, management is not leadership, but it is a component and the two intertwined are not mutually exclusive.

2.1.5 Summary.

As shown in this section, leaders and managers can have distinct work roles and perform different functions within an organisation, while managers rarely have the skills to successfully undertake change. It has also shown that a *leader* would be the preferred style of person to perform organisational change, while a *manager* implemented the policies and procedures designed by the leader. However, the analysis did not demonstrate the different types of leaders involved in change. The next section investigates the different styles of leadership and how these affected the change process, and why *transformational* leaders were chosen for this study and were more successful.

2.2 Understanding the leadership of change

The aim of this section was to identify the key issues for excellence in change leadership. To clarify the roles and responsibilities of a leader there are a number of theories (Hersey & Blanchard 1982; House 1971; Vroom & Yetton 1973) that provided useful frameworks for understanding the leadership of change and the concepts of vision, values, leading by example, communication, rewards and empowerment. The study of leadership began in the 1930s (Rosenbach & Taylor 1993), and in the early 80s there was a major shift in the models of leadership from “transactional” to “transformational” (Gaughan 2001).

Major change began after an individual who already had a track record for leadership was appointed (Kotter & Heskett 1992). The new leader created a team that established a new vision and set of strategies for achieving that vision. Each new leader succeeded in persuading important groups and individuals in the organisation to commit themselves to that new direction and then energised the personnel sufficiently to make it happen, despite all the obstacles.

Changes in strategy, structure and work processes often left managers unsure of their roles and related responsibilities (Kouzes & Posner 1987), which led to a similar confusion for others within the organisation and role ambiguity was a major obstacle to the improvement of organisational performance, innovation and change efforts (Longenecker & Fink 2001). If managers were to serve as the drivers of change efforts, they needed to understand the company's *vision*, and how their own efforts, as well as others in the organisation, fitted into achieving that vision (Kouzes & Posner 1987). To avoid and overcome these difficulties Kotter and Heskett (1992) stated leaders needed to create a perceived need for change, to communicate widely the facts that pointed to a crisis or potential crisis. At the same time, leaders developed or clarified their visions of what changes were needed. Vision and strategies were communicated with words-spoken simply, directly and often. Kotter and Heskett (1992) stated leaders encouraged staff to engage in dialogue with them, by not allowing the communication to flow in one direction only. The values and practices they wanted infused into their firms were usually on display in their behaviour and these actions were seen to give critical credibility to their words.

In particular, this review examined the research by Bass and Avolio (1994), Kotter (1996), and Kouzes and Posner (1987, 1995). A closely related aspect of transformational leadership was charismatic leadership, which was also analysed. This review examined these theories of the behaviour of the transformational leader by analysing the general differences between transactional and transformational leadership, and later the specific details of the three leadership styles.

2.3 Transactional versus transformational leadership

According to Gaughan (2001), the shift in thinking about what constituted effective leadership was essentially a change in paradigm from transactional to transformational leadership. Gaughan (2001) believed the focus of transformational leadership research was not only on the behaviour of leaders, but also about the perceptions of what staff needed in a leader. Transformational leaders, according to Avolio and Bass (2002), motivated others to do more than they originally intended – often more than they thought possible. Such leaders set

expectations that were more challenging and typically achieved better performance (Avolio & Bass 2002).

According to Gaughan (2001), earlier models of leadership such as the situational (Evans 1970; Hersey & Blanchard 1969, 1977, 1996) or contingency models (Fiedler 1964) focused on identifying styles and behaviour that were dependent on a range of situational factors. These different styles adopted by many organisations, enabled leaders to become more effective by considering organisational complexity (Gaughan 2001).

Therefore, transformational leadership according to Bass and Avolio (1994) involved recognising and satisfying the higher-order needs of lower-level managers. These needs included self-esteem, self-actualisation, recognition, autonomy and responsibility (Sarros & Butchatsky 1996). On the other hand, Burns (1978) believed that transactional leadership described a leader/follower relationship where the follower (or employee) received rewards (salary recognition) for completing a job/task satisfactorily. It involved values, but they were values relevant to the exchange process – for example: honesty, fairness, responsibility, and reciprocity (Burns 1978). Hersey, Blanchard and Dewey (1996) believed that without interpersonal competence or psychological safe environments, the organisation was a breeding ground for mistrust, inter-group conflict, rigidity which in turn leads to a decrease in organisational success in problem solving. However if humanistic or democratic values were adhered to in an organisation, trusting and authentic relationships will develop among staff and will result in increased interpersonal competence, inter-group cooperation, flexibility and should result in organisational effectiveness (Hersey, Blanchard & Dewey 1996). Therefore, transformational leaders sought to raise the consciousness of followers by appealing to higher ideals and moral values, such as liberty, justice and equality – not to baser emotions like fear, greed, jealousy or hatred (Burns 1978).

Bass (1985) also distinguished between transformational and transactional leadership, where transformational leadership was thought of primarily in terms of the leader's effect on followers. Followers felt trust, admiration, loyalty and respect towards the leader; they were motivated to do more than originally expected to do (Burns 1978). A leader transformed

followers by making them more aware of the importance and values of task outcomes – inducing them by activating their higher-order needs to transcend their own self-interest for the sake of the organisation or team. In contrast, Bass (1985) viewed transactional leadership as an exchange of rewards for compliance – not only the use of incentives and contingent rewards to influence motivation, but also clarification of the work required to obtain such rewards. Transactional leaders focused on the present; they excelled at keeping an organisation running smoothly and efficiently (Bass 1985).

Other major research into leadership style was by Avolio and Bass (2002), who stated that transformational leadership was an expansion of transactional leadership. Transactional leadership emphasised the transaction or exchange that took place among leaders, colleagues and followers (Avolio & Bass 2002), while true transformational leaders raised the level of moral maturity of those they led and converted their followers into leaders (Daft 1999). Transformational leaders broadened and enlarged the interests of those they led; they motivated their associates, colleagues, followers, clients – and even bosses – to go beyond their individual self-interests for the good of the group, organisation and society. According to Daft (1999), transformational leaders addressed each follower's sense of self-worth in order to engage that follower in true commitment and involvement, an attribute added to the transactional exchange.

Avolio and Bass (2002) and Gaughan (2001) claimed that transactional leadership occurred when the leader rewarded or disciplined a follower on the adequacy of the follower's performance; it also depended on contingent reinforcement (positive or negative reward in either active or passive forms). Therefore, the components of transactional leadership included:

a) Contingent reward: this *constructive* transaction was reasonably effective (although less than the transformational components) in motivating others to achieve higher levels of development and performance. With this method, the leader assigned (or achieved agreement on) what was to be done and offered rewards or promises in exchange for satisfactorily completing the assignment.

b) Management by exception: this *corrective* transaction tended to be ineffectual, but was required in certain situations. Management by exception was active or passive. When active, the leader arranged to actively monitor deviances from standards and errors in the follower's assignments, and to take corrective action as necessary. When passive, the leader waited for deviances and mistakes to occur, and then took corrective action.

2.3.1 Summary.

As demonstrated above, there were many differences between transformational and transactional leadership. Transformational leadership was characterised by the ability to bring about significant change (Avolio & Bass 2002) and to lead change towards the vision and promote innovation in products and technologies (Daft 1999). It was this significant concept of altering the vision, direction, strategy and culture of an organisation that directed this current study towards the transformational rather than transactional theories of leadership. As stated by Yukl (1989), the terms *transformational leadership* and *charismatic leadership* referred to the process of influencing major changes in the attitudes and assumptions of an organisation's members, and built commitment for its objectives.

When undertaking organisational change, the research (Avolio & Bass 2002; Bass 1990) demonstrated that an effective leader must be transformational. Organisations that used transactional leaders found change to be harder, more complex and less energised; staff became frustrated, confused and angry with the transactional leader, as demonstrated in this current study. Therefore, it was important that a transformational leader undertake the change by encouraging vision, inspiring change and to allow staff to feel they wanted the change to occur.

Notwithstanding the effectiveness of a transformational leadership in change, the leader with nothing other than charisma might not be fully transformational and so transformational leadership was usually defined more broadly than charismatic leadership. To develop a greater understanding of charismatic leadership, a brief study follows to compare its closeness to transformational leadership.

2.3.2 Charismatic leadership.

Charismatic leadership was believed to result from the followers' perceptions of leadership qualities and behaviour (Yukl 1989). These perceptions were influenced by the context of the leadership situation and the followers' needs, both individually and collectively (Weber 1947). House (1977) proposed a theory of charismatic leadership that identified how leaders differed from other people and their traits and influences.

According to House (1977), a charismatic leader was defined by: the followers' trust in the leaders' beliefs; the similarity of the followers' beliefs to those of the leader; unquestioning acceptance of the leader by the followers; the followers' affection for the leader; a willing obedience to the leader; the emotional involvement of followers in the organisation; heightened performance goals; and the belief by followers that they could contribute to the success of the group's mission.

Bass (1985) proposed an extension to House's (1977) theory that included: antecedent conditions, leader attributes, and the consequences of being a charismatic leader. However, these theories were superseded by those of Conger and Kanungo (1987) who proposed that charisma was an "attributional phenomenon". Conger and Kanungo (1987) believed that followers attributed certain charismatic qualities to a leader based on their observations of the leader's behaviour. The major features of Conger and Kanungo's (1987, p 208) theory included:

a) extremity of the vision
b) high personal risk
c) use of unconventional strategies
d) accurate assessment of the situation
e) follower disenchantment
f) communication of self-confidence
g) use of personal power.

Consequently, charismatic leaders had the ability to inspire and motivate people to do more than they would normally do, despite obstacles and personal sacrifice (Daft 1999). These

leaders had an impact on people because they appealed to both the heart and the mind. They created an atmosphere of change and articulated an idealised vision of a future significantly better than the present. According to Daft (1999) they had an ability to communicate complex ideas and goals in clear, compelling ways and inspired followers with an abiding faith and had an unconventional way of transcending the status quo and creating change. Charismatic leaders (Bass 1985) were able to earn their followers' trust by being willing to incur great personal risk – and, by taking risks, leaders enhanced their emotional appeal to the followers. In organisations, charismatic leaders were aware of the positive and negative aspects of their leadership.

2.3.3 Summary.

It was seen from this review that charisma was a major element in transformational leadership (Bass 1985; Bass & Avolio 1994). The charismatic leader created an intense emotional bond between leaders and the followers who were inspired to implement the leader's vision (Nahavandi 1993). The strong loyalty and respect of a charismatic relationship paved the way for undertaking major change and resulted in complete loyalty and trust in the leader. The emotional attachment of a follower to the leader and the factors involved in charismatic leadership formed the basis of the transformational leader. As the above analysis demonstrated, the transformational leaders possessed the characteristics of charismatic leaders, which gave them multiple skills for undertaking organisational change.

This research was based specifically around the role of transformational leaders and their impact on successful change. Thus, it was important for a detailed analysis of the transformational leader and the characteristics required for undertaking change and the following section examines this relationship.

2.3.4 Transformational leadership.

The view adopted in this current research was that transformational leadership (Bass 1985; Burns 1978) could be characterised by an ability to bring about significant change in an organisation, and that transactional leadership was inadequate for this task. Since the 1980s, research (Avolio & Bass 2002; Bass 1990; Parry 1996) supported the idea that

transformational leadership was more effective than transactional leadership in generating the extra effort, commitment and satisfaction of those being led (Bass 1990). Transformational leadership was a process where leaders and followers raised one another to higher moral and motivational levels (Yukl 1971). As Bass (1990) asserted, a leader transformed followers by making them more aware of the importance and value of task outcomes.

Schein (1985) suggested that leaders shaped culture by how they reacted to crises, by role modelling and through their allocation of rewards and had the greatest potential for embedding and reinforcing aspects of culture by their selection of key priorities and values. Scheins' (1985) study was pivotal in discerning how leaders challenged old cultural values. As Tichy and DeVanna (1986) asserted, true leaders challenged current assumptions, encouraged objective critiques and sought dissenting opinions. Transformational leaders were characterised by personal interactions, such as being sociable, open and considerate of others, and having a sense of humour (Avolio & Bass 2002).

Transformational leaders, according to Bennis and Nanus (1985), focused on intangible qualities of vision, shared values and ideas and gave meaning to diverse activities, identified common ground and enlisted followers into the change process. According to Parry (1996), transformational leadership consisted of role modelling, inspirational motivation, visionary leadership, and individualised consideration. Guaghan (2001) also stated that the leader's behaviour included: sensitivity to an employee's needs and aspirations; active support for their development; recognition of the importance of maintaining morale; giving praise and job-related support; and displaying a strong sense of loyalty to the employees. Transformational leadership was a process of influencing major changes in the attitudes of managers so that the goals of the organisation and the vision of the leader were internalised (Carlson & Perrewe 1995). These issues were also a major focus of this current study.

Carless (1998) stated that the transformational leader articulated a vision, used lateral or non-traditional thinking, encouraged individual development and gave regular feedback. He also found that transformational leaders used *participative* decision-making and promoted a cooperative and trusting work environment. All of these attributes followed the Bass (1995)

philosophy that transformational leaders inspired followers to transcend their own self-interest for the good of the group or organisation (Avolio & Bass 2002).

2.3.5 Summary.

The literature reviewed has provided an overview of leadership styles and evidence for transformational leadership as the most suitable form of leadership for successful organisational change. The leader must have inspired others, encouraged the change by demonstrating enthusiasm, provided the vision, captured the hearts of staff, and motivated staff by their words and actions. In other words: the leader should possess the qualities of charisma and be transformational as demonstrated in the literature review. In this current study, the leader's style was examined and the transformational leader analysed through the embedded case study. These characteristics have been demonstrated throughout the current research and provided support for the research questions.

However, having a transformational leader in an organisation was not enough in itself for successful change. A leader needed to have guidelines, procedures and policies to work with. Without models of change, the leader may not have the necessary foresight to be a successful transformational change leader. The next section investigates several change models that have been used by leaders in the past for undertaking change and why transformational leadership provided an excellent change tool.

2.4 Leadership frameworks

Bass and Avolio (1990, 1994) frameworks are first investigated, followed by the Kotter (1990a, 1999b) models and finally the Kouzes and Posner (1987, 1995) models. Each model included an analysis of the role of transformational leaders during organisational change.

2.4.1 The Bass and Avolio frameworks.

According to Avolio, Waldman and Yammarino (1991), a leader inspired followers by encouraging them to develop the change, share the vision and challenge the norm. The leader energised followers and promoted positive change to individuals, teams and organisations.

Avolio (1997) reported that the transformational leader emerged through conditions that set the stage for the development, or growth, of a leader: the role of parents; life experiences that shaped various leadership challenges; and events that were unique to an individual leader's development and growth throughout the change (Avolio 1997).

Avolio and his colleagues (1991, p 13) provided a framework in which there were *The Four I's*, or principles of transformation leadership:

1. *Individualised consideration*: transformational leaders paid attention to the individual employee; they listened and took on a mentoring role (1991:13). They went "into bat" for the employee and removed unnecessary blockages that inhibited the development of followers and optimum performance (1991, p 13). They paid special attention to an individual's need for achievement and growth by acting as a coach and mentor. Followers and colleagues were developed to successively higher levels of potential (Avolio & Bass 2002). New learning opportunities were created in a supportive climate, and individual differences in needs and desires were recognised. Two-way communication was encouraged, and "management by walking around" was practised. Interactions with followers were personalised; the considerate leader effectively listened to individuals and delegated tasks to develop followers and were monitored to check if the followers needed additional direction or support – ideally, to assess progress. Followers did not feel they were being checked on (Avolio & Bass 2002).

2. *Intellectual stimulation*: leaders provided reasons and methods for people to change the way they thought about problems and a good leader stimulated the thinking of followers and was open to, and stimulated by, their reasoning and ideas (1991, p 14). They stimulated and encouraged their follower's efforts to be innovative and creative by questioning assumptions, reframing problems and approaching old situations in new ways (Avolio & Bass 2002). Followers were encouraged to try new approaches, and their ideas were not criticised if they differed from the leader's (Avolio & Bass 2002).

3. *Inspirational motivation*: personal accomplishments, the development of communication skills and role modelling created the potential to inspire others. A leader's level of inspiration was strengthened if followers shared a vision of the group's goal. Superior leadership performance emerged when leaders broadened and elevated the interest of their followers. They generated awareness and acceptance among followers of the mission of the group, and moved their followers to transcend self-interest for the good of the group (1991, p 14). Transformational leaders behaved in ways that motivated and inspired those around them by providing meaning and challenge to their follower's work. Team spirit was aroused (Avolio & Bass 2002); enthusiasm and optimism were displayed. The leader involved followers in envisioning attractive future outcomes and clearly communicated expectations that followers wanted to meet by demonstrating commitment to goals and the shared vision (Avolio & Bass 2002).

4. *Idealised influence*: by showing respect for others and by building their confidence and trust in the overall mission, transformational leaders developed referent power and influenced their followers (1991, p 15). They behaved in ways that made them role models for their followers, and such leaders were admired, respected and trusted (Avolio & Bass 2002). Followers identified with these leaders and wanted to emulate them. These leaders shared risks with followers and earned credit by considering the needs of others over their own; they were consistent rather than arbitrary. They could be counted on to "do the right thing", demonstrated high standards of ethical and moral conduct and avoided using power for personal gain – in fact, they used their power only when needed (Avolio & Bass 2002).

In the Bass and Avolio (1994) model, there was a constant interplay between culture and leadership, each similarly affecting the other. Leaders needed to be attentive to the beliefs, values, assumptions, rites and ceremonies embedded in the culture and the power of these factors to influence efforts to change the organisation (Bass & Avolio 1994). When trying to promote cultural change in an organisation, the leader must also understand and respect the past. Accordingly, Avolio and Bass (2002) stated most leaders learnt that, before making a decision, it paid to consult with those who would implement it. Consequently, leaders could

accomplish changes by communicating their nature in the context of the existing culture (Avolio & Bass 2002).

One aspect of transformational leadership researched by Bass and Avolio (1990), possibly more than others, was individual consideration. Individual consideration focused on changing followers' motives, moving them to consider the moral and ethical considerations of their actions and goals. It was developmental, involving the diagnosis of the followers' needs for growth, providing the mentoring or coaching to meet those needs and to expand their potential. As a result, leaders more frequently displayed individualised consideration because of their general support for the efforts of followers. For Avolio and Bass (2002), individually considerate leaders rose above their followers' demands for equality by treating individuals according to their needs for growth.

Many models examined the needs of leaders and followers, especially Maslow (1943), Hertzberg (1968), and McClelland (1985). Maslow's (1943) *Hierarchy of Needs* theory proposed that humans were motivated by multiple needs and they existed in a hierarchical order. The motivating needs were: physiological, safety, sense of belonging, esteem and self-actualisation, and the internal drive that motivated behaviour to fulfil these needs. An individual's needs were a hidden catalogue of the things they wanted and would work for. According to Maslow (1943), the leader of the organisation subconsciously knew what an employee needed and could design the work environment and the reward system to reinforce the employee's (or follower's) energies and priorities towards the attainment of shared goals.

Another form in the development of leaders and followers was the *behaviour approach*. The behaviour approach models of Tattenbaum and Schmidt (1958), Blake and Mouton (1985), and Lewin (1939), illustrated the development of behaviour models for leadership and Lewin (1939) specifically developed a model of autocratic-versus-democratic leadership style. The autocratic leader was one who tended to centralise authority and derived power from position, control of rewards and coercion. A democratic leader delegated authority to others, encouraged participation, relied on subordinates' knowledge for completion of tasks, and depended on their respect for influence. Lewin (1939) found that followers were discontented

with an autocratic leadership and feelings of hostility frequently arose, while the democratic leader found followers with positive feelings and little hostility, who tended to continue to perform effectively. Today's model of transformational leadership evolved from the models that were developed over the decades (Blake & Mouton 1985; Lewin 1939).

Transformational leaders changed their organisational culture by understanding it first and then realigning it with a new vision, amending its shared assumptions, values and norms (Bass & Avolio 1994). They built on assumptions: people were trustworthy and purposeful; everyone had a unique contribution to make; complex problems could be handled at the lowest level possible. Leaders who built these cultures and articulated them to followers typically exhibited a sense of vision and purpose and aligned others around the vision and empowered others to take greater responsibility for achieving the vision. According to Alvesson and Willmott (1992), power could be considered creative rather than limiting; it was inseparable from knowledge rather than directing it, and its productive force came from below and above. Transformational leaders did more with colleagues than set up simple exchanges or agreements and according to Avolio and Bass (2002), they behaved in ways to achieve superior results by employing one or more of four components of transformational leadership stated in the Avolio et al (1991) research.

2.4.2 Summary.

The transformational leader typically inspired followers to do more than was originally expected of them (Den Hartog, Muijen & Koopman 1997); transformational leadership created motivating and emotional arousal in followers (House 1988). Finally, Hater and Bass (1988) stated that the dynamics of transformational leadership involved the followers having a strong, personal identification with the leader – while the Bass and Avolio (2002) frameworks provided a strong basis on which to build a change program. A starting point for change leaders was provided by identifying the components of individual consideration, inspirational motivation, idealised influence and intellectual stimulation change. However in themselves, these components were not sufficient for undertaking a complete change program – further development of these models was needed. The next section investigates the Kotter models of change that added new dimensions to the change models.

2.4.3 Kotter's eight-stage process of change leadership.

Another framework that guided the principles of transformational leadership was Kotter's (1996) eight-stage process of creating major change. This model provided a significant structure for understanding the leadership challenge during major change and Kotter argued that leaders needed to complete each stage in the order defined by his model for successful change to occur. In this section, his model is reviewed first and its similarities to the ideas of Bass and Avolio (1994, 2002) examined.

According to Kotter (1996), at stage 1 the leader needed to establish a sense of urgency. To push up the level of urgency, a manager (or leader) had to remove sources of complacency and to create a strong sense of urgency, he suggested that managers engage in bold or even risky actions.

For stage 2, Kotter (1996) stated that managers should engage a strong, guiding coalition of people with position, power, expertise, credibility and leadership skills. They should build levels of trust and promote shared objectives in a group of senior managers.

At stage 3, Kotter (1996) suggested leaders develop a vision and strategy. He defined vision as a central component of all great leadership: it was a picture of the future with some implicit or explicit commentary on why people should strive to create that future. A vision was part of a successful transformation; it was only one element in a larger system that included strategies, plans and budgets. Strategic feasibility was a vision that was grounded in a clear and rational understanding of the organisation, its market environment and competitive trends.

At stage 4, managers communicated the change vision. In most organisations, managers under-communicated and often inadvertently sent inconsistent messages and resulted in "stalled transformation". To have others accept the vision was a challenging task, both intellectually and emotionally (Kotter 1996).

In stage 5, managers revealed their ability to empower a broad-based action plan. The organisation needed to empower numerous people by removing barriers to the implementation

of the change vision. Kotter (1996) believed the major barriers were existing structures, a lack of training, systems not aligned with the vision, and difficult supervisors.

Stage 6 involved generating short-term wins (Kotter 1996) as a major change process took time. According to Kotter, managers needed to emphasise short-term results that built credibility and sustained managers' efforts. The nature and timing of short-term wins was important; they must be visible, unambiguous, and clearly related to the change effort. They provided evidence that sacrifices were worthwhile and rewarded the agents of change, undermined cynics and built the momentum for success.

At Stage 7, leaders needed to consolidate gains and produce more change. This stage involved increased attention to change systems, structures and policies that did not fit within the vision and many involve hiring and developing people to implement the change vision, and reinvigorating the process with new projects.

In the final stage 8, the challenge was to anchor new approaches in the culture and develop shared values among managers. Shared values were important concerns and goals that shaped group behaviour and persisted over time, even when group membership changed.

One of the goals of any organisation is to make changes to help cope with new and more challenging markets and changed environments. Through his case studies, Kotter (1995, 1996) argued that successful organisational change occurred through the eight phases above and was a lengthy process. He argued that critical mistakes in any phase had a devastating impact, slowing momentum and negating hard-won gains. Most significantly, Kotter's (1996) framework attempted to combine leadership and change.

Others also described many of the stages described by Kotter (e.g. Kanter, Stein & Jick 1992). Kanter's et al. (1992) model of eight stages, for example, included the actions of coalition building: assembling backers and supporters; articulating a shared vision; defining the guidance structure and process; ensuring that communication, education and training occurred; undertaking policy and systems reviews; enabling local participation and

innovation; ensuring that standards, measures and feedback mechanisms were in place; and, the final stage, provided symbols, signals and rewards to managers.

Kotter (1995) provided some useful observations about the major errors made by change managers. Among these errors were:

- *Not establishing a great enough sense of urgency*. He argued the introduction of a transformation program required the cooperation of many individuals, and without appropriate levels of motivation, people would not help and the change would falter.
- *Not creating a powerful enough guiding coalition.* In a successful team, the manager needed to have at least three to five people involved during the first year of a renewal effort.
- *Lacking a vision*. the guiding coalition needed to develop a vision that was relatively easy to communicate and appealed to customers, employees, stockholders and managers. This was critical, as it helped clarify the future direction of the organisation.
- *Under-communicating the vision*. This phase was particularly challenging, especially when downsizing was a part of the vision. In successful transformation efforts, executives used every available communication channel to broadcast the vision.
- *Not removing obstacles to the new vision*. Success required the removal of barriers, including organisational structures and performance appraisal systems that rewarded newer rather than older behaviour.
- *Not systematically planning and creating short-term wins*. Without short-term wins, Kotter (1995) believed that employers gave up or joined those who opposed the change. In successful transformations, managers actively sought clear performance improvements, established yearly goals, achieved objectives, and rewarded those involved with recognition, promotion and remuneration. A commitment to produce short-term wins maintained a sense of urgency and forced detailed analytical thinking that clarified or revised the vision.

- *Declaring victory too soon.* Leaders of successful efforts used the credibility afforded by short-term wins to tackle even bigger problems.
- *Not anchoring changes in the corporate culture.* Two factors were particularly important: a conscious attempt to show how new approaches, behaviour and attitudes improved performance; and taking the time to ensure that the next generation of executives personified the vision.

2.4.4 Summary.

As the analysis demonstrates, Kotter's models (1990, 1995, 1996) provided an extensive range of concepts, processes and tools for leaders undertaking organisational change, though there were still aspects missing from these models. Additionally, Bass and Avolio (1990) and Kotter (1990) provided detailed models on how transformational leaders undertook change. By combining these models, the criteria and dimensions for a change program were developed and the type of leader necessary to perform it was established. The literature review demonstrated there were still gaps in these change models, but the Kouzes and Posner (1987, 1995) model of change provided a more complete framework for transformational leaders. The following section provided an examination of the Kouzes and Posner (1987, 1995) model and the role of transformation leaders.

2.4.5 The Kouzes and Posner framework

A third framework, which provided a set of principles examining the behaviour of transformational leaders, was the Kouzes and Posner (1987, 1995) model. Other theorists (Kanter, Stein & Jick 1992; Yukl 1971) shared many of the principles articulated by Kouzes and Posner (1995) (e.g. taking risks, achieving small wins), however, their work uniquely adopted a broad focus on transformational leadership and addressed general aspects of leadership and organisational change. Kouzes and Posner (1987, 1995) established a model of five principles of change.

These five principles provided specific guidelines for the leader undertaking organisational change, and the guidelines acted as a general framework of change. These broad categories allowed leaders greater flexibility to change the organisation in their own way and to develop

their own skills. Because the framework was broad, it could be made more specific through further research in several areas and was one goal of this current research. Figure 2.1 presents the five principles of the Kouzes and Posner (1987, 1995) framework. Unlike Kotter's (1990) model, it did not suggest a particular order, nor give one set of actions more credence than another.

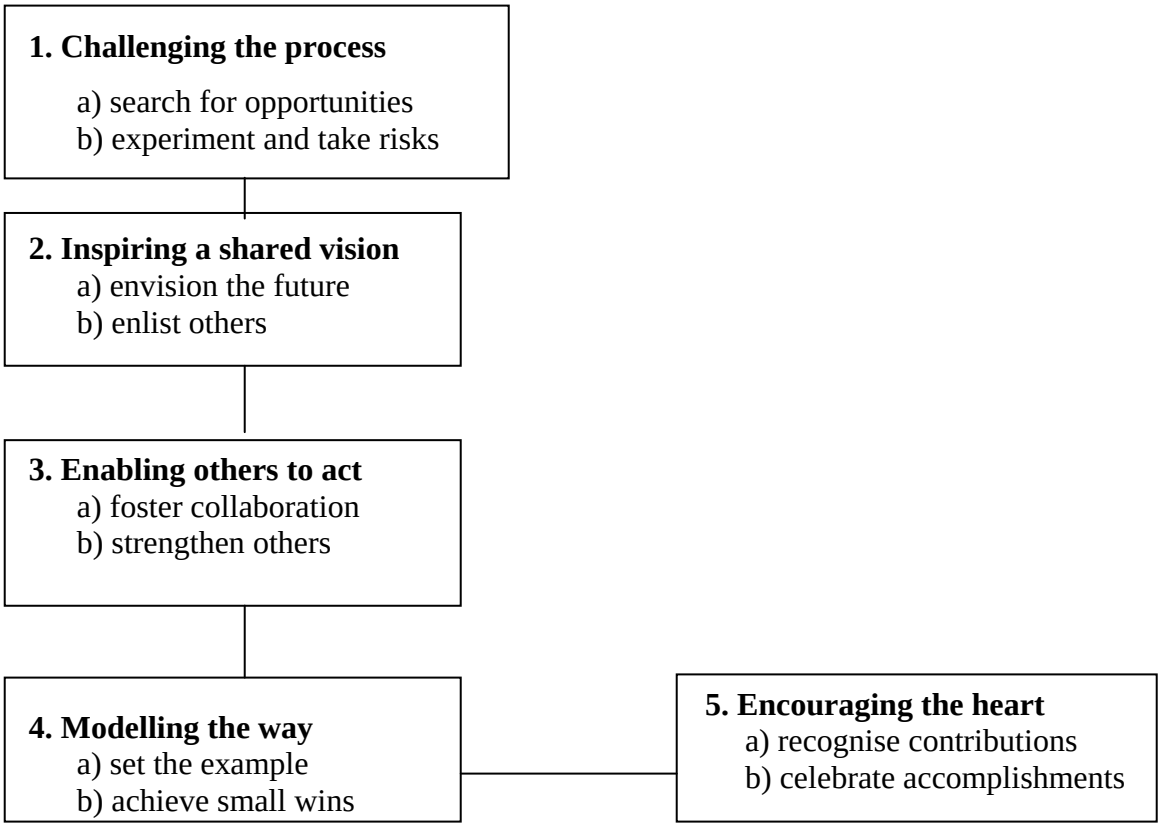

Figure 2.1: Kouzes and Posner Framework

As Figure 2.1 shows, the first principle of their framework was the need to *challenge the process*. Leaders need to search out challenging opportunities, experiment and take risks. In seeking challenges, leaders aroused intrinsic motivation, balanced the paradox of routines, and looked outside for stimulation and information. While experimenting and taking risks, leaders listened to others, opened themselves to ideas, tried untested approaches and accepted that risks accompanied all experiments. Given the importance of taking risks, leaders were inclined to accept them and encourage others to step into the unknown, rather than play it safe.

Linked to encouraging risk taking was the willingness to learn from mistakes and to promote psychological hardiness.

The second principle of Kouzes and Posners' (1987, 1995) model was focused on *inspiring a shared vision.* The leader of the organisation had the ability to gaze across the horizon of time and imagine greater things ahead and to achieve something significant and accomplish results no one else had yet achieved. The leader did this by imagining the ideal and unique images of the future. To enlist others into the change process, leaders needed to attract people to a common purpose by clearly articulating the vision for the organisation. When this happened, followers reported higher levels of job satisfaction, motivation, commitment, loyalty, and clarity about organisational values. To enlist others, leaders needed to use powerful language and demonstrate a personal conviction to their organisation.

Principle three involved *enabling others to act.* The key tasks fostered collaboration and strengthened individuals by sharing power and leaders promoted cooperative goals and mutual trust. Collaboration improved performance, emphasised long-term rewards, and focused on gains rather than losses. Sharing power provided choice, developed competence, and offered visible support for managers.

Principle four was centred on *modelling the way*. It involved setting an example and achieving small wins. In setting the example, leaders needed to do what they said they would do. According to Kouzes and Posner (1987, 1995), leaders must be able to clarify personal values and the beliefs of others and unified constituents around shared values and constantly paid attention to how they and others lived by these values. To encourage cohesion, the organisation needed to score small wins, which built employee confidence and reinforced a desire to feel successful.

Principle five was called *encouraging the heart*. Central to this principle was the need to recognise individual contributions to success and to regularly celebrate team accomplishments. Recognising individual contributions built self-confidence and connected performance to a variety of intrinsic and extrinsic rewards. The leader used public ceremonies

to celebrate team accomplishments and was personally involved. Kouzes and Posner (1995) believed that the secret to successful organisational change was to love and lead a loving environment.

In recent research using the Kouzes and Posner (1987, 1995) framework, Carless (1998) found that there were considerable gender differences in some of the five dimensions. Female managers practised *modelling the way* more than male managers and displayed greater consistency between views that were espoused and behaviour that was practised, and were more able to *encourage the heart*.

Kouzes and Posner (1995) updated their 1987 framework and took into account the ten most important lessons they believed companies had experienced about learning to lead. They proposed that:

- challenge provided the opportunity for greatness in leading and learning to lead
- leadership was in the eye of the beholder
- credibility was the foundation of leadership
- the ability to inspire a shared vision differentiated leaders from other credible sources
- you could not lead without trust
- shared values made a critical difference in the quality of life at home and work
- leaders were role models for their constituents
- lasting change progressed one hop at a time
- leadership development was self-development
- leadership was an affair of the heart, rather than of the head.

However, these additional statements had little impact on the credibility of the original Kouzes and Posner (1987) framework. The analysis of the Kouzes and Posner (1995) framework incorporated many of the dimensions of the Kotter (1990) and Bass and Avolio (1990) models and many of the concepts of a transformational leader. Previous research (Jackson 1999; Jackson & Callan 2001) found the Kouzes and Posner (1987, 1995) model was an excellent change tool and demonstrated transformational leadership qualities. Overall, the

Kouzes and Posner (1987, 1995) framework was an important one that leaders used when undertaking organisational change.

2.4.6 Summary.

The literature review of the three models provided a basis for undertaking this current research. However, the above research demonstrated there were several potential components missing from the transformational leadership models.

2.5 Aims of the present study

As the literature review indicated, there was a high level of agreement among researchers about the principles – or key behaviours – of the transformational leader (Avolio & Bass 2002; Kotter 1990; Yukl 1971). These frameworks mapped and identified a full range of transformational behaviour by the research and used existing frameworks and examined the major practices used by leaders and managers who introduced structured and cultural reforms to organisations implementing change. In this current study, the transformational leadership models studied could be adopted as the guiding concept for their level of detail and comprehensiveness when undertaking successful organisational change. Models such as the Kouzes and Posner (1987, 1995) model encouraged a more exploratory approach than either the Kotter (1990) or Bass and Avolio (1995) frameworks, which were more focused on particular issues. For instance, Kotter's (1996) framework implemented change with a special focus on strategic intentions, while Bass and Avolio (1990) provided a more detailed treatment of the leader-follower relationship and either model could have been used in this study. However, as shown in the Jackson and Callan (2001) research, the Kouzes and Posner model (1987, 1995), arguably allowed more latitude for adopting a broad, descriptive brief in determining how change was implemented through its wider scope.

Overall, Kouzes and Posner's (1995) five principles emerged as a useful tool for researchers (and leaders at a practical level) that covered a majority of areas requiring attention in an organisation undergoing change. Each principle was specific and comprehensive. For example, principle one involved *challenging the process,* one of the first tasks for leaders

introducing change in a new organisation. It clarified the need for leaders to seek challenging opportunities, to experiment, take risks, use intrinsic motivation, stimulate and inform. One of the advantages of the framework was its value as a checklist highlighting many underlying concepts that a leader needed to understand – or, in Kouzes and Posner's (1995) terms, issues that would be felt in the heart, mind and soul of a leader of change.

Other models by Kotter (1990), Mintzberg (1971), Bass and Avolio (1990) and Kanter et al (1992) also provided specific guidelines on how to undertake change. They applied distinct steps to change or challenges and the Kouzes and Posner (1987, 1995) principles could be linked into these, including Kotter's (1996) eight stages. Applying Kouzes and Posner's (1987, 1995) original five principles to previous case studies (Jackson 1999; Jackson & Callan 2001) these five principles emerged as an effective means of undertaking organisational change.

2.6 Supporting the Process

2.6.1 Communication.

An important aspect of any successful leadership and change role in an organisation was communication (DuBrin 1998). Transformational leaders communicated their vision, goals and directives in colourful, imaginative and expressive ways; they communicated openly with group members and created a comfortable climate of interaction. They encouraged two-way communication with team members and promoted a sense of confidence (DuBrin 1998). Kotter (1999) suggested that successful communication was not achieved by simply telling people what a leader wanted them to know, but involved a wide range of activities and tools for nurturing a vision in the consciousness of employees. For management's development programs to be fully effective, managers had to actively assess their own deficiencies and needs (Longenecker & Fink 2001) and considered their short and long-term career goals, the training and experience needed to fill in current gaps, and allowed for future career development. As part of this process, managers (and those in charge of assessing needs) considered their particular learning styles and the programs best suited to them (Longenecker & Fink 2001).

According to Conger (1992), the era of management through dictate has been replaced by managing through inspiration. Conger (1992) believed that both charismatic and transformational leaders communicated by using metaphors and analogies and geared their language to different audiences. The use of a well-chosen analogy or metaphor appealed to the intellect, the imagination and the values of employees (Kotter 1999). While an analogy or metaphor was inspiring to staff, an effective leader must also choose the level of language to suit the employees, and Conger (1992) believed that a leader's ability to speak on a colloquial level contributed heavily to creating appeal.

From the literature, Yrie, Hartman and Galle (2002) suggested that a subordinate's *perceptions* might distort a supervisor's message rendering it ineffective or confusing even when a clear message was sent. Conversely, Schnake, Dumler, Cochran & Barnett (1990), reported that supervisors' *perceptions* might lead them to believe that a message was ideally sent when, in fact, it was not. Distortions arising from a lack of congruence between the perceptions of supervisors and subordinates were seen as a primary problem in organisations affecting the relationship between improved communications and performance outcomes. Similarly Kolb, Rubin and McIntyre (1971) stated individuals high on the status ladder will tend to communicate frequently with one another while those low in the hierarchy will neither like nor communicate with each other as much. The members of lower status will direct most of their communication towards those in the higher status clique, although the subject of their attention does not generally reciprocate it. Yrie et al. (2002) felt that this suggested there might not be one best way for supervisors and subordinates to communicate, rather a varied kind and quality of communication across situations and departments. Each situation was unique with the receiver's perceptions being part of the sender's environment – therefore, communication must be diverse (Schnake, Dumler, Cochran & Barnett 1990).

However, Hersey and Blanchard (1969, 1977) believed that leaders should use more directive styles with less experienced followers, and more participative styles as followers gained experience and competency. Thus, the follower's experience, ability and willingness to complete the job became the basis for determining the leader's style. By 1982 Hersey and Blanchard's view on leadership altered and they believed that a manager should be task

oriented and tell or sell subordinates on what to do or a manager should be relations oriented and participate with subordinates in joint decision making (Hersey & Blanchard 1996). They should delegate the decision to them depending on the subordinates task-relevant maturity – their job maturity (capacity, ability, education and experience) and their psychological maturity (motivation, self-esteem, confidence and willingness to do a good job). The maturity levels manifest themselves in the subordinates performance of their job. The most effective leadership was conceived to depend on whether the leaders were task-oriented or relations-oriented behaviour matched the subordinates maturity. As well Hersey and Blanchard (1996) changed their terms from 'maturity' to 'readiness' and 'development' to apply to the roles of leaders and staff in organisations undergoing change.

Gerstner and Day (1997) found that communication between in-groups and out-groups varied considerably. In-group employees' communication with the leader was less structured, with greater freedom from close supervision for the out-group (Callan & Dickson 1991). The trend in some organisations suggested that leaders changed their communication style with employees based on their personal views rather than considering the abilities of different groups; they treated in-groups and out-groups equally. Terry and Callan (1998) found that out-group employees reported little participation in the organisation, experienced little coordination and sharing of information by the leader, and ultimately felt isolated and confused about the organisation's direction (Ross 1986).

The general models of transformational leadership should explore of the use of metaphors and analogies and of the various channels used by change agents to communicate a vision. The work of Kotter (1995, 1996), for example, provided a detailed and valuable examination of the communication styles and tools available to leaders of change.

According to Clutterbuck and Hirst (2002, p 351), a leader created a climate of open communication when sharing information at both functional and hierarchical levels. Many staff members of organisations undergoing change did not read or respond to communications (Jackson & Callan 2001), as there was often too much information to absorb. Subsequently,

leaders needed to modify their communication to corresponding with the different stages of change (Jackson 1999).

Longenecker and Fink (2001) found that managers considered it critically important that their superiors help them clarify their roles and goals in changing organisations. The leader made mentoring by senior managers an organisational priority to give ongoing feedback on performance. The importance placed on these suggested that managers and staff needed better guidance and feedback to improve their effectiveness in times of rapid change (Clutterbuck & Lazidou 2001).

To be effective, Sobo and Sadler (2002) found managers and staff required: formal career-planning discussions; challenging job assignments; purposeful cross training; and formal performance reviews. According to Longenecker and Fink (2001), these methods appeared successful because they reinforced the general importance of management development programs, and signalled that the knowledge and expertise gained from them played an important role in achieving organisational goals. They also maintained the momentum of culture-change, increased the commitment to other change programs, demonstrated a long-term commitment to the organisation and advancement for career-oriented managers; and, finally, focused on the most important organisational challenges (Longenecker & Fink 2001).

Research evidence (Bass & Avolio 1994; Kotter 1990, 1999) supported the conventional wisdom that effective leaders were also effective communicators. Bass (1990) found a substantial and positive relationship between competent communication and satisfactory leadership performance. Leaders regularly expanded their thinking by actively soliciting new ideas, feedback and fresh information; and they possessed the persuasive skills to convince others of the quality of their ideas (Bass 1999).

There were diverse opinions amongst managers and team leaders about the effectiveness of their verbal skills (Gestner & Day 1997; Yrie, Hartman, & Galle 2002). According to Webber (1970), some managers were highly effective, encouraging others and communicating with

them – while some were unclear about what, how, and how much to communicate (Hatfield & Huseman 1982).

Clutterbuck and Hirst (2002, p 351) stated that communication was central to four main management qualities during change: attention to detail; bringing meaning to the change; showing their own *nature* through risk taking and developing trust with followers; and demonstrating the methods for change. To be truly effective, leaders and managers needed to develop self-awareness, become role models for communication within the organisation, and learn to encourage and manage constructive dissent (Hatfield & Huseman 1982). These four actions followed the theory of Bennis and Nanus (1985) and related directly to the concepts in the Kouzes and Posner (1987, 1995) framework. Bennis and Nanus (1985) also stated that managing one's self was a long-term, continuous project – but the more self aware the manager was, the easier it was to communicate with genuine passion.

Leaders according to Bass (1990) emerged as a consequence of how well they fulfilled various communication functions. Effective leadership depended on receiving, processing, retaining and transmitting information, much of it through talking with others. An important aspect of a leaders style was the way they communicated with colleagues and subordinates. Ordinary, open, easy, ready communication contributed not only to the extent to which the leader and subordinates influenced each other but to the extent to which leaders will be effective in undertaking organizational change (Bass 1990).

Similarly, according to Kotter (1999), once leaders built the basic capacity to communicate they could become more effective leaders by demonstrating trust in others and accepting trust in return. They acquired the skills and courage to confront positively by learning how to promote constructive dissent so that alternative perspectives, where appropriate, were examined, discussed, adapted and incorporated into the larger vision of the organisation. Leaders were often responsible for the ease with which members of a group could communicate with each other (Bass 1990). Finally, they became role models for good communication and worked effectively with others, which was vital to successful change (Hatfield & Huseman 1982).

Clutterbuck and Hirst (2002, p 352) confirmed the findings in Kouzes and Posner's (1987, 1995) research that a leader needed the qualities of vision, trust, empowerment of others and the ability to encourage the heart. However, they believed the leader needed two different processes to achieve these qualities. First, that they develop communication tools for the organisation; and second, to learn how to communicate themselves. Clutterbuck and Hirst (2002, p 351) believed that leaders (or managers) needed the following criteria to be truly effective within *organisations*:

- they must clearly set mutual expectations
- they must ensure everyone has clear objectives and performance measures, and check that these are understood
- that they were good at planning and communicating the steps that lead the team to reach its goals
- that they gave continuous feedback
- that they gave people goals that stretched them, with support from the manager and colleagues
- that they made sure achievements were recognised from within and without the team
- that they encouraged a sense of self-belief in team members.

According to Clutterbuck and Hirst (2002, p 352), to achieve the benchmarks above, leaders needed to be *effective communicators* when speaking. They needed to master the following:

- a higher degree of self-mastery and self-awareness
- how to be superb listeners as a precursor to becoming better communicators
- how to actively manage themselves as role models
- the ability to uncorked their own imagination
- how to link their imaginations and emotions to team ambitions so that their ideas would capture the imagination and emotion of others.

Longenecker and Fink (2001) found formal training methods were not effective in improving performance in rapidly changing organisations as they had a number of shortcomings. Often the programs focused on past problems rather than the future; they provided information that was too general for the specific industry or current situation. Often they did not facilitate the

transfer of information into strategies or actions that improved manager performance. They also found that, despite the fact they were relatively easy to implement, organisations should not develop an over-reliance on these efforts to improve managerial and staff performance.

Sobo and Sadler's (2002) research found that leaders needed to have open and frank discussions with staff groups during organisational change. A leader could achieve this by changing his personal appearance to become more like the employees (e.g. taking off his tie and rolling up his sleeves), meeting staff on a monthly basis, and sharing insights about the organisation's strengths and weaknesses. Staff members of all ranks could establish a conduit to the leader and, in turn, get to know the leader at a personal level (Haskins 1996). Improved communications let employees see the leader's *thought processes* and gave staff first-hand knowledge of leader's views on organisational issues without them being passed down by middle managers. Sobo and Sadler (2002) found that meetings with the leader and other departmental employees served as an important educational and social-network building function for employees, which led to increased performance and acceptance of change.

Decker and Rotondo (2001) researched another form of communication: the use of humour in the workplace. Humour affected physiological, cognitive and affective responses and shaped the communication process by influencing the climate and social networks. The use of humour as a communication tool, according to Avolio, Howell and Sosik (1999), provided psychological rewards, relieved frustration, alleviated boredom and encouraged the transfer of information. However, it had negative implications when used in an inappropriate and unprofessional manner, which led to unproductive and disturbed employees (Decker & Rotondo 2001).

2.6.1.1 Summary.

As the literature review above has highlighted, there are many issues and tools involved in successful communication. The use of an intranet, humour, regular verbal encouragement, bulletin boards and personal contact were only some of the strategies required by a leader during organisational change.

Communication today is not based solely on verbal interaction. The growth of electronic media is a challenge for both leaders and employees (Lai 2001). Many leaders simply use email to avoid meetings and the mass distribution of information to employees. Email is fast and efficient, but many employees find this unsatisfactory and prefer face-to-face contact with managers and leaders.

As the research showed, leaders were required to have skills and an active role in clear communication. Therefore, effective communication in all its forms was a necessary component in transformational leadership models.

2.6.2 Team Building.

According to DuBrin (1998), a team was a small number of people with complementary skills, a common purpose, and a set of goals for which they held themselves accountable. Katzenbach and Smith (1993) stated that a team was characterised by a common commitment and accomplished collective projects with a shared leadership and individual and mutual accountability. In recent years, Webber (2002) found increased attention from leaders to the role of teams contributed to organisational knowledge. Clarke, Amundson and Cardy (2002) theorised that work-teams solved problems at multiple levels, processed information, and combined disparate resources to resolve complex scenarios. The first principle of the original Kouzes and Posner (1987, 1995) framework suggested the need to “challenge the process” in an organisation, and took many forms including financial, technical, traditional and emotional. In some organisations, the main challenge was the removal of a hierarchy and building an effective a team-based environment (Weick & Roberts 1993).

In many organisations, cross-functional teams were formed for both problem solving and reducing inter-group rivalries (Denison, Hart & Kahn 1996). Confronting diversity within teams is an increasingly complex and common challenge during change (Webber 2002) and staff found that creating teams was not just a matter of grouping members of one department (see Denison, Hart & Kahn 1996). Weick and Roberts (1993) highlighted that organisations lacked a complete understanding of the collective learning that occurred in workgroups. Clark, Amundson and Cardy (2002) also believed that there was no clear understanding of

how team decision-making facilitated knowledge creation and learning, or their value to an organisation. In contrast, Conner and Prahalad (1996) stated that successful organisations with teams fostered learning at both individual and organisational levels; they invested in human and technical resources, while developing tools and methods to support them.

One successful development was the cross-functional team (Denison, Hart & Kahn 1996) while members of a cross-functional team were linked to multiple sub-units, or *chimneys*, and were designed to overlay an existing organisation. As the literature on diversity revealed (Richard, Kochan & McMillan-Capehart 2002), such teams differed from conventional ones because each member had a competing social identity and obligation to another sub-unit of the organisation. Such teams were often temporary and experienced abundant pressures and conflict before becoming stable and effective (Hughes, Ginnett & Curphy 1993). Cross-functional teams confronted a different set of performance expectations than conventional ones and were expected to create and disseminate knowledge within the organisation. Mickan and Rodger (2000) found cross-functional teams had three components that differentiated them from conventional teams: the distinct functional responsibility of each member; the temporary, project-driven nature of the team; and, the unique task of creating knowledge and disseminating it within a limited time. Overall, researchers (Heslop 2002; Wake-Dyster 2001) believed the cross-functional team was comprised of individuals from separate functional areas convened with a specific purpose for a defined period.

Similarly, DuBrin (1998) established specific guidelines for a leader's behaviour to foster teamwork. They included:

- defining the team's mission
- developing a teamwork norm
- emphasising pride in being outstanding
- holding a *powwow*
- serving as a model of teamwork
- using a consensus style of leadership
- designing physical structures to facilitate communication
- establishing urgency

- demanding performance
- setting standards
- providing direction.

DuBrin (1998) also included: emphasising group recognition and rewards; challenging the group regularly; encouraging inter-group competition; encouraging the use of jargon; initiating ritual and ceremony; and soliciting feedback on team effectiveness. The use of teams and teamwork emerged as typical tools for change, but few studies explained their use in corporate change. Subsequent studies by Mickan and Rodger (2000) showed that effective teams were promoted as an important means of enhancing organisational performance in business. Fanning (1997) stated that teams facilitating organisational change responded quickly to customer needs and improved customer outcomes. The increased reliance on and explosion of technology and information removed many of the traditional managerial roles and functions (Denison, Hart & Kahn 1996). Organisations have moved towards flatter and more participative structures and employees received the information to make effective decisions, but tasks were more complex and this challenged traditional managerial roles and the development of teams, so, teams have accommodated different perspectives to generate solutions (Clark, Amudson & Cardy 2002).

Kleiner and Lew (1998) stated that the best way for followers to learn was to create a *teaching* environment where processes were explained, demonstrated, corrected and repeated. This environment of learning was likely to increase productivity and motivation, and ultimately led to cross training in a flexible business team (Kirkman, Jones & Shapiro 2000). However, team members must be willing to place the organisation's goals above their own and be committed to the mission and to achieve this. Kleiner and Lew (1998) believed team members must take an active role by communicating and sharing ideas. The manager must set goals that the employees can achieve, by defining objectives, assigning responsibilities, developing performance standards, and appraising performance (Hinds 1995).

Hinds (1995) believed that when developing teams there should be a transfer of certain areas of control and power to them, though only if it directly contributed to achieving team objectives. Hinds (1995) also stated that teams should only be given sufficient authority to

achieve a single objective, and this is at cross-purposes with other models of leadership (e.g. Bass & Avolio 1994; Kotter 1995; Kouzes & Posner 1987). Reaching a desired objective within the time frame (rather than failing to reach multiple objectives), generated an improved performance and made the workplace an exciting and satisfying environment (Hinds 1995). Heslop's (2002) view was that team members needed to be able to collaborate rather than compete.

Deveson (1995) believed that a leader encouraged regular communication sessions with good in-house systems, and every employee needed to know enough to motivate others. In team building, managers needed superior interpersonal skills, the ability to acknowledge other viewpoints, and to understand the work of other team members. Deveson (1995) encouraged feedback and advice from team members rather than working in isolation. Heslop (2002) believed that effective teamwork greatly enhanced satisfaction and productivity. An effective team was one that worked well together, across cultures and across professions (Kotter 1999).

2.6.2.1 Summary.

In conclusion, the above literature review highlights that teamwork was an effective way of completing large and complex tasks during a change program. Employees, however, needed to be directed towards the outcomes through sufficient communication and participation with the managers and leaders and working with other departments also improved a team's effectiveness in supporting organisational change. Team building required careful planning and thoughtful implementation by the leader with significant guidance from the leader was necessary for the success of team building. Team development, where staff from different departments cooperated, led to a more united and smooth-flowing organisation and established a multi-functional organisation.

2.6.3 Stress and coping.

Bennis and Nanus (1985) found many organisations underwent unparalleled levels of organisational change in attempts to overcome debt problems, improve efficiency and competitiveness and because of globalisation. Caught up in these plans for change were the individual managers who were asked to manage the change as effectively and quickly as

possible, despite the stress and their own feelings of uncertainty (Tichy & Devanna 1986). This was a time when they were expected to cope with the stress and lead the way by taking risks that tested and extended their personal vision about the organisation, their reputations and future career prospects (Callan & Dickson 1991).

According to Terry, Tonge and Callan (1995), stressful circumstances were events or conditions that reduced and disrupted people's ability to engage in everyday activities. Job-related stress was associated with lower levels of satisfaction and psychological wellbeing in the workplace. Coping with the stress of organisational change required both individual and organisationally managed responses, according to Pearlin and Schooler (1978). In response to large-scale organisational change, many employees were stressed by change, downsizing, and uncertainty about how the change affected their careers, opportunities for promotion, and reporting lines. A company merger increased the levels of uncertainty and stress in employees, and decreased their levels of job satisfaction and commitment to the organisation (Callan & Dickson 1991). According to Callan and Dickson (1991), many employees experienced a loss of status, power and autonomy with change, and they became unsure about what behaviour was appropriate in the new organisational culture.

From the literature (Callan & Dickson 1991; Terry et al. 1995), it was revealed that employees felt high levels of anxiety and uncertainty during change. The very nature of organisational change was often perceived to be neither rational and predictable nor evenly spread throughout the systems in the organisation. In trying to cope with organisational change, most employees used a mixture of planned and reflective coping efforts (Billings & Moos 1984). Coping involved overt and covert behaviour that reduced or eliminated psychological distress or stressful conditions (Callan & Dickson 1991).

According to Lazarus and Folkman (1984), when people dealt with a stressful event, the resources available to them affected their adjustment to change. In their cognitive–phenomenological model of stress and coping, problem-focused coping strategies were directed towards managing the problem, while emotion-focused strategies dealt with the level of emotional distress caused by the event. They also found that active problem-focused

coping strategies were more likely to assist individuals in moderating the adverse influence of stressful, negative life events. A high level of emotion-focused coping was linked to poor adaptation to stress. As well, Napier, Simmons and Stratton (1989) stated that personality variables, and the contexts in which they occurred, were important during organisational change. It was argued that demographic, personal and contextual factors be considered as they influenced coping responses and a person's longer-term physical and emotional health (Callan & Dickson 1991). Better educated managers and employees seemed more likely to rely on active cognitive coping, logical analysis and problem-focused coping, and less often used avoidance (Callan & Dickson 1991; Lazarus & Folkman 1984).

Anderson (1976) found that managers with a more internal locus of control relied more on task-oriented strategies for dealing with stress. More externally-oriented colleagues responded with anger and hostility and failed to cope with change. Self-confidence and self-esteem were also determinants of coping efforts (Lazarus & Folkman 1984). Higher levels of self-confidence were linked to the use of logical analysis, information seeking, and other effective problem-solving strategies (Billings & Moos 1984). Self-esteem and hardiness emerged as coping resources for middle and upper level executives in organisations, with higher self-esteem associated with lower levels of stress (Kobasa, Maddi & Kahn 1982).

Contextual conditions also influenced individual coping responses more than the personality variable (Callan & Dickson 1991). These included the stressful demands of the situation, uncertainty, and the availability of social resources that provided support and information to individuals (Fleishman 1984).

Kanter (1983) stated that organisations recognised the uncertainty of mergers and change, and used employee/management meetings and newsletters to improve communication in the hope of reducing the levels of uncertainty. Relevant information about organisational change seemed to reduce uncertainty and moderated levels of stress. Kanter (1983) believed that information was a social resource because it provided emotional concern, instrumental aid, and information about the organisational environment as it changed. Realistic communication during an organisational merger helped employees cope with the uncertainty of the situation

and helped to insulate them from some of the negative changes. Where managers secured adequate information about the organisational change which was then relayed to employees, the levels of uncertainty for employees was reduced and they adapted to change more successfully (House 1981).

Central to this was the individual's search for information to reduce the sense of threat and increase the feeling of being in control. Managers receiving information from colleagues were more likely to use all coping strategies, and while the grapevine played a role in information seeking, it also contributed to effective regulation (Schweiger & DeNisi 1991). Rumours both reduced and increased levels of anxiety in change programs. The greater use of emotional discharge and information seeking was associated with lower levels of satisfaction with the organisation's information program (Callan & Dickson 1991).

Case studies have revealed that managers and staff used a variety of coping strategies during organisational change (Jackson & Callan 2001). Some managers undertook stress-management courses, or were more involved in the management of the change (Jackson & Callan 2001) while others felt unable to cope well with change and retreated into their own workspace to await its completion before re-emerging. The psychological costs of change, especially to the leaders and participants, needed to be more fully appreciated (Kanter et al. 1992).

Additionally, staff and managers relied on social support during change (Kanter 1983) and this provided a means for individuals to exercise some control over the work environment and some aspects of social support concerned tangible behaviour to change the individual's environment (Yukl 1989). Based on the findings of this current study, additions to the transformational leadership models need to be incorporate to provide better understanding of how leaders assisted individuals to appraise the events that affected them.

2.6.3.1 Summary.

The literature review on stress and coping mechanisms provided strong evidence that stress created havoc with staff and leaders during change. Staff experienced feelings of grief, of

being overwhelmed by sudden change, and anxiety regarding job losses. Many leaders were not provided with the tools to develop coping mechanisms and allowed staff to continue in stressful situations – this meant increased absenteeism (adding to costs), an increase in rumours (often untrue), and increased psychological disturbance for staff.

Coping mechanisms for stressful situations included: more contact with colleagues; increased external support from family and friends; and developing personal techniques for coping – exercise, hobbies, or socialising outside the work place. The analysis showed that leaders needed to recognise that stress occurred during change and that they should develop coping strategies for staff before implementing a change program.

An analysis of the coping techniques used by staff and leaders during the change studied in this current research and presented in later chapters with techniques implemented for identifying stress and the procedures they introduced for coping with stress. The current research demonstrates the necessity for *stress and coping* to be included in transformational leadership models.

2.6.4 Inter-group conflict.

In the literature on inter-group conflict, Deutsch (1973) stated that conflict existed whenever incompatible activities occurred; while Thomas (1976) defined conflict as the process which began when one party perceived that another was frustrated, or was about to frustrate, some concern of his. It is unclear which view is correct, and perhaps a mixture of both should be considered more in keeping with the development of inter-group conflict during organisational change.

Another researcher, Rahim (1986), believed there were four levels of organisational conflict. First: intra-personal conflict which occurred when a person was required to perform tasks and roles that did not match his/her expertise, interests, goals or values. Second: interpersonal conflict between two or more people of the same or different hierarchical levels of units. Third: intra-group conflict among members of a group, or between two or more subgroups within it. Such conflict occurred because of incompatibilities or disagreements between some

or all of the members of a group or its leaders. Finally: inter-group conflict between two or more units or groups within an organisation. It was not clear which concept of inter-group conflict would provide a valid argument for dealing with change.

This led to the focus of this section, which investigates inter-group conflict (Terry & Callan 1998), as some transformational leadership models focused on the merging of organisations and the development of workable teams resulting in inter-group conflict by the most commonly experienced conflict in organisational change. In this instance, inter-group conflict was discussed according to the Lazarus and Folkman (1984) theory that conflict was classified as either task-oriented (cognitive conflict), or emotion-oriented (affective conflict). In the literature, Cheung and Chuah (2000) revealed that task-oriented conflict was beneficial to team effectiveness, while emotion-focused conflict often damaged team cooperation and effectiveness.

Instances of conflict emerged during many change processes, (Terry, Rawle & Callan 1995) not only during the development of teams and the usual *storming* stage, but also because of the staff redeployment, the physical redevelopment of an organisation, the introduction of new technology, and changed lines of responsibility and authority as found by Jackson (1999).

Kezsbom (1993) observed that conflict was an integral part of any change program, and stated there were two different approaches to conflict management:

a) The traditional approach: which tended to treat conflict as negative and tried to minimise it to achieve harmony and cooperation.
b) The contemporary approach: conflicting views were inevitable, with positive or negative consequences depending on how it was resolved or managed.

Fisher, Grant, Hall, Keashly, and Kinzel (1990) viewed inter-group conflict as perceived threats that play an integral role in the onset and escalation of conflict. When combined with a competitive orientation, ethnocentrism and mistrust, perceived threats helped induce ineffective communication, inadequate coordination, contentious tactics, and reduced

productivity – particularly in groups attempting to resolve conflict. The typical result, according to Fisher et al. (1990), was an escalation of the conflict.

Subsequently, conflict occurred when opposing parties had interests or goals that appeared to be incompatible (Daft 1999; Hughes, Ginnett & Curphy 1993). Since different groups to which staff belong often have different and inconsistent goals and values, corresponding conflicts and pressures are created (Kolb, Rubin & McIntyre 1971). Conflict was seen as an essential part of the problem-solving process and was used to improve group cooperation and increased project team performance. Kolb et al (1971) believed to minimize conflicts and tensions, the individuals involved sought to influence the values and goals of each of the different groups to which they belong and were important to them to minimize the inconsistencies and conflicts in their values and goals. Whitehead (2001) believed that, in most change situations, it was almost certain that senior managers started at a different point from junior staff and that other groups and departments also started from different positions, with the possibility that two different cultures merged. This, according to Whitehead (2001), led to grudges that inspired a negative culture and caused organisational change processes to fail in some way. To avoid such conflict, Kirkman, Jones and Shapiro (2000) believed any change initiative should fit clearly with the organisation's mission, vision, and strategy – and the link between them needed to be clear. Employee resistance to management initiatives was generally associated with negative organisational outcomes, including those associated with job dissatisfaction and grievances (Kirkman, Jones & Shapiro 2000).

Kirkman et al. (2000) believed that employees were mainly concerned about: (i) managerial support; (ii) role clarity; (iii) workload distribution; and (iv) team social support. To help allay fears, management looked at: (a) team members' perceptions of trust; (b) team members' cultural values; and (c) team members' tolerance for change. Without careful consideration (Kirkman & Shapiro 1997), mergers suffered where cultural values were incompatible with management initiatives and led to resistance and employee resistance to change resulting in lower individual and team effectiveness (Kirkman et al. 2000).

Inter-group conflict (Callan, Terry & Schweitzer 1995) was characterised by self-perpetuating and escalating processes that significantly increased the likelihood of destructive, win-lose behaviour. It was extremely difficult for parties to shift their thinking and behaviour toward a collaborative, win-win situation (Keashly, Fisher & Grant 1993).

Callan (1993) found that inter-group conflict was common when two organisations or departments merged. Employees reported feeling anxious and uncertain – especially about how the change affected the nature of their work, career paths and to whom they reported in the organisation. One consequence of a merger was that a new organisational identity was imposed on employees (Terry & Callan 1998), however, they often rejected the new identity and clung to the old one. When this occurred, negative feelings among employees jeopardised the success of mergers, which often failed because of an *us-versus-them* dynamic (Terry & Callan 1998).

Terry and Callan (1998) found clear evidence of in-group bias, particularly among the lower status employees. Their study showed support for the us-versus-them dynamic, which was likely to arise in the context of any organisational change. Low-status group members, according to Folkman (1984), needed to establish a positive sense of group distinctiveness and were motivated to attain a positive social identity by engaging in positive differentiation in status-irrelevant dimensions – for instance, seeing themselves as better in their friendliness, customer service, or value of tradition. Low-status employees were more threatened by an impending change than high-status employees (Lazarus & Folkman 1984).

Granitz and Ward (2001) believed individuals in subgroups interacted more frequently with one another, and thus shared unique cognitive structures. This was strong among functional (departmental) members because they shared common values, a common functional context and inter-group biases (Granitz & Ward 2001). Research showed that group boundaries also created inter-group biases; they caused individuals to perceive similarities with in-group members and differences with out-group members, real or imagined. Granitz and Ward (2001) stated there was a need for senior management to ensure that employees understood one unified set of ethical guidelines and behaved accordingly, and this supported a positive

relationship between profit and ethical behaviour. Therefore, developing an understanding of different subgroups that do not share one set of ethics was important for reasons of virtue, image and profit (Jenn & Chatman 2000). The perception and/or reality of different ethical subcultures among groups led to inter-group conflict, and understanding the source of these differences was a starting point for reducing it (Jenn & Chatman 2000). To reduce internal inter-group conflict Kolb et al (1971) believed competing groups should elect a representative to interact in public with a representative of the competing group to determine which group would provide the best solution to the conflict.

According to Granitz and Ward (2001), different organisational groups developed distinct ideas for several reasons:

1) members of a subgroup tended to develop inter-group biases to differentiate themselves from other groups
2) group interaction developed common values and shared tastes in addition to those that brought them together
3) a shared functional context created a basis for shared ideas.

While Tajfel (1972, p 292) stated: “The individual’s knowledge that he belongs to certain social groups together with some emotional and value is significant to him as belonging to this group membership”. For the individual, social identification was the perception of oneness with the group and helped define self in an inter-group context (Tajfel 1972). Motivated by an underlying need to reduce the complexity of the social world and increase self-esteem, social identification rested on inter-group comparisons that sought to confirm or to establish in-group favouring evaluative distinctiveness (social identity theory) such as Tajfel and Turner (1979) observed. With Hogg and Terry (2000), individuals cognitively represented the defining and stereotypical attributes of groups, including beliefs, attitudes, feeling and behaviour. Consequently, individuals overestimated their similarities with in-group members, and overestimated the differences with out-group members (self-categorization theory) (Hogg & Abrams 1988).

Mullen, Brown and Smith (1992) stated that once individuals were put into different groups, they processed information about themselves, members of their own group (in-group members) and members of another group (out-group members) in ways perpetuated by inter-group differences. According to Terry and Callan (1998), the strongest social ties usually existed between individuals within their functional department (in group). Thus, organisational boundaries created a structure that contained strong interaction between its members. Takacs (2001) found that in certain structural conditions, rational individuals were more likely to be trapped in harmful conflict than less rational people, and rigid assumptions about individual rationality strengthened the effect of clustering on inter-group conflict. Individual networks within and between groups transmitted social and cognitive rewards that influence participation in inter-group related collective action (Grant, Fisher, Hall & Keashly 1990). Experiments confirmed that individuals, in otherwise identical situations of social dilemma, were more inclined to make sacrifices for their group in an inter-group game than for themselves in a two-person game (Takacs 2001).

Olsen (1982) showed that it was precisely this *self-sacrificial* loyalty to subgroups that created conflicts between them. In many situations, collective action was harmful for the out-group and was considered as defection in the inter-group context, however in the long run, group boundaries changed or became less visible. Assimilation was considered as an optimal long-run strategy and avoided the emergence of harmful conflicts between groups (Olsen 1982).

As the literature shows, inter-group conflict was a varied and complex matter. According to the theorists, inter-group conflict was inevitable when organisations underwent change. The difficulty for leaders during the change period was that inter-group conflict produced ineffective communication, caused inadequate co-ordination between merged groups with a substantial reduction in productivity. As well as affecting the organisation, there were many personal difficulties when inter-group conflict occurred. Those who joined established groups experienced negative consequences (like spiteful behaviour, anxious feelings and uncertainty) and were exposed to grudges by existing group members. There was a definite problem with in-group/out-group behaviour (or an us-versus-them mentality) that should be solved before commencing organisational change. A change leader who merged departments or reduced

staff levels to blend different groups (as occurred in this research study), required a strong understanding of inter-group conflict and its impact on staff and the organisation.

2.6.4.1 Summary.

It can be seen from the review of the literature that there are a number of factors missing in part or in whole from the major transformational leadership models. These factors relate to how leaders deal with the effects of change on people during the change process. A number of research questions were derived from this analysis and these are listed in the next section.

2.7 Research Questions

As can be seen from the discussion so far, the theoretical and research literature suggested there might be some new behaviour resulting from the climate of discontinuous change in which organisations now operate that could be added to the concept of transformational leadership. Specifically, it appears that these new practices could reasonably be added to the existing transformational leadership frameworks as described in the previous section. This study, therefore, further investigated these revised frameworks and answered the following questions:

Question 1: What communication skills do transformational leaders use in the organisational change process?

Question 2: How do transformational leaders foster change in the organisation through team building?

Question 3: How do transformational leaders manage the high levels of stress and coping that occur during organisational change?

Question 4: What do transformational leaders do to manage inter-group conflict during organisational change?

Question 5: Are there other components that need to be added to the transformational leadership models not previously identified?

The next chapter describes the methods used to address these questions.

CHAPTER 3
Methodology

3.0 Introduction

The current research was undertaken to investigate organisational change and the role of leaders guiding it based on a potential extension of the transformational leadership models for undertaking change. The literature suggested that there are four components that might be included in extant transformational leadership models: communication, team building, stress and coping, and inter-group conflict. A qualitative approach to gathering and analysing data – specifically Grounded Theory (Strauss & Corbin 1990) – was used, as the questions posed could not be quantified by numerical measurement. This chapter investigates the methodology that formed the basis for this research.

To understand the selection process in this embedded case study, the following sections describe how the four hospitals were chosen and staff involvement determined.

3.1 Sampling

The four hospitals researched in the current study were selected because of their similar external environments that restricted the organisational context in which they operated. The internal changes within each hospital differed and provided distinct settings for change that were influenced by the management and leaders while the external environment remained reasonably stable. The managers and executives were the instigators of organisational change and were responsible for the development and implementation of change in the hospitals.

Each hospital was selected for its size, location, private or public status, and because it had undergone substantial organisational change in the 12 to 18 months prior to the interviews. The hospitals were invited to participate in the research by letter, with follow-up telephone calls to the Chief Executive Officers (CEOs) of all hospital for their agreement to participate and to answer any questions. In all cases participation was on a voluntary basis.

In total, 26 interviews were completed with various hospital executives, managers and staff. The decision to specifically interview the managers was made as they were directly involved in decisions about the implementation of change as a number of managers were present before and after the organisational change. To understand how the changes affected the employees, several non-management staff members were interviewed in each organisation. This allowed a full comparison of the change between the different hospitals and the effect the change had on the managers and leaders who implemented it.

In each case, the organisation's CEO chose the managers and executives for interview, and it was stressed that participation was completely voluntary and that confidentiality would be maintained throughout the project. The researcher was not aware if any potential subjects refused to participate.

Each interview took between one and one-and-a-half hours and was conducted in the meeting room of the relevant hospital, or in the interviewee's office when the meeting room was unavailable. The interviews were conducted in September, October and November 2004, and were undertaken by this researcher. All interviews were tape recorded and later transcribed for analysis and coding. Handwritten notes were also taken.

The case study approach was undertaken in an endeavour to find a theoretical basis for change that reduced conflict, stress and inter-group chaos, while improving communication for managers and staff during change processes. Within the concept of grounded theory, convergent interviewing was used to develop the theoretical structure of the extension to the transformational leadership model.

This chapter examines grounded theory, convergent interviewing, case study analysis and qualitative research as the preferred methods for answering the research questions. The techniques, processes and tools for ensuring quality and rigour in the study have been detailed. The embedded case study sample was used for this research and the methods of data analysis described. Finally, the limitations of the study were explained.

3.2 What is qualitative research?

Historically (Goodyear 1990; Wright 1996), qualitative research was not fairly appreciated and was criticised for its lack of scientific rigour, small samples, and subjective, non-replicable efforts. Today, researchers (Wright 1996) see qualitative research as a homogeneous data collection based on group discussions or in-depth interviews. The key to effective research is its flexibility and disciplined approach through the qualitative method of case studies (Goodyear 1990).

Martinsuo (2001) believed that qualitative studies of organisations and their culture were becoming quite common and Miles and Huberman (1994) believed the appreciation of qualitative studies increased phenomenally during the 1980s and 1990s. However, these studies, frequently suffered from a small scope with a limited target group, or superficiality and they lacked generalisability and had limited application (Martinsuo 2001).

According to Deshpande (1983), qualitative research operated within the paradigms of positivism, critical theory, realism and constructivism – the most important being realism. The realism paradigm was implicit in much qualitative research, but lacked criteria for judging its quality (Healy & Perry 2000). Realism was relevant when moving from theory-building to in-depth interviews and focus-group methodologies.

Critical theory (Healy & Perry 2000) emphasised social realities incorporating historically-situated structures. These researchers aimed to analyse and transform social, political, cultural, economic, ethnic and gender values. Therefore, research involved long-term ethnographic and historical studies of organisational processes and structures (Guba & Lincoln 1994). Henderson (2002) stated that the qualitative research industry leant heavily on sociology, psychology and anthropology – soft sciences that examined how humans operated in different environments. However, qualitative research provided the best proof of the benefits of adapting to change.

Goulding (1998) stated there were mixed messages – or confusion versus creativity – in the field of qualitative research. The mixed messages occurred because of issues in establishing knowledge. It appeared that rules regarding knowing were more transparent in the positivist paradigm: there were strictly formalised procedures for establishing and testing hypotheses. These usually involved focusing on the observable, rejecting the metaphysical and collecting data. A quantified process produced outcomes not obtained during a qualitative research project – scientific rigour tended to be judged by the degree of replication and generalisability of the findings (May 1994).

As the above literature review demonstrates, qualitative research covers a wide range of factors. This current thesis does not examine all qualitative theories, as the topic was limited to grounded theory and the analysis demonstrates those aspects involved in this study (such as realism and critical theory). To help understand qualitative theory, the following sections analyse the methods of qualitative research: phenomenology, grounded theory and case study methods. All were originally intended for the study of behaviour, meaning and experience.

3.3 Justification for the methodology

Phenomenology, according to Morse (1994), summarised the approach in relation to the constraints of qualitative research, comprehension, synthesising and theorising. With regard to comprehension, phenomenologists reflect on their own experiences – the next stage was a dialogue with others to gain experiential descriptions, then transcripts were examined and key words highlighted. Phrases were sought to understand the experience, and literature was used for further experiential descriptions and to test their compatibility with the research (Goulding 1999).

According to Goulding (1999), synthesising involved merging the data and thematically analysing it to identify common *structures* within the experience. These structures provided the researcher with an understanding of the world and contributed to the development of theory; also, qualitative techniques emerged from the phenomenological and interpretive

paradigms (Hussey & Hussey 1997). Phenomenology asked questions about the essence of experiencing phenomena. Typically, the emphasis was on constructivist approaches where there was no clear-cut objectivity or reality (Goulding 1999). Within the literature (Goulding 1999; Morse 1994), phenomenological findings were generally contextualised within the existential framework of meaning and choice. In grounded theory, there was no such restriction. The developing theory directed the researcher to the literature that best informed, explained and contextualised the findings.

The phenomenological research paradigm aimed at understanding human behaviour and interpreted phenomena in terms of the meanings people brought to them (Denzin & Lincoln 1998; Hussey & Hussey 1997). Gillham (2000) stated that phenomenology enabled researchers to explore complexities beyond the scope of controlled positivistic approaches. The phenomenology paradigm was qualitative and collected richer and more subjective data. It generated theories and produced results often overlooked when using quantitative analysis (Stenbacka 2001). The theory was also credited for using inductive logic, where themes emerged from the interviewees rather than being identified by the researcher. Also, patterns, themes and ideas were developed, emerging from the data through the researcher's analysis (Campbell 1975) (as occurred in this study).

This current research study used phenomenology and grounded theory as well as the qualitative method of in-depth conversations with the leaders, managers and staff regarding organisational change. Gorden (1975) argued that the advantages of interviewing were that it gave immediate opportunity to motivate respondents to supply accurate and complete information and to guide the respondent in their interpretation of the questions. This allowed the interviewer greater flexibility in questioning the respondent, allowed the researcher to control the situation, and created an opportunity to evaluate the validity of the information by observing the respondent. The interview allowed a researcher to understand the topic from the interviewee's perspective and why they held that perspective (King 1994).

A qualitative study was often exploratory as the researcher listened to informants and built a picture based on ideas. Interviews provided the researcher with face-to-face encounters and

were directed towards understanding the informants' perspectives about their lives, experiences or situations (Minichiello, Aroni, Timewell & Alexander 1990).

As the above analysis shows, qualitative data collection was an efficient and effective way to undertake research and therefore the interview and case study was an appropriate method for this current study of leadership and change. The following section explains why qualitative research was used to study leadership in the context of change, and how it applies to this current study.

3.3.1 Qualitative methods in study of change leadership.

Qualitative research (Bryman, Bresnen, Beardsworth & Keil 1988; Conger 1998) was widely accepted as a valid research methodology for understanding the management and leadership of change. Recent qualitative studies further advanced theory development in this field and included the change models of Dunphy and Stace (1991), the stages of change leadership by Kotter (1996), and the work of Kanter and her colleagues on corporate change (Kanter, Stein & Jick 1992).

Henwood and Pidgeon (1992) believed there was some confusion in defining qualitative techniques because of their narrow association with particular modes of data gathering. It was perceived that qualitative approaches implied a different perspective of human behaviour than those of quantitative ones. Quantitative research does not supply the rich tapestry of data required by a subject as complex as leadership. Quantitative data related to specific and clearly defined variables that can be repeatedly measured; whereas the study of leadership required the investigation of a complex range of loosely defined variables. The main form of quantitative analysis was via a questionnaire – an artificial instrument that provides a distorted view of social reality. It identifies what people *say* they do rather than what they *actually* do (Parry 1996) and was unsuitable for a qualitative project.

According to Cobb (1996), the purpose of qualitative research was to assess individual impressions, expectations and prejudices. It was predominantly a diagnostic tool to determine

issues and what respondents felt about them (Gregory 1995). This current study required the researcher to go beyond description and to understand how participants negotiated the processes of everyday life using symbols, rituals and roles. The techniques used to gather and to understand these meanings required sensitivity and flexibility while the purpose was to isolate and define categories during the research, and create a sense of integration or pattern matching (Hyde 2000).

McCracken (1988) believed that qualitative research normally looked for inter-relational patterns within categories rather than sharply delineated relationships. Campbell (1975) called this linking of data to propositions as "pattern-matching". This demanded observational techniques that allowed the investigator to sort the data and find patterns of associations and assumptions. In pattern matching (Hyde 2000), several pieces of information from the same case can be related to a theoretical proposition. Consequently, this current research used grounded theory and pattern matching as described by Campbell (1975) and Hyde (2000).

As the above literature review showed, there were various analytical forms that could be used in a qualitative study. The focus of this current study was on qualitative research, and specifically on grounded theory, as the research questions and the form of analysis best related to the subject. The following sections provide a deeper insight into grounded theory and explain why it was chosen for this research study.

3.4 Qualitative research and grounded theory

According to Cassell and Symon (1994), qualitative methods were often associated with the collection and analysis of written or spoken text, or the direct observation of behaviour. The research was driven more by emergent themes and idiographic descriptions than by specific hypotheses and categorical frameworks. The concept of grounded theory, as developed by Glaser and Strauss (1967), supported this qualitative research thesis, and was the foundation of this current study.

3.4.1 Grounded theory method.

Grounded theory was concerned with exploring a process and developing a theory from its analysis (Creswell 1994). Within the concept of grounded theory, a method of qualitative data collection – known as convergent interviewing – was used.

Grounded theory was developed to formalise a set of methodological procedures for studying behavioural experiences. It was used to generate theory where little was already known, or to provide a fresh analysis and data collection (Charmaz 1983). Grounded theory, according to Morse (1994), also included concepts embedded in symbolic interactionism – where investigators attempt to determine the symbolic meaning behind artefacts, clothing, gestures, words, or the objects of consumption that groups and individuals have as they interact with one another (Baker, Wuest & Stern 1992).

Grounded theory was obtained through *social research*, grounded in data (Goulding 1998), and developed in an attempt to avoid highly abstract sociology. The main thrust of the movement was to bridge the gap between the theoretically *uniformed* empirical research and empirically *uniformed* theory by grounding theory in data (Charmaz 1983).

Glaser and Strauss (1967) also used grounded theory to generate hypotheses to understand existing knowledge. It was an interpretation made of enquiry, and its roots were in the symbolic interactionism movements (Goulding 1998). It was a theory of human behaviour and an enquiry of human conduct and group behaviour where language, gestures, expressions and actions were all considered primary to the experience

There are two distinct movements in grounded theory. The first is the original Glaser and Strauss (1967) theory that deals with the fundamental principles and processes of the theory. Later, Strauss and Corbin (1990) developed the grounded theory model in which a systematic set of procedures was developed to inductively derive theory about phenomena. As such, grounded theory was an immersion of ideas into the data so that meanings and relationships emerge (Strauss & Corbin 1990).

Grounded theory and phenomenology (Goulding 1998, 1999) were sometimes linked as similar research techniques. However, notwithstanding the similarities, there were a number of fundamental differences, and these centre largely on the sources of data and the use of literature to inform and locate the developed theory (Goulding 1998). With phenomenological studies, the words of the informants were considered the only valid source of data, while grounded theory allowed for multiple data sources – which may include interviews, observation of behaviour and published reports (Goulding 1998).

The Glaser (1978) study discussed the role of theory and its importance in sensitising the researcher to the significance of emerging concepts and categories. Knowledge and theory were used as though they were another informant. Without this grounding in extant knowledge, pattern recognition would be limited to the obvious and superficial, depriving the analyst of the conceptual advantage to develop theory (Glaser 1978). Theory, according to Strauss and Corbin (1994), was a set of relationships that offered a plausible explanation of the phenomenon under study.

With grounded theory (Goulding 1998; Morse 1994), the hypothesis evolved during the study by the continuous interaction of the analysis and data collection. The theories could be modified as new data was analysed and compared against previous data. The purpose of grounded theory was to build a premise that illustrated the area under investigation (Hussey & Hussey 1997), as occurred in this current study.

An approach properly constructed on grounded theory would meet some of the criteria (fit, understanding, generality, control and modifiability) and ascertain if the theory applied to the phenomenon (Glaser & Strauss 1967; Strauss & Corbin 1990). Fit would emerge if the theory was based on the everyday situation of the organisation and was carefully deducted from the collected data. If the data upon which the theory was based was comprehensive with conceptual and broad interpretations, then the hypothesis should be abstract with sufficient variation for it to apply to a variety of contexts related to the phenomenon (Glaser & Strauss 1967). The theory must allow the researcher control over the structure and the ability to

process the research as it changed and emerged through time; it must be able to be modified as new data is collected (Strauss & Corbin 1990).

Strauss and Corbin (1998) developed the recent basic grounded theory approach using the microanalysis technique. In using the theory, a detailed line-by-line analysis was necessary at the beginning of the study to generate initial categories and suggest relationships between them: namely by using a combination of open, axial and selective coding. Strauss and Corbin (1998) stated that analysis was not a structured, static or rigid process. Rather, it was a free-flowing and creative one in which analysts move quickly between types of coding. Microanalysis (Strauss & Corbin 1998) involved the very careful and minute examination and interpretation of data (as occurred in this current study) and has three major aspects:

i) The data (actual events recounting by participants, texts, observations, videos).

ii) The observers' and actors' interpretations of those events, objects, and happenings.

iii) The interplay between the data and the researcher – meaning that a researcher is actively reacting to and working with the data. The researcher should self-consciously bring discipline to the analysis while enhancing its creative aspects.

3.4.2 Understanding grounded theory.

In grounded theory, the constant comparative method is central to the process (Parry 1999). Data is collected, coded and analysed concurrently so that decisions about what data to collect next could be made. Theory emerged, was modified and developed as more data was collected and analysed (Strauss & Corbin 1998).

The three techniques used in the microanalysis of grounded theory established by Strauss and Corbin (1998) were: open coding, axial coding, and selective coding.

1) Open coding: "the analytic process through which concepts are identified and their properties and dimensions are discovered in data" (Strauss & Corbin 1998). The first step in theory building is conceptualising. The ways of undertaking open coding were: line-by-line (the most time consuming form); paragraph-by-paragraph; then by entire documents. A phenomena provides an abstract representation of an event, object, or action/interaction that a

researcher identified as being significant in the data. The purpose of a phenomena is to enable researchers to group similar events, happenings, and objects under a common heading or classification (Strauss & Corbin 1998). Data is broken down into discrete incidents, ideas, events, and acts – and then named. The analyst may name the objects, or use the words of respondents themselves, called *in vivo codes*. In further data analysis, the researchers come across other objects, events, or acts that are identified through comparative analysis as sharing some common characteristics with an object and place it in the same code. Categories are concepts derived from data that stand for phenomena, and phenomena are important analytic ideas that emerge from the data.

Initially in this current study, line-by-line coding was undertaken. The process was time consuming and tedious, but quickly generated codes and classifications that allowed the researcher to develop the categories into a theoretical sampling. The interviewees often used code words, and this led to an accepted and well-understood terminology with the interviewees.

2) Axial coding: "the process of relating categories to their sub-categories, termed 'axial' because coding occurred around the axis of a category, linking them at the level of properties and dimensions" (Strauss & Corbin 1998). The purpose of axial coding is to begin the process of reassembling data fractured during open coding. Axial coding requires the analyst to have some categories, though a sense of how categories are related often begins to emerge during open coding. A category stands for a phenomenon that has the ability to explain what is going on. Each category is a problem, issue, event or happening that is defined as being significant to respondents. In addition sub-categories answer questions about the phenomena (such as when, where, why, who and with what consequences), thus giving the concept greater explanatory power. Although the text for analysis provides clues about how categories relate, the actual linking takes place at a conceptual level rather than descriptively.

With axial coding, there are two levels of explanations:

i) the actual words used by the respondents

ii) the conceptualisation of the respondent's words.

Within axial coding lies the organisational scheme called a paradigm: the perspective taken toward data (another analytic stance that helps to systematically gather and order data in such a way that structure and processes are integrated). These form the ideas in which phenomena are embedded and formed:

a) conditions
b) the actions and interactions
c) the consequences of the action.

In this current research, the concept of a paradigm (Strauss & Corbin 1998) assisted in developing an understanding of the relationship between categories, especially when they were not evident from the interviewees. The paradigm was a perspective of the data and sampling that helped to validate these relationships. Moving back to the data for verification is an essential step in grounded theory, and moves the researcher from inductive to deductive thinking – then back again.

3) Selective coding: "the process of integrating and refining the theory" (Strauss & Corbin 1998). The first step in integration is deciding on a central category that represents the main theme of the research. The criteria for the analysis in the selective coding process includes:

a) Choosing a central category:
    i) all major categories must be related to it
    ii) it must appear frequently in the data (in almost all cases there are pointers to the concept)
    iii) the explanation that evolves by relating categories was logical and consistent
    iv) the name to describe the central category is sufficiently abstract for use in research in other areas, leading to a more general theory
    v) as the concept is analytically refined through integration with other concepts, the theory grows in depth and explanatory power
    vi) the concept is able to explain variations and the main point made by the data (i.e. when conditions vary, the explanation still holds, although the way a phenomenon is expressed might look somewhat different);

b) Choosing between two or more possibilities;

c) Difficulty deciding on a central category.

As occurred in this current research, four components were tested, however, through analysing the data repeatedly, several sub-themes emerged that added to the development of new theory.

As shown above, grounded theory was appropriate for this current study for two reasons:
i) pattern matching, theory development and a full, detailed analysis of the data was required;
ii) the interviews needed to be analysed to identify emerging themes and to allow free-flowing concepts from the data. All of the grounded theory concepts have emerged from the collected data. Another way to investigate the data is with the methodology.

The following section provides an overview of the methodology and the role it plays in grounded and qualitative theory.

3.5 Methodology

According to Murphy (1995), methodology was the way one made sense of the object of inquiry. A qualitative methodology was a procedure that made sense of management practice within the terms set by management competencies.

A qualitative approach may become descriptive instead of analytical and lack applicability and conclusivity (Martinsuo 2001). By narrowing the scope of a study, one may increase the depth of the topic but lose touch with the original question and merely respond to a fraction of it (Martinsuo 2001). Part of qualitative research according to Martinsuo (2001) is a thorough write-up of the procedures, context and researcher's roles – all designed to give readers an accurate description of the study and the validity of the researcher's interpretations (Creswell 1994).

Murphy (1995) stated that qualitative research established the meaning of relationships in terms of influences and actions. Its aim was to articulate the scenarios that may occur under different circumstances. The methodology of the research was established in the thesis and the procedure was open and replicable according to the theories described. Murphy (1995) believed that by deconstructing management functions into a series of identifiable competencies, the analyst isolates the key issues for development programs. A qualitative approach was concerned with the depth of information required to make sense of an individual's actions and experiences.

Methodology, according to Healy and Perry (2000), involved the concepts of methodological trustworthiness, analytic generalisation (theory building), and construct validity:

a) Methodological trustworthiness (Yin 1994): referred to the extent research can be audited by developing a case-study database and by quoting in the written report.
b) Analytic generalisation (Yin 1994): was theory-building. Given the complexity of realism, research into it must be primarily theory building rather than testing the applicability of a theory to a population (the primary concern of positivism).
c) Construct validity (Yin 1994): referred to how well information about the theoretical constructs were measured in the research.

Qualitative research (Murphy 1995) involved the task of finding out from managers the standards that they expected of themselves and their peers, and to use this criteria as the framework to evaluate management practice. It was not concerned with how many managers did or did not adhere to certain practices, but rather attempts to explain why managers with different practices adhered to them or not.

Murphy (1995) investigated a related characteristic in qualitative research: to code and statistically test the qualitative data for evidence of a relationship. The contextual quality was studied and the actions were exclusively understood within their context. Another form of

investigation was the theoretical quality, an approach where the optimum conditions for the practise of relationships were modelled (Dey 1993).

There were many qualitative methods (Pierce 1994), but the fundamental approach was through open-structured questions allowing the participants opinionated responses to set the terms of understanding for the analysis. This current study allowed staff and managers to answer open-ended questions and developed new theory through the questioning and data analysis.

When undertaking qualitative research, numerous checks need to be undertaken to prove its authenticity. Stenbacka (2001) found that, in qualitative research, the quality concepts required were validity, reliability, generalisability and carefulness. The following sections provide an analysis of each of those concepts.

3.5.1 Validity.

Validity was "the intended object of measurement that is actually measured" (Eneroth 1984, p 59). Eneroth (1984) proved this because the purpose of qualitative research was to never measure anything. A qualitative method seeks a certain quality for a phenomenon that is typical or differentiates it. Martinsuo (2001) assumed that validity in the exploratory case study dealt with establishing correct operational measures for the concepts being studied (construct validity), truth value for findings (internal validity and credibility), and the domain to which findings can be generalised (external validity and transferability) (Miles & Huberman 1994; Yin 1994).

Sykes (1991, p 10) tried to find "how to formally prove validity in qualitative research". Primarily, the validity of data depended on the *purpose* of the study. The reason to understand a social phenomenon was to comprehend another person's reality in a specified problem area (Stenbacka 2001). This meant that the understanding of the phenomenon was valid if the subjects were able to speak freely according to their own knowledge. Validity was achieved

in this study when it used voluntary interviews with strategically well-chosen informants (Sykes 1991), and the interviewees were able to respond using their own experiences. The second component to be established was reliability.

3.5.2 Reliability.

Reliability, according to Stenbacka (2001), concerned the ability of research to repeatedly produce the same results, as this was not possible in qualitative research. According to Eneroth (1984), the basic issue was the researcher's ability to use the circumstances that made it possible to use the interaction with the method to its fullest. Martinsuo (2001) argued that reliability meant demonstrating that the operations of the study – such as the data collection procedure – can be repeated with the same results. Yin (1984, 1994) also referred to reliability as confirmability and dependability of the data (Miles & Huberman 1984).

Reliability can be difficult to establish in a qualitative study. In this current study, each of hospitals researched experienced individual changes, with individual personalities and a differing internal environment making reliability difficult to evaluate. The third concept to be established was generalisability.

3.5.3 Generalisability.

Sykes (1991) indicated that data generation and interpretation was needed to create a definition that focused upon the unique relationship between researcher and the subject. A thorough description of the whole process that enables conditional inter-subjectivity is what indicates good quality research when using a qualitative method (Stenbacka 2001). With generalisability (Stenbacka 2001), the issue was whether the resulting conclusions were common for a population – in this current study, it was established by using multiple hospitals and a significant number of subjects. Yin (1989) pointed out that results in a qualitative study were intended to be general in respect to theory, not to population.

According to Yin (1994), analytical generalisability was the basis for simplification in qualitative study. The researcher's goal was to expand and generalise theories, not to establish the frequency with which a phenomenon was likely to occur in a population. The depth of understanding in qualitative research was based on a detailed knowledge of the particular and its nuances in each context (Stake 1994). Even a single case, if studied in sufficient depth and with sufficient insight, may provide the basis for a theoretical explanation of a general phenomenon as occurred in this case study. The goal was to expand the existing transformational leadership models by developing an additional principle for the theories.

Yin (1994) distinguished between analytical and statistical generalisation. Analytical generalisation was relevant in qualitative research, where understanding people's motivations came from lifting the empirical material to a general level and analysing their behaviour. When undertaking careful research or *carefulness*, Walker (1995, p 3) stated that "analysis of qualitative material is more explicitly interpretative, creative and personal". For grounded theory, Glaser (1992) proposed that the most relevant aspect in research was to obtain the *purpose* of the study. Strauss and Corbin (1990) advocated a systematic method (reliability) and forced Glaser (1992) to provide a valid understanding of the studied phenomenon. The qualitative researcher brought valuable insights to the process and continuously reflected upon the studied phenomenon while generating understanding.

Hyde (2000) believed that a qualitative inquiry adopted an inductive process. The traditional view was that the quantitative researcher followed a *positivist* paradigm, while a qualitative researcher followed a *relativist* (post positivist) view (Easterby-Smith, Thorpe & Lowe 1991). According to Hyde (2000), there were two general approaches to the acquisition of new knowledge – inductive and deductive reasoning:

a) Inductive reasoning was a theory-building process, which started with observations of specific instances and sought to establish generalisations about them.

b) Deductive reasoning was a theory-testing process, which commenced with differentiating an established theory (or generalisation) and sought to see if the theory applied to specific instances.

The following sections analyse the two components of inductive and deductive reasoning.

a) *Inductive Reasoning*: The role of qualitative inquiry involved the classic qualitative study where findings are *grounded* in the data (Glaser & Strauss 1967). The grounded theory approach suggests that researchers commence their study with minds open to the possibilities of the data and the subject's perspectives (Strauss & Corbin 1994). A qualitative study seeks to identify underlying concepts and the relationships between them. The data for a qualitative study might include transcripts of in-depth interviews, observations or documents (Patton 1991), as occurred in this current study. Qualitative enquiry often takes the form of a case study; an approach to research rather than a single qualitative method – simply an in-depth study of a particular instance, or a small number of instances of a phenomenon (Hyde 2000). This concept formed the basis of this research study and potential development of new theory.

According to Yin (1994), a case study was the preferred research approach when *how* or *why* were being posed. Case studies searched beyond mere snapshots of events, people, or behaviour (Bonoma 1985), and were appropriate for qualitative research which occurred in this research program rather than using a quantitative method (Hyde 2000).

A key distinction, according to Hyde (2000), between quantitative and qualitative research was that the first sought to describe the general characteristics of a population and ignore the particular, while the other sought to explain the particular. Rather than creating a general profile of the subject population, the qualitative study provides conclusions for the particulars of every case; it allows researchers to study issues in depth without limiting data collection to predetermined categories. Qualitative methods produce a wealth of detailed data on a small number of individuals (Patton 1991). Again, this demonstrates the suitability of the current study to the research method used.

b) *Deductive procedures* (Hyde 2000): introducing formal deductive procedures into qualitative research is important in assuring conviction in the findings. There was a need to formalise the deductive process through:

i. The use of *hold out* samples (Yin 1994): strict deductive procedures required that the dataset for theory building was not the same as that used to test that theory. Lincoln and Guba (1985) advocated a "referential adequacy" technique of deductive procedures.
ii. Replication case study designs (Perry 1997): involved the use of multiple rather than single cases.
iii. Analytical induction: (Cressy 1953) required that a theoretical explanation of a phenomenon be inductively constructed from the first case or cases examined.
iv. Pattern matching: The theory is expressed as a pattern of predicted independent outcomes. Pattern matching involved a number of steps:
    - theoretical propositions must be stated before gathering data (Campbell 1975)
    - a counter theory must be proposed
    - independent judges must undertake a case-by-case comparison of the theory and the counter theory using the deductive dataset
    - a record of hits and misses must be recorded.

All of the above points for analytical and deductive procedures were demonstrated in this current research study. These points highlight how to develop new theory and test established theory when doing qualitative research. The following section details how to undertake case-study analysis (which was the basis of this current research study).

3.6 Reasoning to support using the qualitative and case study approach

It was commonly asserted (Hyde 2000) that qualitative research in the organisational sciences lacked the rigour and objectivity of the quantitative, or case-study approach. According to Patton and Appelbaum (2003), a case study was an empirical inquiry that investigated a contemporary phenomenon within a real-life context (where the boundaries between them

were not clearly evident) and in which multiple sources of evidence were used (Yin 1984). Case studies typically combine data-collection methods such as archival searches, interviews, questionnaires and observation (Eisenhardt 1989).

The natural science school of social sciences (Gummesson 1991) harshly criticised the use of case studies in research. Hamel (1993) underlined that the case study had been strongly faulted for:

a) its lack or representativeness in observing social phenomenon
b) its lack of rigour in the collection, construction and analysis of the empirical materials that give rise to the study.

The first criticism concerns the view that generalisations cannot be made based on case studies; the second (lack of rigour) was linked to the problem of bias, which was introduced by the subjectivity of the researcher and the field informants on whom the researcher relied (Patton & Appelbaum 2003). The following sections address these problems and attempts to validate the use of the embedded case study method in this research.

3.6.1 The use of case analysis.

Patton and Appelbaum (2003) believed case studies offered the opportunity for a holistic view of a process as opposed to the reductionist, fragmented view so often preferred in research. According to the holistic view, the whole is not identical to the sum of its parts; consequently, the whole can only be understood by treating it as the central object of the study (Gummesson 1991).

As a research endeavour (Yin 1984), the case study uniquely contributed to the knowledge of individual, organisational, social and political phenomena. The distinctive need for case studies arose out of the desire to understand complex social phenomena. In brief, the case study allowed an investigation to retain the holistic and meaningful characteristics of real-life events (Yin 1984) – and this was developed in the current research study.

The case study's unique strength was its ability to deal with a full variety of evidence: documents, interviews, artefacts and observations (Yin 1984). Other researchers (Orum, Feagin & Sjoberg 1991) believed that some organisational issues were related to the intersection of human agents and organisational structures. Therefore, an argument could be made that major organisational issues cannot be addressed until in-depth case studies are viewed as having an independent role in advancing sociological issues, rather than as an adjunct to natural science models (Sjoberg, Williams, Vaughan & Sjoberg 1991).

3.6.2 When and why case studies should be used.

According to Patton and Appelbaum (2003), the case study takes shape as part of an inductive approach where the empirical details of the studied object were considered within the particular context (Hamel 1993). This was in contrast to the deductive reasoning methods of the natural science approach which did not consider the uniqueness of a particular case (Stake 1995). Qualitative researchers press to understand the complex interrelationships between all elements in a particular case (Stake 1995) – such as in organisational change and the role of leaders. They concentrate on the instance, trying to pull it apart and put it back together again more meaningfully.

As with in this current research, case studies according to Yin (1984) were the preferred strategy when the investigator had little control over events and the focus was on a contemporary phenomenon within a real-life context. Yin (1984) identified four different applications for case studies:

1) To *explain*: a) the causal links in real-life interventions that were too complex for the survey or experimental strategies; b) the particular case at hand with the possibility of coming to broader conclusions.
2) To *describe* the real-life context in which an intervention had occurred.
3) To *evaluate* an intervention in a descriptive case study

4) To *explore* those situations where the intervention being evaluated has no clear, single set of outcomes.

Eisenhardt (1989) argued that the in-depth style of the case study and its use of different techniques freed the researcher from the shackles of strict procedure, unfroze thinking, and increased the likelihood of generating novel theory.

In the study of generalisation, Yin (1984) found many researchers believed a theory could not be generalised from a single case study, and that case studies could only create hypotheses without testing them. Yin (1984) pointed out that an investigator's goal was to expand and generalise theories (analytic generalisation) and not to enumerate frequencies (statistical generalisation). According to Normann (1984), and as found in this current study, the key was to build a proper case with analytic sophistication rather than one that could easily be replicated repeatedly. For case studies, generalisability was determined by the strength of the description of the context. Such descriptions were a cornerstone of case studies and allowed the model to determine the relationship of different cases.

Case studies were also criticised by Miles (1990) as lacking rigour because standard methodological procedures were absent. However, not having pre-determined steps made case studies harder and more demanding. Still, Miles and Huberman (1984, 1994) developed formal methodologies to collect and code qualitative data, analyse events and conduct unstructured interviews.

In light of the evidence presented above, case studies were used for this investigation, and a strict protocol for undertaking grounded theory research was developed. Following is the case study road map used for this current research study.

3.6.3 The case study roadmap.

Through the work of Stake (1995), Hamel (1993) and Eisenhardt (1989), a clear vision of the activities needed to conduct a useful case study emerged:

1) Determine the object of study: it is important to outline the aims and construct tentative hypotheses.
2) Select the case: the researcher must select a case pertinent to the object of the study which could be fully investigated.
3) Build initial theory through a literature review: enhance the validity, generalisability and theoretical level by tying the emergent theory to exiting literature (Eisenhardt 1989).
4) Collect and organise the data.
5) Analyse the data and reach conclusions: the ultimate goal is to uncover patterns, determine meanings, construct conclusions and build theory.

In this current study, all five components of the roadmap were followed and new theories were developed, which vindicated the use of qualitative research.

Supporters of qualitative research design (Strauss 1987; Van Maanen 1983) stressed its potential for theory development through rigorous coding and interpretive procedures. Strauss and Corbin (1998) proposed that qualitative research was “to uncover and understand what lies behind any phenomenon about which little is yet known”; or “to gain novel and fresh slants on things about which quite a bit is already known”. Strauss and Corbin (1990, p 19) also claimed that “qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods”, indicating the usefulness of qualitative data in interpreting quantitative findings.

Supporters of a qualitative approach (Van Maanen 1983) claimed that a deductive methodology constrained researchers within current theory, whereas an inductive method (Denzin 1989) encouraged theory development or extension. While Simon (1994) supported

the inclusion of two-phases of qualitative research in the research process: initially recommending the use of in-depth interviews, followed by structured, open-ended qualitative interviews to *flesh out* the themes produced through the initial unstructured interviews.

Yin (1989) argued that the researcher must understand the theoretical issues, as judgments are made during the data collection phase; and Simon (1994) actively supported a literature review as an integral component of the exploratory phase of data collection. Strauss and Corbin (1990, p 41) defined knowledge of the literature as one source of gaining "theoretical sensitivity", which was a "personal quality of the researcher" indicating they were aware that data had subtle meaning.

However, caution was required in systematically accepting previous meaning when trying to tease new light in understanding behaviour in the early stages of data production (Jarratt 1996). An in-depth knowledge of the literature helped develop theoretical sensitivity, but may lead to important relationships being overlooked. A partial solution to this dilemma lies in the use of analogous bodies of literature and mid-range theories to search for a range of theoretical perspectives before starting the qualitative component of the investigation (Jarratt 1996).

Ericsson and Simon (1984) stated that the "accuracy of verbal reports depends on the procedures used to elicit them and the relation between the requested information and the actual sequence of needed information". Invalid reports may be due to "lack of access to thoughts, inadequate procedures for eliciting verbal reports or requesting information that could not be provided even if thoughts were accessible".

As established in this current research project, qualitative research methods were more intrusive and less structured than quantitative research techniques and were appropriate when: the research was exploratory in nature; the subject was unfamiliar to the researcher; and the

research was clinical (Jarratt 1996). In all of these situations, the interviewer through in-depth interviews must be able to gain insight into a specific topic area (Ericsson & Simon 1984).

According to Sampson (1972), in-depth interviews were one approach to qualitative research, and may be either non-directive or semi-structured. In non-directive interviews, it was important that a sympathetic relationship developed between the interviewer and the interviewee and that probing did not cause a bias in responses. The interviewer must be able to guide the session back to the topic when the interviewee digresses, or the exploration of a particular area becomes fruitless (Reynolds & Gutman 1988). On the other hand, Sampson (1972) stated that a semi-structured approach allowed the researcher to cover a specific list of topic areas, with the time for each topic left to the discretion of the interviewer. The open structure ensured that the unexpected could be easily explored (Jarratt 1996).

The next section detailed the use of convergent interviews which were used in this current study and the interview process will be analysed.

3.6.4 Convergent interviewing.

Convergent interviewing is a technique used to gather information (Dick 2000), and most valuable when the researcher is in doubt about the information to be collected. Convergent interviewing uses both unstructured and structured interviews and is a process that, of itself, is highly structured in its development. With each series of interviews, the information obtained is systematically analysed. Only relevant information is extracted from earlier interviews and used in the following interviews. This improves the efficiency and reduces bias. According to Dick (2000), the convergent interview employs the following steps:

1) define the reference group
2) define the information to be collected
3) define the target population
4) inform the target population
5) select the sample to be used
6) select and train the interviewers

7) plan the interviews
8) conduct the interviews
9) interpret the interviews
10) compare interviews
11) review the process
12) recycle, return to step 8, and repeat the process with new interviewees
13) report the findings.

Henwood and Pidgeon (1992) believed that only qualitative methods were sensitive enough to allow a detailed analysis of organisational change. The qualitative approach allowed a holistic view of the situations or organisations that researchers were attempting to understand. Individual or organisational behaviour was perceived as a *lived experience* within the social setting, rather than the outcome of a finite set of discrete variables. Therefore, the focus within many qualitative studies was with understanding the individual's *life-world* as they proceed through corporate change (Henwood & Pidgeon 1992).

A qualitative study is designed to be consistent with the assumptions of a qualitative paradigm. Any qualitative study is an inquiry to understand a social or human problem by building a complex, holistic picture, and by reporting the detailed views of informants. As a result, qualitative research is often described as the constructivist (naturalistic) approach that involves studying real-world situations as they naturally unfold (Creswell 1994).

Blalock (1970) suggested that in building deductive (testable) theories, complex enough for new insights, one must begin with simple models and add new variables a few at a time. The result was the construction of more realistic theories by an inductive process (Bourgeois 1979).

Conger (1998) asserted that in studying leadership, qualitative research methods used three dimensions: multiple levels of analysis, dynamism, and social construction. The qualitative method of studying leadership offered several distinct advantages and provided more opportunities to explore the leadership phenomena in significant depth. There was the

flexibility to detect unexpected phenomena and an ability to investigate processes more effectively. Conger (1998) also held that the qualitative approach was more sensitive to contextual factors, allowing processes to unfold rather than focus on the structure. Conclusions that emerged from qualitative research were impressionistic rather than definitive.

Accordingly, the qualitative method was judged the most appropriate for this current study because the research required flexibility. The interpretations by interviewees of specific situations provided the basis of theory generation; a quantitative study would only provide one view of change.

3.6.5 Summary.

This section detailed the processes used to collect data for this current study. Sampling was used to specifically target informants who were interviewed with the convergent interviewing technique and data sensitivity was achieved by using the researcher's knowledge of the topic to become established as a legitimate group member. The analysis of the data from the informants assisted with the development of additional questions and added a reasonableness check to the collected data.

Triangulation was achieved using interviews, documents and literature, which provided different perspectives to establish consistency and confidence in the findings. Since the research was based on grounded theory and the use of an embedded case study, the following section contains a detailed review of the interview process and provides guidelines on conducting convergent interviews.

3.7 The interview process

The interview process used for this study was a flexible and adaptable way to discover information; the crucial option being the ability to modify the line of inquiry to respond directly to the information provided by the informant. However, the process was time-consuming with each interview lasting between one hour and one-half hours. Triangulation

was achieved using various data collection methods and sources of interviews, documents and literature.

There were two main types of interview (Jarratt 1996): structured and unstructured – with questions ranging from closed to open-ended (Creswell 1994; Lincoln & Guba 1985; Patton 2002). In structured interviews, the interviewer asks all respondents the same set of pre-established questions, and records the responses according to a pre-determined coding scheme (Simon 1994).

As stated by Sampson (1972), unstructured interviews can provide a greater depth of data than others as they gain insight into the informant's understanding of a situation or process. The questions were open-ended, so the informant's answers were not limited by previous categories imposed by the interviewer. Depending upon the type of unstructured interview, a set of previously developed, open-ended questions might or might not be necessary (Creswell 1994; Lincoln & Guba 1985; Patton 2002).

For this current study, the research was conducted using convergent interviewing as the means of gathering data, as this met the requirements of grounded theory on which the study was based. In convergent interviewing, the interviewer commences by asking open-ended questions that focus on the research questions, but can be broad enough to encourage the informants to provide long and detailed answers (Dick 1998). This provides the researcher with the opportunity to identify key issues raised by the informant. The researcher can then probe the issues raised by the informant through subsequent questions that develop as the interview progresses.

Although casual in approach, the process involved a defined structure focused on the research questions. The interviews for this current study followed five definable stages of convergent interviewing (Dick 1998, 2000). First, rapport and trust was built at the beginning of each interview by outlining its purpose. Issues of consent and confidentiality were addressed and details of the interview transcripts were discussed. The interviewees were reminded that they

were free to terminate the interview at any stage. Each interviewee was informed that ethical clearance was obtained to undertake the study.

In the second stage, the researcher asked a broad opening question that allowed the informants to respond freely – for example: "Can you tell me about the organisational changes your hospital has been through in the last 12 to 18 months?". The third stage involved keeping the informant talking without asking specific questions. This was achieved by techniques that included nodding, smiling and asking questions that encouraged the informant to continue, like: "Do the patients find the new system good?" In the fourth stage, the researcher asked more probing questions developed *on-the-go* to explore specific aspects of the data and emerging theory. As the number of interviews increased, the probing questions became more specific and related to emerging categories. In the fifth and final stage, the researcher asked the interviewees to provide a summary of the key points to keep them thinking about other issues not raised during their interview.

The strength of the convergent interview approach (Dick 1998, 2000) was that it allowed the researcher to be flexible, spontaneous and responsive to individual differences and situational changes; questions could be personalised to strengthen communication with the informant. The inevitable biases and preconceived ideas were minimised using the convergent interviewing technique, as the informants directed the content of the discussion after the first broad question.

The next section details the procedures and guidelines for undertaking interviews and the ethical considerations necessary for interviews.

3.7.1 Guidelines and procedures for interviews.

Various technical writers on interview techniques (e.g. Bryman 1995; Bryman, Bresnen, Beardsworth & Keil 1988) were often critical of interview design. Following their guidelines, in the current case study the interviewer worded questions so they were clearly understood by the respondents. A vocabulary was selected so the respondent could answer questions without violating the etiquette of the situation.

In this current study, questions were based and worded according to the transformational leadership frameworks. The questions were unambiguous, easily understood and provided long and detailed responses. A strong relationship was established between the interviewer and the respondents, making questions and probes easier and facilitating detailed responses. Many of the respondents expressed their feelings and ideas about the changes at the hospitals being researched. As reported (Gorden 1975), qualitative research was often fluid and flexible and allowed the discovery of novel and unanticipated findings. This sense of discovery existed in this current study.

Additionally, Shouksmith (1968) provided a series of rules for the orientation of interviewing, and a list of *do's and don't's* for conducting an interview that were adopted in this study. For instance, the interviewer listened to the respondent in a patient, friendly, intelligently critical manner, without displaying any kind of authority. There was no advice or moral admonition, and the interviewer did not contradict or interrupt the speaker.

3.7.2 Recording and transcribing the interview.

In this current study, the researcher tape-recorded each interview. The informants were asked beforehand if they would agree to be tape-recorded, and all consented; they were advised that tape recording could be discontinued at any time at their discretion.

The interviewees were informed that the tapes would be transcribed by a professional, who had signed a confidentiality agreement and was supervised by the researcher. They were also advised that the transcriptions would not contain the names of any individual or organisation, and each interviewee was given a personal code. Codes for interviewees and companies were detailed separately from the transcripts and tapes to ensure confidentiality. The hospitals were coded as Hospital One, Hospital Two, Hospital Three, and Hospital Four.

In addition to the tape recording, the researcher made notes during the interviews to prompt further probing questions and to provide some record of the interview in case of a faulty tape recording – however, interviews were properly recorded.

3.7.3 Interview planner.

An interview planner was created to assist the researcher and ensure that the interview progressed as intended. While not detailing specific questions, it provided an interview structure and ensured a number of issues (such as confidentiality and consent) were addressed at the beginning. The planner contained instructions for the interview, key questions, probe areas to follow the key questions, and space for recording comments and reflective notes. Also, the interview planner provided room for the researcher to add summary comments after the interview. Appendix 2 contains the interview planner used. The following section investigates the ethical considerations of this study.

3.8 Ethics

3.8.1 Ethical considerations.

Ethical practice in research is vital. The researcher has an obligation to respect the rights, needs, values and desires of the participants (Creswell 1994). There were several key ethical issues to be addressed in this study: informed consent; privacy and confidentiality; protection from harm; the consequences of participation; and honesty and trust.

3.8.2 Informed consent.

Informed consent concerned the voluntary participation of the respondents, based on them receiving full and accurate information about the study before their involvement. The nature and consequences of the current study was explained to the interviewees and they were free to withdraw at any time.

For this current study, an *Informed Consent Form* was provided to each participant before the commencement of the interview and explained in detail; it was signed by both the researcher and the participant. The form detailed the procedures to be followed, the responsibilities of both parties, freedom of consent issues, the ability to withdraw at any time and the possibility of further questions and questioning being required.

A copy of the *Informed Consent Form* is provided in Appendix 3.

3.8.3 Privacy and confidentiality.

The researcher's code of ethics provided safeguards to protect the identities of those interviewed as well as their hospitals and locations. In this current study, only the researcher knew the identity of the participants. Both in discussions and the written documentation, the organisations have been referred to as Hospitals One, Two, Three and Four. Codes were recorded in a separate document and kept apart from the audio tapes and transcripts.

Interviews were only tape-recorded after obtaining approval from the interviewees. The interviewees were advised the tape would remain in the possession of the researcher for a period of five years and secured from other research programs.

3.8.4 Protection from harm and the consequences of participation.

This current study involved the informants taking part in an interview lasting approximately one hour at a time convenient to the interviewee. Informants were free to withdraw at any time before and during the interview and this was explained to them verbally and in writing in the *Informed Consent Form*. It was the researcher's aim to protect the informants from harm as far as possible.

3.8.5 Honesty and trust.

Trust was established with the interviewees from the initial telephone contact, when the researcher provided full information and made commitments that were carried out as stated. This honesty created a feeling of mutual trust between the researcher and the participating hospitals. A trusting rapport with each participant was further developed at the interviews when details of the process were explained.

3.8.6 Summary.

Throughout this current project, the researcher was the only individual involved in the questioning and all ethical considerations were maintained. The informants were provided with appropriate information before their participation and their privacy protected.

3.9 Conclusion

According to Miles and Huberman (1984), qualitative research provided a well-grounded, rich description and explanation; it preserved time flows, chronologies and causality, and its findings could generate new theory. In this current study, the existing transformational leadership models provided the guidelines for framing the interview questions. The interviews provided an opportunity for managers and staff to express their viewpoint and feelings about organisational change at their workplaces. They also allowed the researcher to appreciate the complexities of organisational change, especially how it affected individuals and teams. Qualitative research using case studies was the most appropriate method to use for this current study on leadership and organisational change.

In Chapter 4, the research into the four hospitals is presented with specific analyses of the changes that occurred. It provides a general understanding of the impact of the changes on the leaders, managers and staff and the role of the transformational leader in the organisational change is identified.

CHAPTER 4

Debacles, Dilemmas and Successes

4.0 Introduction

This chapter discusses an embedded case study of four hospitals and details the organisational changes undertaken in the Hospitals by the leaders and executives. The hospitals, One and Two were privately owned and Three and Four publicly owned, were chosen because of their diverse locations, cultures and financial situations. These three factors produced a unique study of each hospital and the subsequent results of the changes undertaken. This chapter discusses the changes in Hospitals One and Two separately while changes in Hospitals Three and Four are discussed as a combined unit as the changes were undertaken as a discrete district.

4.1 Nature of interview

In this current study, the terms *manager*, *senior manager* and *executive* refer to those members of staff interviewed who were the instigators of the organisational changes. The term *staff member* refers to those employees not in management roles but who contributed views about managerial and executive performance, and their perspective of the organisational changes.

The author used the Strauss and Corbin (1990, 1998) grounded theory method with convergent interviews. The data was analysed using interview transcripts of hospital staff, secondary and archival data, and general observations from visits to the hospitals. Strauss and Corbin (1990, 1998) suggest researchers need sensitivity and insight into the data, seeing beneath the obvious to discover the new and to give new meaning to events during organisational change. Understanding grounded theory methods allows a detailed analysis of the challenges faced by the senior management and executives in implementing change.

4.2 Analysis of interview data

According to Strauss and Corbin (1998), microanalysis is an important step in theory development in conjunction with careful line-by-line scrutiny of the data to uncover new concepts, relationships and dimensions. Interviews were hand coded and the categories identified as described more fully in Chapter 3.

A skilled research assistant transcribed the interview tapes and manual coding of the transcripts was undertaken by the researcher in conjunction with the extant literature on transformational leadership. Coding was completed by reading the text and referring to the four components of Communication, Team Building, Stress and Coping and Inter-group Conflict that formed the basis of the research questions. Each component was considered in conjunction with the interview responses to develop a relationship between the principles and responses.

Two main questions were asked in the convergent interviews, and were consistent for each interviewee:

- Can you tell me about the organisational change your hospital has been through in the last 12–18 months?
- I am looking at how your hospital handled communication, inter-group conflict, team building, stress and coping during your recent organisational change. Could you tell me how the hospital has undertaken those four topics?

The interviewees were asked the following four specific questions to focus their responses on the change initiatives in the Hospitals:

- How has this change been communicated to you?
- Can you tell me about inter-group conflict during the organisational change?
- Can you tell me about your team and team building in the organisation during the change?
- How did your organisation handle stress, and how did you cope with that stress?

Throughout the interviews, unstructured questions were utilised to continue the dialogue and to give respondents an opportunity to fully describe the changes in their hospitals. The following section details the unstructured components of the interviews.

4.2.1 Unstructured components of the interview.

A sample of the unstructured questions used to elicit additional information from the respondents included:

- Can you provide an example of the types of communication used in the hospital?
- What sort of communication methods would you like to see in the hospital?
- How have you personally dealt with stress?
- What processes have you instigated to overcome inter-group conflict?
- How have you developed teams in your department?

The following section deals specifically with the organisational changes in the four hospitals and briefly highlights the consequences of organisational change and its impact on staff.

4.3 Hospital One – Introduction

Hospital One was a large private hospital in the centre of a major city and drew on a large population including outlying rural areas. It was originally owned by the Catholic Church and managed by nuns and had an outstanding reputation. After its sale to a private consortium, the focus moved from a religious and caring model to a more business-orientated one resulting in substantial improvements in technology and service delivery. In addition, there was a re-focus on financial management and the longer-term viability of the hospital.

4.3.1 Detail of changes.

Hospital One had been through numerous changes, the most significant being a fundamental structural and financial change: moving from a not-for-profit hospital to a profit-oriented operation. After the hospital was acquired by a private firm, the new executive could see that its previous status as a not-for-profit organisation had allowed it to place importance on issues other than financial ones. The hospital was being run "*along some lines of a commercial*

operation, but there were a lot of other values, missions, church functional, community functional roles that the hospital played that a commercial business wouldn't normally be involved in". The new executives embarked on an organisational change to move it from a not-for-profit basis to a business-orientated one. These changes were dramatic and painful for many of the staff.

Other changes principally involved incorporating more commercial procedures, including payroll, IT, and new clinical systems. Approximately one-third of the workforce was retrenched (i.e. around 90 full-time employees, leaving approximately 300 casual and permanent staff). According to one executive: "*… we did that for a financial imperative, but also to ensure that we're delivering good, consistent, clinical care*". One manager felt the change was well overdue and: "*… there were a lot of outdated procedures that were still in place; the hospital needed a whole restructure*".

Another manager stated that: "*… our purpose was to implement our change in strategy quickly, so that staff would not be traumatised and the process wouldn't be dragged out. We had a very definite plan – we all knew exactly what we had to do*". The new management team was small, reducing much of the bureaucracy "*… which was fantastic …*" and, according to one manager, *"we were able to have direct contact with each other"*. As well, the management was a "*type of team*" when they came together to the hospital – they knew the changes necessary, and weren't given a definite description of how to achieve it. It appears the executives told the managers: "*… this is what we need to do, and then we would go away and draw up and formulate our own operational plan*".

According to one executive the reason the restructure needed to be completed quickly was because of the radical nature of the restructuring:

> *"… that was not the norm in other Queensland private hospitals. The hospital wanted to eliminate the middle-management structure and to place more clinical nurses on the floors. That meant that the current positions with the old structure in the hospital were to be made redundant.*"

The major role of one manager was to take control of the workforce administration: analysing rosters, surgical activity and clinical areas to improve efficiency. The executives quickly established that both the Clinical Pre-Admissions Centre and the Clerical Admissions Centre needed reorganisation.

The Human Resource and Industrial Relations departments investigated hospital staffing, which resulted in a flattening of the management structure. Previously the structure was "… *typical of almost any public hospital: where there was a CEO, and directors of nursing, assistant directors of nursing, and level-three's all over the place taking responsibility for different components of work. Then there was level-two staff, who had split functions between clinical functions and administrative functions*". The new executives removed the majority of the staff levels, and today there is a CEO, a Director of Clinical Services and a Director of Finance. Under this structure, three business managers took full administrative responsibility for their business units, and eliminated the split clinical/administrative functions. The reason driving this was that "… *when manager functions are split, the hospital tends to lose good clinical hours in patient care and they get absorbed in people chasing bits of paper*".

As stated by the managing director/CEO of the hospital regarding the flattening of structures:

> "… the board of directors includes myself (and I fill the role of clinical services director) and the other director fulfils the role of commercial services director. So the board is the executive minus two people who also sit on the board but are silent in the business. There were originally 15 middle management positions that have been replaced with three managers. The three business managers were recruited and only one of the original 15 managers [was] left in the organisation."

According to one executive: "… *we changed just about every department head when we came in here. That wasn't the intention when we first started, but it became pretty evident that we had to do the changes quickly*". It quickly became obvious in both the clinical and non-clinical areas that some department heads were not performing. These observations were

made from *"… walking around the hospital and in the feedback we were getting from staff as we talked to people. Some names just kept on popping up"*.

Within four months, the new management team had "*… reduced the workforce in the order of 33%*". According to one manager: "*… all middle management, except for one other person, were moved on or offered redundancy over a period of time*". There were many "*… dramas played out during that time*" and many employees stated they did not know what was happening.

The following example illustrates the confusion felt by staff during the initial stages of the acquisition. The executives were not allowed open contact with the staff until the actual day of the takeover. Special rooms were provided for the executives and staff were conscious of new people in the hospital, but had no idea why they were there. One manager only found out about the sale of the hospital through the newspaper and a subsequent flyer in her pay slip announcing the takeover. Many of the staff found it "*… a bit daunting seeing people in suits walking around with their clipboards and not being introduced to them or even being acknowledged in the wards when they were walking around.*" The managers and staff understood certain information was privileged, but they felt that "*… it would have been nice to hear about the sale and subsequent changes beforehand and to have a general overview of what's happening and why*".

The organisational change was undertaken by experienced managers in a reactive manner rather than proactive and planned fashion. The reactive management style led to a lack of formal processes to address stress with appropriate coping methods and effective communication, and a clear lack of understanding for the potential for inter-group conflict.

The next section provides an overview of the changes that occurred in Hospital Two.

4.4 Hospital Two – Introduction

Hospital Two is a medium-sized private hospital in a rural town that competes with several other larger public and private hospitals in the same patient catchment. It attracts loyal patients from the surrounding countryside when extended hospital stays are required. Local business men managed the hospital until 2004 when new owners purchased the hospital management rights. The majority of managers are from the original staff, though the Hospital One administrators placed several new key managers into it. Although the new owners of Hospital One had acquired the management rights of Hospital Two, the changes in Hospital Two were different to Hospital One as the requirements of a country hospital differed to a city one. The financial, technological and staff training issues were similar to those in Hospital One, however consideration for loyal staff, cultural values and community issues were radically different.

4.4.1 Detail of changes.

In the 18 months prior to the takeover by Hospital One management, Hospital Two management had undertaken considerable organisational change themselves. The financial performance of Hospital Two had deteriorated to such an extent that the Board Chairman, the Finance Committee, and the Board of Governors developed a plan of action to address the serious problems. After a series of meetings, the governors agreed that Hospital One administrators possessed the scientific knowledge, management experience and the general know-how to implement change in Hospital Two. The first official announcement of a restructuring occurred on January 28, 2004, when the Board of Governors of Hospital Two unanimously voted to enter into a five-year agreement allowing Hospital One to provide operational management services. The Board of Governors believed this agreement was the correct decision to ensure the hospital remained as a stand-alone, not-for-profit, private hospital. The hospital's administration needed restructuring to return it to a financially sound position.

On the morning of January 29 2004, the Board of Governors and management met with staff to inform them of the changes. The CEO stated that a range of new issues arose, "… *the least*

of which staff were obviously very, very, anxious about their jobs, job security, career opportunities and the direction the hospital was taking". Many staff members felt threatened by anyone from Hospital One walking into their hospital suggesting change; effectively, Big Brother was telling them what to do and many "… *were all in shock mode*". Another manager said that, at the first meeting, the introductions were poor and staff were blatantly told, "*These blokes from Hospital One are taking over*". At first, staff were told they were "involved in a partnership" – however, they were later informed it was *not* a partnership, but a takeover. There was considerable staff resentment to the executive from Hospital One, as the new administration came with the attitude: "… *stand aside, we're from Hospital One, so we know how to do everything much better!*".

Six to eight months after the Hospital Two restructure was completed, research revealed its financial position had improved considerably. However, staff were still stressed and concerned about their job security and future opportunities. According to one manager: "… *in this type of situation, it's effectively every man for himself. Those who want to get on with life – put their head down and work hard, and work through the restructuring – will retain their jobs; and those that want to challenge, object, make a nuisance of themselves, affect the other ones, may find themselves effectively without employment*". The manager thought there were a significant number of loyal staff who had been through restructures before and remained strong supporters of Hospital Two management.

There was a considerable change to employment patterns, with approximately 400 pre-restructure permanent staff – both permanent full-time and part-time – now employed as casual staff. Prior to the new management taking over, during low-activity periods in the hospital, a high proportion of staff were effectively not working. Following the restructure, the hospital managed low-activity periods by reducing casual staff with decreases across all departments. Some losses occurred through redundancies (e.g. where there were five in a group, two were made redundant and three reduced to lower levels of responsibility), while other staff were redeployed resulting in significant changes in the wards. Initially, the redeployments created problems, as experienced leaders were transferred and new leaders were found and learnt new skills.

The following section details the changes in public Hospitals Three and Four, and are reported jointly as both institutions are managed by the same administrators and directors.

4.5 Hospitals Three and Four – Introduction

Hospital Three is the only medium-sized public hospital in its region and was originally the base hospital for the surrounding district. Today, the hospital has been reduced in size physically, operationally and financially. The majority of its services have been transferred to Hospital Four and has only remained open because of community protest and political intervention and expediency.

Hospital Four is a new, purpose-built, medium-sized public hospital in a neighbouring region located some 30 minutes drive from Hospital Three. It was originally built to replace Hospital Three, and the older original Hospital Four. It was to accommodate a larger, fast-growth area and took over many of Hospital Three's services and staff, which angered the staff and community of Hospital Three. Hospital Four was fully equipped with state-of-the-art equipment and was the flagship hospital in the region. When opened, many staff from Hospital Three were transferred to it, a move that caused considerable internal conflict between the two hospitals. It was anticipated that, in the future, Hospital Three would close with Hospital Four becoming the main hospital for the region.

The following section provides a detailed analysis of the changes that occurred in Hospital Three and Four.

4.5.1 Details of the changes.

Hospitals Three and Four are public hospitals run by the Queensland Government. The two hospitals need to be analysed as one unit since the same staff and management control both hospitals. The hospitals belong to the one Health Service District, with approximately 500 staff in each hospital. Hospital Three has had large upheavals because of changes in policy, nurse training methods and government legislation. For many years, it was the base hospital

for the whole district, with over 300 beds servicing outlying rural areas and the local city. The hospital was also a major teaching hospital with up to 300 students at various times.

The new Hospital Four was opened in May 1997, as a sub-acute facility within the district and the sister campus to Hospital Three. Initially it operated as an emergency department with around 40 medical beds. Within 12 months, it had established an intensive care/coronary unit, day surgery, elective and emergency surgery, maternity services, a level 2B nursery and a paediatrics department. Because of these additions, the hospital underwent a major redevelopment increasing its capacity to 120 beds and the closure of the original Hospital Four. With the increase in services came a change in staffing. Initially there was a new-facility culture with the original Hospital Four workforce principally staffing the new Hospital Four. This resulted in a period of transition where there "… *were certainly divergent cultures and traditions that had to be melded into a new identity of a new organisation*".

The original Hospital Four, which was closed, was a small facility and staff moved to the new Hospital Four with only minor difficulties. The blending of cultures was achieved by creating a vision with all the various staff members involved in the development of new departments. Initially, operational services, nursing and some medical staff were involved in the development, and that "… *galvanised staff into what we were able to achieve*". According to new Hospital Four management, the approach at the start was: "*We want the staff to bring in all the positive things that they have gained from previous experience in other organisations to improve the hospital and to strive for best practice*". The direction was based on the mission and vision developed by management and staff for the original and new hospitals. At corporate induction programs held each month, the managers told the new staff of management expectations and challenged them to use their knowledge and experience to develop Hospital Four.

In 2002, the State Government decided that the two hospitals would be complimentary, and united to become the District Health Services. Since then, Hospital Three has had a dramatic decrease in its bed numbers, with around 90 beds operating by 2006, and mainly undertaking

elective surgery. The majority of other medical work (such as emergency services, acute services, after-hours emergencies, birthing) moved to Hospital Four.

The unified district concept was a dramatic change for staff and generated a high degree of stress at Hospital Three. The staff felt they were significantly downgraded. These feelings created an "… *enormous amount of antagonism towards Hospital Four, which was not personally directed at the staff, but unfortunately did carry over*". Management failed to foster good staff relations between the hospitals or encourage them to work as a district team. According to management and staff: "*It has taken a long time to work through all of these issues of loss and grief*".

By 2005, a decision had been made to retain Hospital Three and the staff understood the necessity of working together in a complimentary fashion. A major restructure was required and the whole range of services needed to become complimentary. By this time, Hospital Four was a 24-hour acute surgical service and birthing site, with intensive care and after-hours services, while Hospital Three became the primary hospital in the district for elective surgery. Both hospitals cater for the local towns, and around 90% of the admissions are from the surrounding communities. A similar percentage of patients are maintained at their original admissions hospital, with about 10% transferred between hospitals depending on the level of care required.

There was considerable resistance among Hospital Three staff to moving between the two hospitals. This emanated from the pride they had in their work experience and the traditional culture of their respective hospitals. For some it was grieving, as they perceived a loss of service to the local community. The staff in the new Hospital Four also faced similar feelings of loss. In Hospital Three management felt staff gradually came to accept that the changes were necessary because of the growth in the community and the increased demand for services.

At the time of the changes, there was a major push for efficiency in both Hospital Three and Four. Before the transformation, the district was running over budget by approximately $6

million a year, but both are now on budget. There have been some major efficiency gains for the community and the hospitals' activity has increased by around 10% each year. According to the manager: "… *not only has the hospital become more cost efficient in terms of our budget management, but in terms of our service from being what was considered by a benchmarking, the worst district in the state to now performing well above the peer average"*. As a result, efficiency and cost effectiveness of services have shown "*some good outcomes*" according to the manager.

The leaders and managers in Hospitals Three and Four demonstrated the necessity of communication when undertaking organisational change. According to one manager**,** the key factors in organisational change are "… *communication, communication, communication"*. A clear direction needed to be set – and, in this case, it was the district strategic plan developed through a process of meetings and consultations and because of this, management found it was "… *a little easier to do another step on the ladder each time*". Leadership in Hospitals Three and Four was essential to help staff and management focus on what was essential for the organisation. Management provided a supportive environment that featured openness, consultation and collaboration.

4.6 Summary

This brief overview of the organisational changes in the four hospitals revealed that staff and managers were fatigued from the changes and new processes. Staff lacked trust in management as many staff were not given access to adequate communication tools in two hospitals and staff were moved out of their comfort zones and were obliged to improve their skills and learn new technology.

The leaders and managers in all four hospitals strove to fulfill the expectations of government and their private business owners, and as a result mangers and staff were overworked and found it hard to maintain motivation and enthusiasm for change. Managers started to implement new ideas and philosophies into these hospitals, but had to discontinue some programs because of the lack of time to successfully introduce them.

Overall, the hospitals initiated strong and productive changes to their operations and each one provided in particular new concepts for their own growth. However, managers needed to understand that staff were stressed and confused by continual change and found the lack of support after the changes were implemented to be confronting. The weariness, stress, and loss of enthusiasm among staff and managers, caused by organisational change, clearly demonstrated the need for these issues to be considered in transformational leadership models.

The next chapter analyses statements from managers, executives and staff and links these findings to the literature described in Chapter 2.

CHAPTER 5

Results and Discussion

5.0 Application of *four components* to transformational leadership models

This chapter discusses the interview findings in detail, and reports the changes experienced in the four hospitals. The initial findings are presented as a summary and specific changes highlighted by literature reviews and statements from the interviewees.

5.1 Communication

Whilst analysing communication a summary of the changes in the hospitals and their impact on staff has been presented. Following the summary, a detailed analysis of communication and an integration of the communication literature and interview statements are made and the communication tools and techniques used by managers and staff are explained in the summary.

General communication techniques common to all four hospitals.

- An intranet was available to all staff in Hospitals Three and Four, but limited staff access in Hospitals One and Two.
- Communication books were utilised.
- Managers had an open-door policy.
- Rumours were circulated extensively by staff.
- Communication was a major issue since staff required a range of communication styles.
- Trust was an important issue with communication.
- Psychologists or mentors were employed to assist communication between staff and managers.

Hospital One: large private city hospital.

- Staff forums were held and all staff attended to be advised of the changes.

- Floor-by-floor and unit-by-unit meetings were held.
- Monthly meetings were minuted and made available to staff.
- Managers met monthly and then met with their own staff to pass on information.
- Very little consultation was undertaken with staff regarding the change.
- The committee structure was removed with limited consultation with committee members.
- Staff required considerable education on health services.
- Executives used a filtered-down process where staff were informed of decisions via pay slips, memos and email.
- Managers believed there was excellent written communication.
- Executives believed they were direct and open with their communication.
- Staff circulated rumours extensively.
- Staff contacted external sources to obtain information about their hospital.
- Communication was poor and ineffective at the commencement of the change.
- Managers felt left out of the information loop, with only one meeting a month with the executive.
- Managers were very secretive in the hospital.
- Meetings ceased with staff after a short period.
- An intranet and a communication book were established.
- Newsletters were published for several months, but did not continue.

Hospital Two: small private hospital in a rural area.

- Staff required considerable education on the health system.
- Executives used a filtered-down process and informed staff about the changes via pay slips, memos and emails.
- Executives believed they were direct and open with their communication.
- Staff expected better communication from the executives.
- Executives walked around the wards, however staff found this ineffective.
- Managers were well known to staff, so it was not necessary for them to visit the wards as often.

- Staff relied heavily on rumours and external sources to find out what was happening at their hospital.
- Communication was ineffective and poor at the commencement of the change.
- Managers and staff had limited meeting time and required more contact with the executive.
- Staff felt they were not given accurate information regarding the changes.
- Managers were very secretive.
- The majority of meetings with staff ceased.
- An intranet and a communication book were established, however, the communication book was removed from some departments because of unconstructive entries.
- Newsletters were published for several months, but did not continue.

Hospital Three: large public hospital in a rural area.

- The management used considerable two-way communication with staff.
- The management involved staff in decision-making.
- The changes were discussed with focus groups from Hospitals Three and Four.
- Staff were actively involved in the changes.
- Specific departments met to discuss the changes and develop the best plan for the hospital and the community.
- Rumours were only used to a limited extent.
- Management realised they needed to communicate face-to-face with staff for the changes to be effective.
- Managers were open and communicative about the changes.
- An intranet and a communication book were established and both were used effectively and informatively.
- Newsletters were published.
- Staff were involved in planning, developing and implementing a district model of care.

Hospital Four: small public hospital in the country.

- Staff discussed the changes in Hospitals Three and Four with management through focus groups and participated in the process.
- Staff were actively involved in the changes.
- Specific departments met to discuss the changes and developed plans for the hospital and the community.
- Managers used effective, two-way communication.
- Rumours were only used to limited extent.
- Managers realised they needed to effectively communicate with staff face-to-face.
- Managers were open with information about the change process.
- An intranet was available to staff and a communication book was introduced.
- Newsletters were established.
- Staff were involved in the development of a district model of care.

This summary demonstrates the varying ways that leaders and managers communicated during the organisational change, and it highlights both the effective and non-effective communication techniques used by the leaders in the four hospitals.

The following section provides a detailed analysis of communication and its effects on staff and supports the inclusion of communication in the new proposed component to the transformational leadership models.

5.1.1 Communication literature and interviewee reports.

Introducing change within an organisation usually precipitates resistance from those who have the most to lose from that change (Proctor & Dukakis 2003). One key element to the successful introduction of change was seen to lie in effective communications (Lawrence & Greiner 1970). The customary cascading down of information from the top of the organisation to the rank-and-file managers was often found to be ineffective (Coch & French 1948). Communication used by executives from the top directly to all employees was through new technologies: an intranet and extensive use of email (Proctor & Dukakis 2003).

Resistance to change emanated from many sources (Proctor & Dukakis 2003), particularly fear of the unknown, lack of information, threats to status, fear of failure and lack of perceived benefits (Lawrence & Greiner 1970). According to Thomson (1990, 1993), people liked to feel they were in control of what was happening to them, and the more that change was imposed from the outside by others, the more they felt threatened and resisted change (Thomson 1993). This research shows that staff and managers displayed the points raised above.

In Hospital One, the executives used a number of communication methods during the changes. To overcome the fear of change, executives used a "*filtered down process*" of communication, and there were a number of staff forums that all could attend. The executives stated: "… *we said to staff quite openly that in all likelihood there were going to be redundancies, that we made a commitment to addressing the organisational restructuring from a people perspective. We gave them a time line from day one, and we gave them a date by which we would be completed*".

The executives in Hospital One were excited when the changes were completed and "… *on the date we had given them* [the staff], *we stood up in front of them in an open forum and told them we were finished*". The changes took approximately four months and an additional two months to see a "… *significant improvement in morale and trust, or the beginning of trust*". The executives stated: "*We have general forums, general staff meetings, specific floor-by-floor, unit-by-unit meetings to pass on the information to the staff*". Also, managers had monthly ward meetings and provided minutes to staff.

The executive met with the business managers as part of a weekly executive-team meeting. All decisions were made in these forums, including the signing off of large components of repairs, maintenance, capital expenditure, recruitment and marketing. According to one executive in Hospital One: "*We have weekly meetings with the three business managers and the senior managers and they review the week that's been and the week that is coming up and identify critical issues occurring in the future*". The business managers had a direct input into the management of the businesses but not the clinical roles of the doctors. As well as the

managers having autonomy, the executive provided an open-door policy for the managers to approach them about any issue.

The key, according to Coch and French (1948), to effect change was to involve people early in the process; to consult with them and have them take ownership of the new ideas introduced (Proctor & Doukakis 2003). To sustain a program of change, it was essential to understand the culture of the organisation (Kotter 1997), as new ideas that ran counter to the organisation's traditional values were the ones most difficult to introduce. Kotter (1997) believed that before organisations thought about implementing change, they needed to create a readiness for it. The managers needed to think of the organisation as an internal market for change initiatives, where ideas had to be marketed (Coch & French 1948). This meant that opinions and attitudes had to be assessed and potential sources of resistance identified. A commitment to change can be instigated by helping people develop a shared diagnosis of an organisation's problems and deciding what can and must be improved (Proctor & Doukakis 2003).

However, these philosophies were not followed in Hospital One, where the major change with the new executive was: "… *there was not going to be a lot of consultation*". The executive stated: "… *they knew what had to be done, how to do it and, unfortunately, the staff were going to be passive participants in the process*. [The executive] *made it clear to people that this wasn't a democracy; that it was a consultative dictatorship. We would take their views, but at the end of the day, we would make a decision and we would wear the consequences*".

The management of Hospital One dramatically changed the communication style of the previous management where the communication was "… *excessively over-consultative and, as a consequence, there was a rather elaborate committee structure*". There were many meetings, and a lot of people who "… *didn't do much but go to meetings*". There was an expectation within the hospital that everybody be consulted and have their say. According to one manager, the new executives are "… *very business like; they're doers, whereas the previous management promised things to staff that would never happen. With the new executive, they do a lot more rather than say they'll do a lot more*". The managers supported

any issues they took to the executives, whereas the previous owners "… *always [tended] to leave you sitting there wondering – and the new executive don't do that, which is good*".

Effective communication was a key factor to consider when implementing, planning and evaluating change (Croft & Cochrane 2005). Without this, a high percentage of change strategies stood a good chance of failing. According to Hogg (1996), it was crucial to recognise that altering behaviour was a long-term objective, not something to be forced upon employees overnight. Staff would only embrace change strategies if they were given a context for the change and if they understood its need. It was critical to establish two-way communication, encourage the audience to interact, and keep up a constant dialogue (Rust, Zahorik & Keiningham 1996). These aspects were not undertaken in Hospitals One and Two, but were utilised effectively in Hospitals Three and Four.

In Hospital One, managers continually educated the staff about the changes while implementing them. The manager said: "… *it was a really amazing phenomenon to walk into an institution that had been not-for-profit, and dealing with nurses that had worked in that environment for so long*". What surprised the managers was the limited knowledge staff had about health care and hospital management. Staff thought that all hospitals should be run similarly to obtain the same results that were good quality outcomes to minimise the risks for the patients, the hospital and the staff.

As one manager from Hospital One stated: "*As we were going along and implementing major processes, you were also teaching staff along the way in what it's all about and why we're doing it – because their perceptions of what we were doing was just totally wrong at times. We all knew that it would probably just take time for them to understand, because it was also about convincing them and getting their confidence and trust with what we were doing*". The managers openly admitted that staff were terrified about the changes occurring in the hospital.

Communication was the spearhead for ensuring that successful change took place (Proctor & Doukaks 2003). It helped to overcome ambiguity and uncertainty; it provided information and power to those who were the subject of change. It gave them control over their destiny,

and enabled them to understand why change was necessary, thus providing a suppressant to fear (Kotter 1997). People express their doubts about the effectiveness of proposed changes and understand the necessity for new ideas through open communication channels. As stated by Proctor and Doukaks (2003), relying on the implementation of ideas only from the top led to difficulties. Grassroots change was the only way to ensure that processes became firmly embedded.

Grassroots change occurred in Hospitals Three and Four because the manager met with all staff in both hospitals through various focus-group meetings. The determination of the plan for change was undertaken by equal numbers of staff from both hospitals, based on their particular specialty areas. Hence, they all felt part of the changes and took ownership of them, thereby supporting Proctor and Doukaks' (2003) theory.

According to LeTourneau (2004), there was a four-E's model of communication – engage, empathise, educate and enlist – to produce an effective organisational change program. This occurred in Hospitals Three and Four, but not in Hospitals One and Two. The goal of the *engage* stage was to introduce and generate interest in the change. Staff also provided the organisation with information about how the changes affected their departments. LeTourneau (2004) suggested that answering questions and discussing how concerns might be addressed initiated the *education* process. The process of explaining, listening, answering questions and listing and addressing concerns began *enlisting* staff into the change process.

Management and staff undertook these four steps in Hospitals Three and Four. The managers chaired user and planning groups, so the staff developed a number of outcomes for themselves. There was considerable consultation towards the end of the change: externally with the community, with local mayors, with local government and members of parliament. This allowed staff to see that losses and gains had political sensitivity, as well as difficulties for themselves.

As the research has shown and as Croft and Cochrane (2005) found, the change audience cannot be viewed as a homogenous mass – individuals at different levels and differing roles

within the organisation reacted to change in various ways. It was crucial to subdivide the audience and communicate with each segment appropriately. This can extend to the use of communication channels, which must be chosen carefully to deliver the appropriate message in the right way to the right people (Croft & Cochrane 2005).

One manager believed that within specific departments, such as the birthing facilities in Hospitals Three and Four, the changes were communicated very well. A review team evaluated the maternity services across the district and developed different scenarios for the hospitals. This team went through the management advisory group and decisions were made after considerable consultation. Maternity staff met regularly with the management teams, were well informed, and their views at every level were considered and represented. Two-way communication was exceptionally good at Hospitals Three and Four.

According to Croft and Cochrane (2005), it was crucial to establish two-way communication, encouraging the audience to interact and keep up a constant dialogue. The emphasis should be on face-to-face channels and ensuring that feedback loops were incorporated into every channel (LeTourneau 2004). Two-way communication did not occur in Hospitals One and Two – instead, communication was one way: from the top down.

A manager in Hospital One stated that there was considerable written communication "… *we had very good written communication*". There were policies and outlines communicated to staff regarding future changes. Besides the written communication, the manager also believed they had an excellent committee structure – the Medical Advisory Committee (MAC) – despite previous assertions that few committees still operated in Hospital One. The MAC was the main vehicle of communication for the staff and meant there was a "*clear and clean communication system*" for the nursing staff. The managers and executive felt the communication system was effective because the committee consisted of only a handful of people – so when "*we went to the staff, they got the direct, clear, accurate communication at ward meetings and daily briefs*".

Research (Croft & Cochrane 2005) showed that most employees heard about change directly from their line managers, and it was vital to dedicate time to team meetings where everyone could ask questions and have some input. This was unsuccessful in Hospitals One or Two, despite management walking around the wards and having MAC guidelines in place.

It is crucial to realise that change took time (Kotter 1997). Values and behaviour were deeply embedded within an organisation and the process of re-educating cannot happen overnight (Thomson 1993). Senior management must be seen to embrace change and lead by example – as occurred in Hospitals Three and Four, but only to a limited extent in Hospitals One and Two.

The executives in Hospital One attempted to lead by example and embraced the change by undertaking hospital walk-arounds, having weekly and monthly meetings with department heads. One executive made sure "… *he pops his head in and says hello to various people at times, just to make sure they see me and I see them*". Another executive stated that he tried to get into the wards everyday to make sure he knew what was happening there and to chat with some of the staff. He said walking around the wards "… *is worthwhile to make sure that you're out there and the staff see that you're interested in what's happening in the ward and with them. To be interested in the staff is critical for the staff support and their comfort in knowing that you know what's going on and that they can talk to you*". However, many staff felt the executives did not talk about the changes and were uncommunicative during their walks and supposed "chats". Despite the staff's lack of involvement in the changes at Hospital One, managers believed that staff were "… *a bit taken back about how in touch and direct the managers and executive were*". Staff were surprised at the executive's informal style, and yet there were formal processes behind the management procedures. They were continually surprised at the executives "… *getting out on the wards, coming up and saying hello and bouncing around*'.

In Hospital One, the issue of communication was a significant problem and the procedures put into place for the staff only involved communicating issues the new management wished to change. When management first arrived at the hospital, "… *they were very bad at*

communicating. They would often make decisions and do things without explanation". Later, the executives met with staff more often and the communication processes started to improve.

Managers in Hospitals One and Two felt that communication was poor as most of the managers' information was obtained through emails, department heads' meetings and from other lower-level staff members. The managers believed communication under the previous Church administration was more effective than the new one, despite the old Church management team being "… *procrastinators, whereas the new executives are doers and get things done when they say they will do something*".

During organisational change, employees naturally experienced insecurity, uncertainty and a loss of sense of control (Blake & Mouton 1983). According to Berger and Bradac (1982), communication efforts, such as interpersonal interactions, often aimed at reducing the uncertainty in an attempt to regain predictive and explanatory control. DiFonzo and Bordia (1998) found that rumours were similarly instrumental in providing meaning to ambiguous events thus restoring a feeling of preparedness or understanding to the rumour participants. Rumours were often a symptom of the uncertainty that accompanied organisational change and persisted, or even flourished, when poor communication strategies failed to adequately assuage this uncertainty (Shibutani 1966).

These aspects occurred in Hospitals One and Two more than in Hospitals Three and Four. According to one manager in Hospital Two, there was either no communication with the staff, or it was: "*very bad; very poor*". Hence, staff were uncertain about the changes and rumours became a significant communication device used by them.

Much later, staff in Hospital Two found the communication processes began to "… *open up a little*"; however, they still felt they were walking around on "*eggshells*" and, in general, communication remained poor.

It was found by Proctor and Doukaks (2003) in their research that staff understood there was a need for change, but often believed the focus was on financial objectives at the expense of

services. The management style in Hospitals One and Two was viewed as "*macho, remote and secretive*", and it was felt that there was a "*veil of secrecy*" over everything that happened within the organisation. The process to cut staff numbers was seen as indiscriminate and poorly managed. As a result, a culture of fear existed within the organisation; people did not know if they were on the list of people to be retrenched.

To reduce the sense of fear among staff during change, April (1999) stated there were three specific attributes a transformational leader needed for excellent communication skills: i) creating space for dialogue and conversation; ii) generating organisational awareness, or communities of practice; iii) feedback, which can occur on two levels – from within a group or individually. To provide effective feedback (Argyris & Schon 1978), organisational mentors (psychologists) were important; they provided the important link between peoples' experiences and organisational life. Within the four hospitals studied here, a mentor was used and the three guidelines of April (1999) were embraced. Hence, all four leaders could be classed as having transformational qualities.

According to Allen and Griffeth (1997), communication was critical in organisations. The first function of an executive was "to develop and maintain a system of communication" (Barnard 1938, p 82). Being at the top of the organisational hierarchy, the world of executives was subjective, and this shaped reality for the rest of the organisation. Research (Daft & Lengel 1984; Daft & Weick 1984) showed that managers communicated among themselves and developed common meanings and frames of reference – then they used these meanings and references to communicate and to justify their managerial actions to others.

An example of the role of communication in Hospitals Three and Four was illustrated when staff and management were involved in the changes to the maternity department. In the final report developed by staff, it was recommended that a trial be started, or "a district model of care" be established for maternity. Incorporated into the model was a team staffed by midwives from across the district that undertook the care of pregnant women and followed them through anti-natal to post-natal care. Subsequently, those on the teams who developed the model worked at both hospitals, and saw mothers through the different stages.

Management discussed the models of care openly with staff, who were pleased with the consultation process and the outcomes for the mothers in the district. Again, staff felt they were part of the change process because of their involvement with the leader and felt great pride in their achievements.

From an organisational perspective, this research study showed high-level personnel (such as leaders and managers) needed verbal communication to solve their problems, while those at the lower end of the hierarchy performed their organisational roles with written and quantitative information (Daft & Lengel 1984, 1986). From an individual perspective, people preferred oral communication, as the information received was evaluated more precisely. The primary benefit of verbal communication was access to the accompanying *non-verbal* behaviour that many perceived as a valid source of information (Forsyth 1987). Networks of oral, written and electronic contact improve group interaction and individual interactions according to Bass (1990). Getting across the meaning of a message was crucial and may require the development of innovative approaches. Not only do the feelings as well as the ideas in the message need to be communicated effectively but messages have to be remembered. Bass (1990) believed that the messages sent by leaders that were memorable were brief oral injunctions. The memorable messages, provided information about the norms, values, expectations, rules, requirements and rationality of the organisational culture.

In line with Bass's (1990) theory, senior managers, according to Saskin and Kiser (1993), were instructed to provide a clear image of where an organisation was going and what was required to get there. They had to show the benefits employees could expect when goals were achieved, while ensuring those employees were respected and received loyalty and commitment from their organisation (Harber, Burgess & Barclay 1993)

In Hospital One, the executives did not demonstrate a transformational leadership role, as managers still believed that communication was not effective. To overcome any problems with staff and the lack of information provided, one manager provided them with "*considerable information, training and support*" without the executive's agreement. For example, when the new systems (preadmissions and nurse clinics) were introduced, the

manager organised some days with a trainer who came to the hospital to show the staff how to operate the new system. Additionally, department staff expressed their ideas and concerns regarding the new systems and contributed to the development of ideas. The manager believed in providing feedback to the staff; he listened to their grievances and suggestions to improve the hospital. Staff were included on different committees (like workplace and fire safety), which expanded the communication channels and their exposure to change. A similar involvement by managers with staff development did not occur in other departments in Hospital One.

Similarly, in Hospital Two, the managers found their roles "*becoming heavier and heavier*", because staff, rather than looking at the positive aspects of change, were "*catastrophising*" it. They found that some staff upsetting other employees and patients, resulting in some being unable to function at work. As stated previously, it was important for a mentor to be available in an organisation undergoing change. In Hospital Two, the manager/mentor was a psychologist, who spent time as a support person for staff when they were requested to meet with the executive during an "*audit period*". The staff were more comfortable if the psychologist was present and supported them through the process. Another mentoring role was the drop-in sessions, where staff discussed issues with the psychologist.

Allen and Brady (1997) stated that a good relationship between employees and top management was one where employees perceive top management communicated honestly and openly with employees. A positive communication relationship, as stated by Anderson, Rungtusanatham and Schroeder (1994), was characterised by trust, mutual respect and openness between superiors, subordinates and co-workers working in a collaborative environment.

Staff of Hospital One felt the communication process was more effective and personal under the previous Church management. Then, an in-house circular existed containing general items of interest, including staff departures and arrivals, personal news, information about the organisation, training days and quality projects for staff. This circular was free to every staff member and many felt they were considered a part of the hospital because of the newsletter

and always up to date with current events. Under the new executive, the circular was no longer published, and a new newsletter established by the executive only ran for a few months before ceasing. Since then, the only way staff were able to access information was through their managers and the "*lunch table*". As one manager stated: "*if you didn't go to lunch, you could get very isolated and not know what was happening*". This manager attended the department-head meetings, but found out more information in the lunchroom than from the meetings themselves.

Several managers in Hospital One felt isolated from the executive although one manager believed there was adequate communication with the executive. Each manager was provided with access to the executive through a list of phone numbers: "*from their direct line to their mobile numbers and email lists, which the executive answer straight away*". This direct communication allowed managers to discuss their problems with the executives. However, one manager stated that if she had not been a head of department, "… *I would probably feel very isolated, because I'm not nursing staff. I'm in a totally different building to everybody else in an old part of the hospital, and I feel very left out sometimes*". To overcome her isolation, she distributed her own newsletter to staff and doctors, reaching 90–95% of the staff through it. She felt that if she had not provided the bulletin, many would believe that she had left the hospital and would no longer utilise her department's services.

Management in Hospital One were asked how they would like to improve communication within the hospital. All said they would like a chatty monthly newsletter, email access, and more contact with the executive. The noticeboards in the hospital were not as effective as they might have been, as staff were too busy to stop and read the notices and many remained uninformed about functions, training, or events in the hospital. Similarly, the email books in each department, where the managers printed important emails for staff, went unread – and again, because staff were too busy to look at them, they missed many important news items.

During periods of organisational stress, employees desired more information at a time when managers cannot give it (DiFonzo & Bordia 1998). Fearing they may mislead or that they had erroneous information, managers often fall silent (Richardson & Denton 1996). When

information was communicated via the grapevine, management inevitably lost control over its content (DiFonzo, Bordia & Rosnow 1994). Employees faced anxiety and uncertainty regarding issues of high relevance to them and conjured scenarios that were often worse than reality, even attributing malevolent intentions to management (Blake & Mouton 1983). Management attempts at denying rumours and innuendo were unlikely to succeed, as they lost the trust of employees (Burlew, Pederson & Bradley 1994).

Researchers (Blake & Mouton 1983; Mirvis 1985) argued that change should be made in a series of incomplete announcements, rather than have the whole change explained in one session as occurred in Hospital Two.

In Hospital Two, when the Board of Governors entered into a five-year agreement with Hospital One the decision of the board was articulated to staff in full at two general staff meetings. The staff were surprised, amazed and taken aback by the announcement. All information about the changes was given to staff at those meetings. The Board of Governors stated a number of communication initiatives would be undertaken for staff:

a) There would be an intranet site, through which staff could pose questions and have answers provided for them.
b) A number of memoranda were issued.
c) There were weekly meetings with representatives of the industrial associations and the Director of Employment Relations (who was contracted to Hospital One, but who attended the meetings).
d) The CEO had an open-door policy for the staff to air any concerns they had.

Many staff members in Hospital Two stated that the information at the general meetings about the changes did not make sense. They did not know the extent of the changes or what areas they would include, despite a full disclosure of the changes at the initial staff meetings. According to one manager: "*Staff were just quite happy to huddle together and create their own realities rather than seeking out information*". This was a typical reaction to change. Miller, Ellis, Zook and Lyles (1990) believed that a collaborative effort in planning individual and organisational change produced better ideas and secured cooperation from all sectors of

the organisation. It also resulted in reduced stress and burnout (Gopinath & Becker 2000). However, the implementation of change in Hospital Two did not occur as theorised above.

Managerial communications affected attitudes and behaviour over and above their indirect effect through perceptions of justice (Gopinath & Becker 2000). In their communications with employees, managers had the opportunity to establish and develop relationships with them. In such communications (Lind & Tyler 1988), managers may built rapport, display consideration and concern, and exercise their transformational qualities. These actions directly enhanced employee trust and commitment (Bass & Avolio 1994). In Hospital Two, and in contrast to the theory, staff were not involved in any discussions about the changes. They were told what would be happening and how long the changes would take, but no rapport, consideration or concern was shown to them. The leaders displayed no transformational qualities with regard to the changes, and this led to reduced trust and commitment from staff.

According to Sarros (2001) transformational leaders expanded the followers' portfolio of *needs and wants* and, in terms of Maslow's (1943) hierarchical needs, elevated followers' needs to a higher level. They focused on transcending followers' self-interest and elevated their subjective probability of success. Yet, transformational leaders changed an organisational culture by first understanding it, and then realigning it with a new vision and an adjustment of its values and norms (Bass 1985). This re-aligning of the vision did not occur in Hospital Two, but did in Hospitals Three and Four where leaders and staff were actively worked together and created the desired changes.

Bass (1985) asserted that transformational leadership resulted in followers performing beyond expected levels of performance because of the leader's influence (Ozarelli 2003). The underlying influence was a raised awareness of the importance of designated outcomes, and by intellectually stimulated and inspired followers to transcend their own self-interests for a higher collective purpose, mission or vision (Bass 1985).

According to the manager in Hospital Two, the big change issue was the restructure – it was undertaken quickly and management ensured the right information was given to staff at the right time. Decisions were made on the run with little reflection given to Bass's (1985) processes of transformational leadership. This was thought necessary to prevent the restructure from stalling and becoming bogged down in detail. The required outcome was to reduce staff numbers quickly to appropriate levels.

However, the management in Hospital Two stated that if they restructured again, they would do things differently, with a more formal plan and definite time frames. This would be in accordance with Rouche, Baker and Rose (1989), who stated that a leader's ability influenced the values, attitudes, beliefs and behaviour of others by working with and through them to accomplish the organisation's mission and purpose. Management felt that if they communicated more to staff during the restructure, there would be greater understanding of the restructuring even though the required change would take longer to complete.

One of the successful tools used in Hospital Two was the communication board. According to one manager: "*They put in a communication board so that if people actually had any concerns about the change process, people could put up their questions and they were answered in 24 hours*". One manager was pleased with the information provided, and believed information was provided at a consistent rate with little misinterpretation by staff.

Early during the change process, the managers in Hospital Two acknowledged that a number of staff did not have access to email – and since major pieces of information were disseminated through the intranet, not all staff were being informed about issues. The management ensured all emails were printed and posted in the staff areas, particularly in wards or units. These printed emails appeared to have enhanced the communication processes and improved morale – however, as previously shown, the communications book was removed from several departments because of disruptive comments entered by some staff.

According to Proctor and Doukakis (2003), poor communication was a key driver of negative feelings amongst organisations' employees. Employees in Hospital Two felt the senior

management team did not have a clear vision, or that communication was open or honest about the changes (DiFonzo & Bordia 1998). Staff required a more managed approach to communication – including a schedule for change that was adhered to by management – and more than lip service paid to staff consultation (Proctor & Doukakis 2003).

Underpinning the success of any change program was the concepts of trust, empowerment and effective communication (Cook 1994; Kotter 1997; Mink, Owen, & Mink 1993). Staff stated that trust, empowerment and effective communication were missed in Hospital Two. As demonstrated in the following section, one difficulty encountered with communication in Hospital Two was that the new management team did not speak to staff. Many commented that management did not acknowledge them when they passed in the corridors, or ignored them when they introduced themselves. Consequently, many staff ignored management and certainly did not go out their way to perform because of the "*supposed rudeness of the executives*" – trust in management was eroded.

As well, many of the staff and managers in Hospital Two remarked that when they met with the executive (or person involved in the change), their experiences and situations were not understood. Staff found this situation trying and stressful, so they ceased trying to talk to the executive and felt resentful and detached from the organisation. Several staff felt this might have been the environment the executives wanted to create: not wishing staff to be involved in the workings of the hospital. The executives simply required staff to turn up for work and complete the tasks set for them.

During organisational change, trust was violated when management said nothing but enacted change (Richardson & Denton 1996), and the change was reported to employees from outside sources (as occurred in Hospital One). Trust was also violated when management said one thing and did another (Smeltzer 1991). To maintain credibility, management should emphasise both the risk and opportunities inherent in the change (Smeltzer & Zener 1992).

In contrast to Hospital Two, the managers in Hospitals Three and Four met with staff regularly; they had departmental meetings every month where issues of change regarding the

district were dealt with. After departmental meetings, staff returned to their specific departments and reported to their co-workers. According to the District Manager, staff knew if there were specific issues that needed to be addressed outside of the meeting times, the manager was contactable. The District Manager also attended specific individual meetings with staff, as well as larger staff meetings, but stated that: "*It's impossible to get out and talk to everyone and that has been a real challenge and an area that I wish I could find a way of doing it better*". The manager felt that communication was the main aspect they had concentrated on during the changes. They had been open and relaxed about releasing information and provided forums for staff to discuss issues. Hence, the manager displayed transformational qualities and established trust with staff.

In Hospitals Three and Four, email was made available to all staff to communicate with most hospitals in the district, as well as a hospital-based electronic site where meeting minutes were placed and accessible to the district staff. According to the manager, there was good accessibility of information for the staff and agreed with April's (1999) theory which stated communication and conversation were often seen as tools for announcing and explaining change, and preparing people for the positive and negative effects of change. Communication also increased others' understanding and commitment to the change, and reduced confusion and resistance to change (Kanter, Stein and Jick 1992).

As shown by the research above, a number of sub-themes emerged. The themes of rumours, trust, intranet use and the availability of psychologists reoccurred as important in successful communication during organisational change. To explore these aspects more fully, the sub-themes are briefly addressed and related to the case study in the following sections.

Sub-Theme 1: Use of rumours.

Several studies associated rampant rumours with unsuccessful communication during change (DiFonzo & Bordia 1998). Smeltzer (1991), Burlew, Pederson and Bradley (1994) found that when the rumour mill was active there was negative consequences: the erosion of trust, lower employee morale, negative emotions and decreased dedication to the corporation. All of these occurred in Hospitals One and Two and to a lesser extent in Hospitals Three and Four.

Smeltzer and Zener (1992) found rumours had a large impact on culture, climate and timing, and that organisations needed to recognise the importance of grapevine information and monitor it. Grapevine information was a major cause of rumours because of a lack of information about issues important to employees (DiFonzo, Bordia & Rosnow 1994).

Within Hospitals One and Two, the use of rumours played a significant role in communication. According to one manager: "… *there were a lot of rumours going around at the beginning of the change*". Management felt that "… *no one seemed to be communicating to the staff that they were* just rumours, *and things mentioned were not going to happen*". To quash the rumours, one manager decided to obtain information regarding the changes in the hospital where he was employed from external sources, and spent considerable time asking questions to get that information. Another manager thought that there was a lot of "… *scare-mongering and a lot of uncertainty for a few months*". People were unhappy; they were not sure what was going on and it was an uncomfortable situation.

Within Hospitals Three and Four, managers learnt from experience that few forms of communication replaced face-to-face discussions. However, they could not talk to everybody and learnt that messages being relayed could be misconstrued or misrepresented, making them unreliable. Management spent considerable time repairing the damage from the delivery of incorrect messages and often found that emails were a source of destructive misinterpretation of messages.

As the current research has shown, rumours play a significant role during organisational change. Leaders and managers need to effectively control the use of rumours as a source of communication to assist successful organisational change.

The second sub-theme that emerged from the current research was trust, and this is briefly discussed in the following section.

Sub-Theme 2: Trust.

Trust emerged as an essential component during the changes examined in this current study. According to April (1999), developing trust between individuals involved encouraging everyone in a group to reveal thoughts and feelings about themselves to others through self-disclosure, and by receiving feedback from others (Davenport & Prusak 1998). In the workplace, Ford and Ford (1995) found that when people were willing to communicate information openly, including their fears and feelings, it resulted in a willingness to accept change rather than resist it. Trust went beyond basic rational cooperation and became an emotional force that was called upon in risky situations to allow individuals to progress (Giddens 1994). Cooperation increased when conditions were unpredictable, because people realised their futures depended on each other. Thus, when organisations faced turbulent change, trust building was vital (April 1999).

In Hospital Two, many staff felt that they might eventually lose their jobs, despite their support for the changes and their cooperation in the process. This feeling led to considerable animosity towards the new executive and morale was very low. Staff felt pushed aside by the new management, and these feelings seemed affirmed when executives toured the hospital without acknowledging them. Staff were upset at being ignored and felt they had been misled, by management with regard to job security and found it difficult to build trust with the new executive and managers.

As highlighted throughout the current research, trust is a major issue during organisational change.

Another theme that emerged from the current research was the availability of the intranet to staff. The following section provides a brief overview of the use of the intranet during organisational change.

Sub-Theme 3: Intranet.

According to Lai (2001), all kinds of organisations took advantage of intranets to disseminate corporate documents, forms, news, policies, phone directories, product specifications, and

pricing information. Rai and Bajwa (1997) stated that in addition to using technology to improve corporate communications and to integrate individuals and groups, business managers explored intranets to enhance their organisation's business strategies.

Intranets supported communication among widely scattered corporate departments –including individual employees – while enhancing overall corporate performance (Lai 2001). Intranets were communication tools used to unify geographically dispersed work forces (as occurred in Hospitals Three and Four) and empower employees by supporting collaboration, interaction and real-time sharing of corporate information across functional boundaries and organisational levels (Streeter, Kraunt, Lucas & Caby 1997).

Davenport and Short (1990) found the major benefits of intranets generally helped reduce communication barriers between management. An intranet's ability to provide data access and intra-organisational communication, employees distributed and communicated their ideas more readily, and it enabled them to be more involved in the decision-making process (Lai 2001).

The intranet was a major tool used by the executives and managers in Hospital Two. One manager stated that staff were completely up-to-date with the changes, because emails were printed and updates posted on the bulletin board – information was also provided in a dedicated *communications book*. All staff read the emails and notices and were consulted about all issues. The intranet was not as widely used by managers and executives as the communication books in the four hospitals.

However, the communications book was misused in Hospital Two, with the situation becoming so unbearable for several managers that the book was discontinued. Staff had decided it should be used as a *complaints book* rather than as a mechanism for passing on information. The original purpose of the book was lost as it became a venting tool for staff. Eventually, management and staff became "*fed up*" with the constant and depressing complaints recorded in the book. Once it was removed, morale increased and the complaints

decreased. Without a communications book, staff were totally reliant on management for passing on information.

In Hospitals Three and Four, with a transformational leader, the intranet and other communication tools worked successfully in an open environment. Within each ward and department there was a communication book where memos and other information were recorded and printed emails stored. Email was accessible to the majority of staff and used daily – they found it a positive and useful tool.

Besides the intranet another communication tool used within Hospitals Three and Four was a newsletter, called *Nursing Notes*. This newsletter was started six months into the changes as staff found they were not receiving information in a timely manner. Those who attended regular meetings or met separately with management were not passing on complete or accurate information to other staff. *Nursing Notes* was circulated every few months throughout the district. Like the district newsletter, it was maintained as a professional newsletter with a section acknowledging staff achievements, profiles on staff (like births, deaths and marriages), and information from professional nursing organisations. Also, the district manager had a section in *Nursing Notes* where he discussed issues about service delivery. Generally, the nurses were extremely pleased with the newsletter; the feedback was positive and staff enjoyed the publication.

Organisational change, although often presented as a tonic for ailing organisations, may be a bitter experience for employees (DiFonza & Bordia 1998). Communications and widespread employee participation were crucial to successful change (Covin & Kilmann 1990). Organisational transformations that failed were often the result of poor communication within those organisations that underwent large-scale terminations, facility relocations or mergers (Burlew, Pederson & Bradley 1994; DiFonzo & Bordia 1998). Leaders who were described as highly informative and trustworthy contributed considerably to the clarity of their staffs' role (Bass 1990). Trustworthiness and credibility of leaders tended to depend on the leader being a careful listener, on being informal and open in two-way communication and staff viewed their leaders with increased satisfaction and effectiveness.

5.1.2 Summary.

The previous section provided a detailed discussion of the issues involved in dealing with communication and the techniques used to improve communication to staff during a period of change. It can be seen from the present research that to succeed in organisational change, leaders need a carefully crafted communication objective: one where staff will embrace and accept the change through knowledge.

Overall, the public hospital system provided more information and communicated more effectively with its staff than the private hospital system. Staff in the public hospital system were included in the hospital's planning process and responded to management decisions effectively. Conversely, staff in the private system were removed from the communication process and reacted negatively to change and directions made by management; they simply worked for their own rewards without the involvement or job satisfaction displayed by staff in the public hospital system.

This current research has shown that staff who were actively involved in the communication processes within Hospitals Three and Four were happy in their working environment. With happier nurses and doctors the patients received better care and treatment. Staff had the opportunity to improve their education and training by being actively involved in the decision-making that affected their future employment. Overall, staff were pleased with the positive influence the changes made to their work environment and lifestyle.

However, within Hospitals One and Two, staff were dissatisfied with the communication from executives and management and also with the internal communication systems. As previously stated, staff talked about their troubles with patients who were unhappy being burdened with these concerns. Staff were not involved in decision-making; they received limited information and were not active participants regarding patient care or their future employment. They were disgruntled with both the level and type of communications they received from management in Hospitals One and Two.

The current research has shown that the leaders in the public hospital system demonstrated strong transformational leadership, encouraging staff by their actions, while those in the private system did not. Instead, private sector leaders exhibited bullying tactics, pulling staff through the change process rather than lead them.

The above discussion indicated the importance of the element of communication in the proposed extension to transformational leadership models and that leaders should possess transformational qualities for a successful organisational change. Good communication is essential to the development of a change program, its implementation and its ultimate success.

5.2 Team building

The second component addressed was *team building*, and this is presented as a summary of the changes within the four hospitals and the impact on staff of team building. Following the summary, a detailed analysis – integrating the team building literature and interview statements – is presented. The team-building tools and techniques used by managers and staff are explained.

The following summary highlights the team building experienced by staff in each hospital and the techniques used by hospital leaders and managers for developing teams.

General team-building concepts common to all four hospitals.

- Trust in and of management was a major factor influencing staff decisions about forming teams.
- Conflict among staff members regarding the changes in the hospital often disrupted the development of teams.
- Communication was important when developing teams.
- Both managers and staff believed that team building was important.
- The managers used email to communicate with staff when there were problems with team building.
- Conflict within the team caused difficulties for staff and managers.

Hospital One – large private hospital in a city.

- Resistance to team development by managers.
- Management required staff to create their own teams.
- Team building was absent for a considerable time and management only introducing *team nursing* to develop teams.
- Agency staff became part of hospital teams, but this increased the workload and stress for staff.
- Management did not encourage team building.
- Conflict was reduced by meeting staff to develop team nursing.
- Limited formal communication with staff about team development.
- Limited formal team training.

Hospital Two – small private hospital in a rural area.

- Resistance to team development by management.
- Management required staff to create their own teams.
- Team building was not an issue, but management introduced *team nursing* to start developing teams.
- Team building was non-existent prior to the changes.
- Team building became an important post-restructure issue.
- Meeting with staff to develop team nursing reduced conflict.
- Staff lost trust in management and found it difficult to develop teams.
- Staff tried to develop their own teams rather than have a formal structure proposed by management.
- Staff moved rosters around without the manager's knowledge to re-establish old team structures.

Hospitals Three and Four – a large and a small public hospital in a rural district.

(These hospitals need to be considered together as the changes were completed as one)

- Teamwork was developed around corporate governance.
- The district manager was instrumental in developing teams.

- Managers developed management advisory groups to work with staff.
- Different levels of staff asked onto committees involved in hospital decision-making.
- Staff went through a grieving process, which affected team development.
- Job effectiveness and interdependence promoted as team development.
- Staff were entrepreneurial in developing team building.
- Social interaction was important to developing teams.
- Staff designed and printed their own departmental T-shirts, which enhanced team building.

The following section provides a detailed analysis of the summary in relation to the literature and interviewee comments and statements.

5.2.1 Team building literature and interviewee reports.

In the past, many theorists (Gersick 1988; Govindarajan & Gupta 2001; Tuckman 1965) did extensive research into organisational teams and team processes. The models they developed presented an array of variables that influenced team productivity: personality characteristics, group size, reward structures, work norms, task characteristics, group structure, communication and conflict (McFadzean 2002).

Dionne, Yammarino and Atwater (2004) included these organisational variables in their work and investigated the larger external environment including globalisation. The globalisation of marketplaces, increased competitiveness, and information availability – through speed and the capacity of technology – has changed the way organisations function and respond. Katzenbach (1998) believed the need for increased flexibility and responsiveness and the urgent and frenzied pace of product/service development yielded tasks that prove too complex and time consuming for individual attention and completion. Organisations around the world have significantly increased their dependency on teams because they provide better directed and collaborative efforts to address complex tasks (Montoya-Weiss, Massey & Song 2001).

Beagrie (2004) states the constant pressure on companies to perform in competitive markets places a premium on teamwork, whilst many managers realise the value of teamwork, but feel

ill-equipped to undertake a team-building role. Bass (1990) believed that any member of an organisation can emerge as a leader depending on how much of the functional roles they enact and the particular patterns of behaviour they display in relation to the task of socio-emotional development and operation of the group.

With regard to this research, Preston (2005) believed that for many reasons teams made sense in the provision of medical care and processing myriad clinical and administrative activities – teams and functional groups were significant aspects of hospital and healthcare facilities. Yet there was considerable managerial resistance within healthcare organisations to the wider acceptance and reliance on team collaboration, and this was found in Hospitals One and Two.

Preston (2005) stated that when individual work was emphasised, management could lose the synergy that comes from collaboration and the shared commitment to patients and the institution. Management erected *stovepipes* that restricted the full and free flow of information and communication throughout the organisation (Manz & Sims 1993). A well-thought-out team-building effort across the organisation was fundamental to change success. Bass (1990) believed that team leadership was attained by participation, openness, trust and respect, involvement and commitment, open confrontation to resolve conflict, change and development through feedback. Suggestions towards such an effort included: i) regular and frequent scheduled team-building sessions; ii) emphasising the satisfaction and fun of team building for all involved; and iii) basing team-building efforts on trust.

Regarding the development of teams in Hospital One, one executive felt management had been honest with the staff and stated: "*Some of you aren't going to like this because you'll think that it is a threat to your autonomy as a practitioner, and you may choose to leave – and that's okay. If you're not going to be happy here, we would rather you be somewhere else than destroying something that's going to be better for the patients*". This attitude of the executives did little for the development of teams and created barriers to team building in Hospital One. The executives in Hospital One created a process called *self selecting*, where staff removed themselves from the organisation, if they were unhappy with the changes rather than trying to develop a cohesive team.

As demonstrated above, it was easy for managers to build barriers to developing teams. Barriers to team building (Preston 2005) included the following managerial attitudes and behavioural patterns, and demonstrate resistance to the development and widespread use of teams:

1) Distrust of interdependence: managers knew they needed others, but feared this would be taken as a sign of weakness.
2) Unfamiliarity with actual staff contributions: managerial ignorance was sometimes a result of over-work, or having insufficient time to oversee employees.
3) Aversion to planning: building and managing effective teams required a lot of planning – something at which many managers failed.
4) Attraction to staying busy: when leading a team, seeing and enjoying the completion of a job was not immediate – frequently, the satisfaction went to the team members instead.

According to executives in Hospital One, teamwork was not a major factor in their work or planning. Most of the team building was "… *up to the new department heads that we've appointed rather than anything else. We just left it to the departmental heads to put their teams together and get their teams happening*" – and this affected the design of the organisation. The department heads were new to the organisation and were actively recruited by the executives; they were people the executive "… *already knew that we could work with and had a similar mind-set to us*". This meant that the executives concentrated on other issues other than creating new teams, and this severely affected the development of teams within both Hospitals One and Two.

According to Katzenbach and Smith (1993), a high-performing team will also be empowered, self-aware and attentive to feelings and emotions – this did not occur in Hospitals One and Two, as the teams did not perform because of barriers placed on the staff by the executives.

According to one manager in Hospital One, the executive undertook few formally structured programs to develop teams. Contrary to this manager's view, one executive stated that "[Within one department] *the team was kept pretty much intact. It was really me stroking the*

particular manager and saying, 'You're doing fine; you're doing okay. You don't have to worry about losing your job". Once mutual confidence was established, the manager became more supportive of the changes, however, this did not result in new teams, but did keep an existing one.

A manager in Hospital One felt that teamwork had been lacking for a long time and was a project the executive was just starting to develop. Management hoped that a new *team nursing* model would overcome the team development problems. Many organisations experimented with new work designs to improve productivity and flexibility to meet the demands of a fast-paced and changing environment (Arnold, Barling & Kelloway 2001). Despite the development of team nursing in Hospital One, one manager stated that at the start of change, "*… we lost a lot of our team to elsewhere in the hospital. We had to bring in agency staff to cover the fact that we had lost those people*". This manager believed the agency staff had become part of their team and organised for them to return on a regular basis as part of the existing staff structure. The use of agency staff had caused stress in several departments, as they required orientation and education in the areas they would be nursing – which "*became very tiring and draining on staff*". To combat this stress, the manager endeavoured to use the same agency staff each time.

However, in Hospital One, management's overriding belief was that there was a limited need for team building in the hospital and managers were left to build their own teams if necessary. Subsequently, management's perception of team building was to help staff out during difficult times rather than providing constructive mechanisms for building strong, permanent, self-managed and cohesive teams.

According to Montebella and Buzzotta (1993), in today's world teamwork replaced the outmoded adversarial approach (which was used in Hospitals One and Two) to managing people. Teamwork was more productive, produced higher-quality outcomes and provided more cost-efficiency than individual efforts (McFadzean 2002).

In Hospital One, the managers of many departments were too busy to conduct formal team-building exercises and only undertook general day-to-day business. Staff were left to their own devises in developing bonding strategies, and management tended to "… *pick up the pieces later on when trouble occurs*". Despite these difficulties, management had enormous admiration for the staff, recognising the troubles they had experienced during the change. Management appreciated how many staff members handled the changes and formed cohesive work-groups without executive support. Both remaining and new staff worked together in effective units and teams developed through the hard work of individual managers who strove to resolve the difficulties inherent in the changes.

As the literature and the current study shows, teams within organisations can have a range of guises and names, like *cross-functional* teams, *quality circles*, and *self-managed* teams (Wellins, Wilson, Katz, Laughlin, Day & Price 1990). The responsibilities of teams were quite comprehensive: the distribution of duties; the planning and programming of schedules; making decisions about products and services; creating new ideas and solving problems (Kirkman & Shapiro 1997).

Within Hospital Two, team building became an important post-restructure issue according to the manager, and an issue the hospital considered seriously. After the restructure, staff felt they had been "*decimated*", however they rebuilt with a new organisational structure, which provided for team building in both a horizontal and vertical manner.

Although management in Hospital Two firmly believed that team building was important, new teams were not established. One manager confirmed that team building had been a very slow process with limited development since the changes were introduced. As an example of this, one manager stated that a number of the level-three staff in charge of the wards were redeployed elsewhere within the hospital, while the level-two staff were moved into higher positions and made responsible for running the wards and decision making. The level-one staff also had their positions elevated, with more responsibility and delegation of duties. By reassigning staff, a gap was created between the work skills and age groups of those with responsibility in the hospital. The older, more experienced staff found that they were required

to "*help out*" the younger staff, but without the authority or recognised position to do so. This *ad hoc* way in which teams were formed in Hospital Two demonstrated management's lack of team building.

The manager of Hospitals Three and Four, reported that team building was not a priority for them because teams were in place before the changes. However, management looked at teamwork for corporate governance as the mechanism for people working together. Consequently, the manager was not aware of any dysfunction needing external intervention as Beagrie (2004) established, or requiring the reinventing the groups within Hospitals Three and Four.

Theory shows that a significant concept in developing teams is the role of transformational leadership, and this provides a framework to investigate a leader's impact on team performance (Dionne, Yammarino & Atwater 2004). Avolio and Yammarino's (2002) research shows that idealised influence/inspirational motivation, intellectual stimulation, and individualised consideration produced intermediate outcomes such as shared vision, team commitment, an empowered team environment, and functional team conflict when developing teams. These outcomes may positively effect team communication, cohesion, and conflict management (Atwater & Bass 1994).

The transformational leader was particularly visible in Hospitals Three and Four, where the current District Manager provided the most help with building teams. The District Manager set up a structure of management advisory groups across the district. These were based on service streams with an executive member chairing each group, which was led by a steering committee. As well as divisional responsibilities, each staff member had responsibilities across the district. The group met once a month and looked at service issues from a balanced perspective. They assessed activity and quality issues, staffing issues and financial issues and one manager investigated "… *how the hospitals meet the staffs' professional development needs"*.

Different levels of staff were invited to join the management advisory groups in Hospitals Three and Four. Representatives from each level met to discuss issues and take suggestions from departments – then reported the outcomes back to staff. Specialist units had unique representation: for example, in maternity, midwives were invited to join the steering committee and participate in brainstorming workshops.

As the case study research has shown in Hospitals Three and Four, transformational leadership has positive effects on trust, commitment and team efficacy (Arnold, Barling & Kelloway 2001). Results (Cohen, Ledford, & Spreitzer 1996) suggested that while encouraging strong values and norms within a team led to increased commitment, focusing on transformational leadership in teams was a more effective way to encourage the development of trust, commitment and team efficacy (Barling, Weber & Kelloway 1996; Bass 1985; Hater & Bass 1988).

Within Hospital One there appeared to be little team building and limited transformational leadership. Executives believed team building occurred in the wards because staff, "… *tend to aggregate into teams now, and team-building exercises aren't a big part of the wards*". However, with the new concept of team nursing developed in the hospital, staff changed their perceptions about team building. The executives did not exhibit specific transformational leadership skills because they felt the new team nursing model "… *isn't really team building – it's that aggregation skills need to be learnt because the senior nurses will have to build teams and they'll be flexible teams, as shifts change, as patients change*". The staff have not undertaken traditional team building, but introduced a formalised structure to supply continuous care to the patients.

Hospitals and health-care organisations have struggled to rely on teams (Preston 2005) as demonstrated by the new team-nursing model in Hospital One. They face in-fighting, unnecessary intra-organisational competition, and narrow mindsets – all of which interfere with lateral and collaborative communication (Cohen, Ledford & Spreitzer 1996). When departmental boundaries were high and defended, working in cross-functional or patient-focused teams became difficult for employees (Preston 2005). Their allegiance to the team

was undercut by the need to maintain their position in their *home* department. According to Manz and Neck (1997), some employees who participated in cross-functional or patient-focused teams actually feared that their future within their home department was threatened because of their team involvement.

Management was aware there were still pockets of resistance and cynicism within Hospital One, but hoped the resistance to change would be broken down when the new team nursing commenced. Many staff had a poor perception of the concept of team nursing, so workshops were established to develop the model. The managers found that many attended the workshops with "… *preconceived ideas that team nursing was all about trying to use different categories of staff and making staff do task allocations*". These concepts caused considerable conflict within the hospital and management worked effectively to change staff attitudes.

De Dreu & Van de Vliert (1997) showed conflict within teams caused difficulties for management, and suggested that conflict was an important antecedent to team effectiveness. Conflict, as stated by Deutsch (1973), was defined as incompatible activities, and occurred when the behaviour of one person interfered or obstructed the actions of another.

Conflict was ultimately reduced in Hospital One as the workshops changed the attitudes and ideas of the staff. Staff were pleased to have greater contact with the executives at the workshops and developed a greater respect for the executives in the process. One manager supported the executives' involvement in the workshops because "… *the executives sound really positive and are so passionate about nursing and nurses and they do want to make a change. The executives want to improve the standards of nursing care and how the nurses are looked after*". The attitude of the executives had a considerable impact on the staff and reduced the conflict many of them felt; greater contact changed their opinions of the executives. Consequently, a limited attempt to be transformational leaders emerged and staff were inspired to visualise the changes. The changes promoted a climate of trust between the staff and the executives, and limited ideas about teamwork sprung up within the hospital.

As in Hospital One, Hospital Two introduced the concept of team nursing. Some of the older staff were experienced in team nursing from their training days in the public system. According to one manager, team nursing worked well in their ward and had been operational for many years, but would only work if there were sufficient numbers working under the system. This manager also felt that team nursing needed to operate in each shift with everyone included. Delegation was a major factor in team nursing and all staff had to be able to give out tasks; it was a whole-ward concept with all staff involved for the process to work. In Hospital Two, rather than have a formal structure to develop teams, the staff tried to organise them themselves and their efforts were supported and encouraged by the managers.

As this current research showed, the communication atmosphere within a team developed because of team member attitudes and behaviour (Lovelace, Shapiro & Weingart 2001). Team member feelings about expressing doubts influenced the collaboration or contentiousness of the communication they exhibited (Brett, Shapiro & Lytle 1998). When the norms for communication of doubt opened, feeling free to express them and doing so collaboratively were both likely (Innami 1994). The communication behaviour exhibited by a team further influenced member's freedom to express their concerns or doubts (Innami 1994). The use of discussion in team building was one approach to increase power sharing in the decision making process and increased the influence of the teams decisions on individual members according to Bass (1990). When the leader supported communication in teams, team members felt free to solve problems and succeeded in undertaking organisational change.

Research showed that a team leader will also influence the communication atmosphere, the way in which team members interact, and how free members feel to disagree with each other (Lovelace et al 2001). Bass (1990) found a leaders feedback about a teams performance and the leaders reward practices had a positive impact on the teams desire to achieve success. Positive intentions motivated subordinates to perform and increased how much challenge and stimulation the team members felt they received from their jobs (Bass 1990). According to Manz, Barstein, Hostager and Shapiro (1989), an effective leader's importance was that he or

she could create a positive climate and resolve issues that might otherwise result in extensive dysfunctional conflict.

Chen and Tjosvold (2002) believed that developing conflict-management capabilities appeared to be particularly critical for teams. Effective conflict resolution was needed for group members to manage their internal functioning successfully and to make decisions to which they were then committed (Tjosvold 1987).

Conflict was a disruptive factor for team building in Hospital Two, especially in two merged departments. To build teams, the manger swapped staff around and provided opportunities for them to work with others and experience different working environments. However, a number of staff feared their relocation; they did not understand the work requirements in their new departments, or know where equipment was located. Eventually, management found that by moving staff around they became more familiar and confident with their new settings. Despite staff gaining confidence in their new surroundings, management found that some "*[were] bucking the system*". The manager said that many of her staff reorganised the roster after-hours to suit themselves and returned to the old ways of working; they relocated themselves to departments and wards to work with staff they had known before the merger. She even noted that after returning from meetings of a few hours, staff had relocated themselves without her knowledge. She found this difficult to cope with and impossible to work towards united teams, but recently has detected growing acceptance of the new work environments with shared work between the merged wards. She credits this turnaround to several staff resignations and the removal of staff causing the disturbances. Hence, the conflict within several departments was reduced, despite staff relocations still occurring without management knowledge.

Although teams are increasingly relied on to develop new products and solve problems, conflict can contribute to them being ineffective and frustrated (Chen & Tjosvold 2002). Tjosvold (1987) found group members must be able to constructively manage their conflicts to make their team effective.

Conflict was a problem for management in Hospital One and continued after the changes were completed. One manager felt that there was a strong team within her department from the beginning of the change. However, she was aware that she had to "… *break my way in, or crack through the shell to allow them to let me in*". Consequently, since the staff were shell-shocked by the changes, she took a retiring strategy within the department, deciding to approach the staff gently and communicate with them constantly. She conducted both informal and formal meetings and instigated all her recommended changes, and this improved the staff acceptance of both her and the changes. The situation she found was "… *that it was building the trust first – and now they look at change differently, and they feel more acceptance of change when it occurs*". This manager believed that once she established trust with the staff and achieved some results, the staff saw the improvement and morale improved.

Leaders can create many different forms of teams. – for example, the self-managed work team (SMWT), one of the most widely used organisational structures associated with downsizing (Manz & Sims 1993; Osterman 1994). To develop successful SMWTs, Kirkman and Shapiro (1997) stated there were two dynamic components which needed to be established: i) the process of self-management; and ii) collaborative teamwork research. Because of both global competition and company downsizing, multinational firms increasingly use self-managing work teams (Kirkman & Shapiro 1997).

One major SMWT in Hospitals Three and Four developed because of community outrage at the closing of the maternity department in Hospital Three. To deal with this backlash, a specific SMWT was created in the form of an advisory group, and a mode of care was developed to meet the clients' needs of a continuum of care for the staff and expectant mothers. Also, staff were able to maintain their professional skills with the new model, and today there is a rostered midwifery team that works across the district with midwives and nurses moving between Hospitals Three and Four covering the clinics and the labour wards. They were able to work in the teams established for the birthing mothers in the actual maternity unit at Hospital Four. This highly specific SMWT has reduced tension, increased morale, and improved staff behaviour and attitudes. Again, the transformational leader emerged in Hospitals Three and Four.

Manz and Neck (1997) stated that self-managed work teams (SMWT) have largely emerged in response to challenges like declining productivity and quality, as well as increased employee dissatisfaction, absenteeism, turnover and counter-productive behaviour. In addition, Manz and Sims (1993) found work-system designs were needed that were capable of succeeding in increasingly complex, interdependent and uncertain organisational environments. SMWT's have been credited with many positive payoffs (Manz & Sims 1987), including increased quality, productivity, employee quality of work-life, and decreases in absenteeism and staff turnover (Trist, Susman & Brown 1977).

Management in Hospital Two tried to establish SMWT's in two distinct divisions within the hospital: clinical and non-clinical. With clinical services, there were three business streams: i) medical services (including medical, mental health, oncology clinical programs), with one business manager who effectively brought those teams together; ii) surgical and ICU services with a business manager; iii) the remainder (including the intensive care unit and a number of wards) with one business manager. Each business manager facilitated individual meetings and created opportunities for staff to develop a team model and its platform.

With the non-clinical programs in Hospital Two, there were designated managers in individual departments. They had their own team meetings, with departmental meetings once a month, which the managers attended. At these meetings, staff learnt about changes at the strategic level, plus the previous month's developments in other areas. Staff and management worked together to form SMWTs within smaller departments, then formed larger, more strategic response units at a higher department level.

To build teams and overcome difficulties in Hospital Two, the manager of the non-clinical departments stated that she "… *treats all staff like they are intelligent human adults*". When staff numbers were short in her department, she assisted the staff to complete their work. She claimed that getting involved in the front-office work and catching up on her own work later, built a strong, united team. She also employed a job rotation system in the department, where staff moved around so they did not become specialists in one area: "… *everybody can do*

everything; so that you just jump in where you're needed". She also found she was able to place staff throughout the hospital when required. Building general and cross-functional work teams was important in this department and reduced conflicts in Hospital Two.

Henderson-Loney (1996) found that team building during organisational change was extremely difficult. Dealing with profound organisational change was a painful and disruptive experience for everyone on the team. Both planned and unplanned change in organisations had an element of loss inherent in the process and was felt but often not acknowledged by either employees or their managers (Beagrie 2004). Left unaddressed, according to Kubler-Ross (1969) and Tuckman (1965), the emotions experienced throughout the stages of change, like those that accompanied the stages of grief, were expressed by employees in obstructionist and destructive behaviour.

According to the grief-work approach (Tuckman 1965), managers and supervisors facilitated team building while honouring team process. The psychosocial process of team formation as described by Tuckman – combined with Kubler-Ross's (1969) grief model that addressed the emotional issues associated with change – included the growth of a new team and created a powerful supervisory tool. The four stages of the shared model include: i) denial – forming; ii) resistance – storming; iii) exploration – norming; and iv) commitment – performing. The complete grieving process was experienced within all four hospitals with many staff and managers experiencing grief personally, with the managers acknowledging the grief felt by staff.

Newly formed teams confronted the challenges of moving through the stages of grief as a natural process and in a more or less orderly way (Tuckman 1965). This was determined by the level of awareness of group members and the facilitator. Well-established teams dealt with significant change, cycled through the stages of grief and were prepared to expect the emotional responses (Henderson-Loney 1996). According to Henderson-Loney (1996), managers and supervisors, who understood and facilitated the movement through these developmental phases were rewarded by quickly reaching peak team performance.

One of the largest groups to experience change in Hospitals Three and Four was the midwives, and their example demonstrates the grieving process experienced by staff. In Hospital Three, the midwives moved from a busy maternity unit and accepted additional responsibilities (e.g. in the day surgery, chemotherapy and the colposcopy unit). Hospital Three maintained the antenatal clinics and postnatal care, but the patients were required to travel to Hospital Four to birth. Expectant mothers had a member of the Hospital Three team at the Hospital Four birthing facility during the birth and during the *"episode"* of their care. This allowed mothers a continuum of care from the nursing staff and followed the model of SMWTs (Wellins, Wilson, Katz, Laughlin, Day, & Price, 1990). Staff at the Hospital Three birthing unit had been through a "… *real grieving process, and are just getting to an acceptance stage [of the change now]*".

To help overcome the grieving process in Hospitals Three and Four, staff and management worked together on an advisory committee. In addition to assisting staff in the grieving process the committee also helped staff maintain their professional skills in teams across the different hospitals. One team member stated the advisory committee: "… *unified the staff and they have actually been a role model to other staff in the district in the way they have become a team and work together*". The maternity and day-surgery wards were combined in a newly created ward, which meant there were non-midwives on shift. This caused difficulties for rostering. The maternity ward required midwives for elective caesarean sections, postnatal admissions and babies needing special care facilities. According to the manger, "… *it is a very mixed ward, and the workloads can be very heavy at times because of the mixture*". In Hospitals Three and Four the combination of SMWTs and transformational leadership of the manager assisted the development of the advisory committee with the staff and worked together to support the changes in the wards.

To date, the research and this current study have investigated the role of the team in improving the organisation's function and the impact of teams on the organisation. The remaining sections investigate the impact of teams on staff. Work team characteristics can be related to effectiveness (Campion, Papper & Medsker 1996). Enhancing motivation was expected to increase effectiveness in team jobs as it does in individual jobs (Campion & Medsker 1992).

These characteristics motivate partly because they increased the sense of responsibility and ownership over the work, and partly because they made the work more interesting to perform (Shea & Guzzo 1987). Characteristics include self-management, participation, variety, significance, and identity (Campion & Thayer 1985).

Interdependence was also a defining characteristic of teams (Guzzo & Shea 1992) and was related to effectiveness because interdependent tasks were completed more efficiently in a team (Salas, Dickinson, Converse & Tattenbaum 1992). Shea and Guzzo (1987) stated it also increased motivation by enhancing the sense of shared responsibility for, and reward value of, group accomplishment. To be effective, teams needed adequate training, managerial support, and help with communication and coordination (Guzzo & Shea 1992).

Job effectiveness and interdependence in Hospitals Three and Four was the focus of the nursing department. As stated by one manager: "*Our team building has been one of building the nursing executive, so building our middle manager level and for the level threes, then to build their teams at their unit level*". The skills of the nursing executive – the ones originally employed at Hospital Four when the hospital first opened – were exceptional in that they were a values-based management strongly focused on improving service delivery. According to management, there were no actual team-building exercises, but weekly meetings where values and professionalism were addressed. Staff conveyed those attributes, management expectations and other issues through debate and discussion in an environment that was friendly, cooperative and trusting. Hospital Four was proud of its ability and allowed staff to be open and trusting. Staff and management commented on the fact that in meetings there was "*… no attitude of: 'Well, I'll be blamed, or something will happen to me if I step out of place and say something*'".

Teams were an outgrowth (Dess & Miller 1993) of the quality-management process and go beyond the quality circles and empowerment trends that achieved popularity in the 1980s (Dionne, Yammarino, & Atwater 2004). Stout, Salas and Fowlkes (1997) believed that when used effectively and provided with proper training, teams led to increased production, morale, creativity and innovation.

Training, meetings and many forms of quality management were missing in Hospital One. One manager admitted: "*I am a bit slack lately and feel that we do need to have regular staff meetings. But they've fallen by the wayside and need to be picked up again*". The manager sent out emails, if she noticed something getting a "*bit slack*". If she heard staff speaking a certain way or incorrectly dealing with an issue, she dealt with the problem on an individual basis. Again, this was not a form of team building, but rather as a way of keeping the team running effectively and smoothly.

According to one manager in Hospital Two, there was no structured model of team building – but there was an *encouraged* model from the executives. The encouraged model was having a designated manager with facilities for staff to meet regularly with the manager to form a group or department that would provide a needed service. It also provided for the senior managers to meet with the executive.

In contrast to Hospitals One and Two, the staff in Hospitals Three and Four were more entrepreneurial with team building. The manager stated that if a need for team building was identified, staff presented the suggestion to their functional head and no restrictions were placed on staff requests or ideas. The managers responded well if a need was identified, or if a staff member made a request. However, to date, staff have identified no team building needs because of the high level of team building already existing at the hospital. The manager stated: "… *whether that's ignorance in terms of our perceptions, or the fact that it's not needed is another issue, or whether the existing structures allow it to occur sufficiently*". However, because of transformational leadership and the support of managers, staff felt free to develop teams and ask for improvements.

Regarding the personal aspects of team building, the first requirement for a team to perform well was strong social interaction between its members (Erdem & Ozen 2003). The most important factor creating that interaction and the synergy related with it was the existence of a climate of trust. Trust caused the development and protection of the team spirit by providing the cooperation and solidarity among team members (Kirkman & Shapiro 1997). Trust also

affected the output of the team and, consequently, the output of the organisation both directly and indirectly (Jarvenpaa, Knoll, Leidner 1998).

Team-building projects in Hospitals Three and Four involved social interaction within different departments, which was achieved by designing and printing departmental polo shirts. All staff members contributed to the design of the logo and the printing, and were encouraged to wear the polo shirts of their department. This small, team-building idea improved morale and developed a strong team spirit across the two hospital sites.

In groups, as tasks become more complex, novel and ambiguous (McFadzean 2002), teams developed skills so they could use more powerful problem-solving tools and techniques. Teams, according to Hackman and Morris (1975), consisted of appropriate members who have a wide range of skills, abilities and experiences.

As stated by one department manager in Hospitals Three and Four: "… *team-building would be a really good idea*" as overall hospital team building was pushed aside although individual departments tried to continue with team building programs. One department recently held a competition between Hospitals Four and Three, and this was successful in developing team spirit. Previously, the two maternity wards had a yearly competition for a trophy, but it was discontinued because of heavy workloads (although talk continued of starting the competition again). Unfortunately, the district manager believed that team building was unnecessary as "… *everyone should just think in terms of being a district and we should all be prepared to work at either site*". This did not contribute to the building of teams.

According to Montebello and Buzzotta (1993), teamwork was successful partly because of the focus it placed on people. They stated there were five characteristics inherent in any job: i) skill variety; ii) task identity; iii) task significance; iv) autonomy; and v) feedback. Research showed that jobs with a high degree of these characteristics tended to motivate workers, and this had a significant effect on the outcome.

The management in Hospitals Three and Four developed the five characteristics. When one staff member's skills were desperately needed in Hospital Four, a private car was provided to transport that person between the hospitals for a shift. Because of this, management decided to provide a car-pooling service for staff for inter-hospital travel. The staff accepted this movement between the hospitals because management was listening to and addressing their concerns.

Results of research by Arnold, Barling and Kelloway (2001) showed that organisations implementing teams should concentrate on encouraging and training their team members in how to be effective transformational leaders. A culture of transformational leadership should be promoted (Barker 1993). This would seem to be a more effective way to engender trust, commitment, and team efficacy (Bandura 1997; Kirkpatrick & Locke 1996; Sosik, Avolio & Kahai 1997) than the encouragement of strong values and norms (Arnold, Barling & Kelloway 2001).

Overall, the management team in Hospitals Three and Four listened to suggestions from staff, accommodated their needs and generally considered all matters they suggested. Consequently, staff were happy with the team changes and felt they were valued members of the hospital community.

As was shown in the research on communication, a sub-theme of *trust* emerged. Trust also emerged as an issue managers and leaders needed to address in team building.

Sub-theme 1: trust.

Teams that experienced high levels of trust performed better (Erdem & Ozen 2003). Modern organisations have increasingly adopted structures that required intensive interdependence among individuals, groups and work units (Manz & Neck 1997).

Trust, according to Mishra (1996, p 265) was, "one party's willingness to be vulnerable to another party based on the belief that the latter party was competent, open, concerned and reliable". Edmondson (1999) stated that trust provided an atmosphere of psychological safety

for team members, and only in such an atmosphere can members easily accept criticisms, discuss mistakes, and express their thoughts freely to increase synergy. Team trust was defined as: "a function of other team members perceived ability, integrity, and benevolence and as of the members own propensity to trust" (Jarvanpoa, Knoll & Leidner 1998, p 29).

In contrast to the development of trust and team building in Hospital One, Hospital Two's major concern in this area was staff's loss of trust in the management. Concern about this loss of trust was expressed, and was a major reason for the continued fragmentation of staff. According to one manager, existing management had a new manager placed above them whose attitude was "… *it's do as I say; I know best; I'm in charge*". Staff felt this new manager was less experienced than the previous one and many were antagonistic towards him/her. Staff believed that if the new manager listened to those with experience, pooled ideas and formulated a plan, there would be less conflict. Experienced departmental staff were not consulted by management and so trust was lost. Many also believed there was little point in talking to their managers, as they "*knew*" they would be ignored, so "*why waste their time talking to management*". The result in Hospital Two was that staff stopped communicating between themselves or management – few teams worked and team spirit was lost.

5.2.2 Summary.

The previous section provided a detailed discussion of the issues involved in dealing with team building. The current research showed that team building was an integral component of successful organisational change and needed to be included in a management change program.

As can be seen from this current study, there was little similarity in team development between the four hospitals and there was limited use of a formal structure for team building, and managers mainly left it to staff to develop their own teams.

Within the private hospital system, management did not contemplate developing teams, but were aware of the need for them. However, some staff and managers started to form their own teams without the support of executives. These teams were without a formal structure

and not integrated into the rest of the hospital system; they were limited to specific departments.

Within the public hospital system, the leaders used the skills of the staff and managers to form teams and allowed staff to decide how the teams should be comprised. They received support from management when the final team structure was developed. Staff worked across different departments and employed the best teams within the hospital. They received praise and support from management for their team building ideas and the implementation of them. Additionally, management encouraged competition between departments and the formation of teams across the two hospitals.

Overall, management in the public hospital system was more supportive of their staff developing teams than the private hospital management. It was clear that the leader in the public system (Hospitals Three and Four) fostered collaboration by team-building, encouraging trusting relationships, sharing power and empowering the employees with goals, throughout the change process. The leader's encouragement led to the successful development of team building structures and the successful implementation of change. To encourage the development of teams, the leader showed his vulnerability, listened to employees and provided support in the development of new cross-functional teams. The development of teams and the changes in Hospitals Three and Four were substantial; they were completed with minimal loss of staff and services to the community, which was credited to the successful role of the leader in these hospitals. Conversely, the leaders in Hospitals One and Two did not develop trusting relationships, and this resulted in the limited development of teams and less successful attempts at organisational change. The leaders in Hospitals One and Two struggled to create team building activities and procedures and did not display transformational leadership.

The current research study demonstrates the need for team building to be included in the extended framework of the transformational leadership models. The research also demonstrated that a sub-theme of *trust* appeared during the development of teams, and this

was a significant issue for staff in all four hospitals. It is important that the sub-theme of trust be included in further research on developing teams using the extended framework.

The third component to be addressed was *stress and coping*.

5.3 Stress and coping

Stress and coping was the third component to be analysed and is presented as a summary of the stress experienced by staff followed by the coping techniques applied by managers and staff for dealing with it. Following the summary is a detailed analysis of stress and coping with a review of the literature and staff interview statements. The methods the leaders, managers and staff developed for dealing with stress will be studied. The analysis of organisational change is the third component of *stress and coping*.

The following points highlight the stress experienced in each hospital by managers and staff and the techniques employed by them for coping with the stress of organisational change.

General stress and coping details common to all four Hospitals.

- Mergers within the hospitals.
- Staff dealt with stress differently.
- There was an increase in sick leave.
- There was an increase in emotional distress.
- Staff redundancies caused considerable concern.
- Staff rallied around each other as a coping mechanism.
- Loss of trust was a major issue during change, which increased stress.
- Numerous staff left the organisations to avoid the stress of change.

Hospital One – a large private hospital in the city.

Stress

- Increase in work hours during the change.
- Staff and management felt they lacked support from the executive during the changes.

- Some information about the changes was relayed by rumours.
- Access to intranet was denied to staff.
- New staff and management felt extreme emotional stress because of the pressures of the change.
- Some managers felt isolated with no one to talk to.
- No specific coping mechanisms were put into place by the executives.

Coping techniques

- The hospital used an internal counsellor.
- Staff relied on external support to cope with the changes.
- Staff helped each other with the changes.
- Staff obtained needed information from other hospitals.

Hospital Two – a small private hospital in a rural area.

Stress

- Staff were terrified of the changes.
- Staff lacked support from management.
- Management and staff relayed messages using rumours.
- Problem-solving techniques were not properly employed, which increased stress.
- Staff were extremely stressed by management's lack of regular information about the changes.
- No specific coping mechanisms were put in place.

Coping Techniques

- An internal counsellor was used.
- An intranet was provided for staff and management to use.
- Staff used external support mechanisms for coping.
- Management were confident of the need for change, which prevented them stressing.

Hospital Three – a large public hospital in a rural area.

Stress

- Staff were relocated from Hospital Three to Hospital Four.
- Staff feared a Hospital Three closure with the remaining staff being retrenched.
- Management were under considerable community pressure to keep Hospital Three open.
- Staff were exposed to community pressure.
- Management were under political pressure to close the hospital.
- Staff had to improve their skill competencies, which increased stress levels.
- Staff were stressed dealing with the requirements of the State Government Public Hospital system guidelines and changes within the system.

Coping Techniques

- An external counsellor was employed to assist staff.
- There was considerable communication between staff and management.
- Staff were involved in group meetings and decision-making processes.
- Staff were consulted regarding the changes and a limited rumour-mill.
- All staff had access to an intranet, which was used effectively.
- Staff used external coping resources during the change.
- Staff effectively used problem-solving techniques during the change.
- Management introduced internal coping mechanisms.

Hospital Four – a small public hospital in the country.

Stress

- The old hospital was closed and staff moved to a new hospital.
- Staff were concerned they would be retrenched.
- Staff had to undertake radical skill improvements.
- Staff were exposed to community outrage.
- Management were exposed to political pressure to make the hospital work.
- Management experienced staff shortages.

- Management and staff would not move from Hospital Three.
- Staff who moved from Hospital Three were not accepted by Hospital Four staff.
- Staff moved between Hospitals Three and Four for shifts, causing increased stress.

Coping Techniques

- An external counsellor was used for staff and management.
- There was extensive communication within the hospital between staff and management.
- All staff had access to intranet, which reduced stress.
- Staff used external assistance (such as families, church, and social groups) to relieve stress.
- Staff and management used problem-solving techniques to reduce stress.

The following section provided a detailed analysis of the summary in relation to the literature and interviewee comments and statements.

5.3.1 Stress and coping literature and interviewee reports.

In the past decade, researchers focused on ways in which individuals cope with stressful life events (Aldwin & Revenson 1987; Lazarus & Folkman 1984). One major conclusion from the research was that the coping process cannot be investigated apart from the context in which the stress and coping behaviour occurred (Billings & Moos 1981, 1984; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen 1986). However according to Bass (1990), staff can cope with stress when a common threat was perceived such as change and when a common goal and action towards the threat were maintained under an apparent plan of action. Therefore the leader who can transform a group of staff with different self-interests into a group with goals that transcend their own self-interests will make it possible for the group to cope more effectively with potentially stressful circumstances (Bass 1990).

According to Baruch and Woodward (1998), stress was a major component of a change program in any organisation. Research (Marks & Mervis 1985) into mergers showed the

existence of a *merger syndrome* – a defensive and fear-of-the-worst response, which resulted from the uncertainty and stress of mergers. Other reactions found by Buono and Bowditch (1989) included the loss of personal and organisational identities, feelings of conflict because of ambivalence, and incompatibilities between management, business systems, organisational culture and goals (Baruch & Woodward 1998).

In the four organisations reviewed, there were mergers of some sort. In Hospital One, there was the merging of the *old nun* culture with the new business culture and Hospital Two merged with Hospital One. Hospitals Three and Four merged to form one large district hospital, while each attempted to work independently. Each organisation experienced merging dynamics as well as the conflict between management, goals, and business systems. Every member of staff experienced stress in some form, and each individual coped by using different techniques. To alleviate these conflicts leaders need to be more directive and they are expected to revise goals, define common objectives, restructure situations and suggest solutions to deal with the sources of stress and conflict (Bass 1990).

The staff and managers in all hospitals showed many of the characteristics defined by Folkman (1984). Folkman (1984, p 843) defined coping as: "cognitive and behavioural efforts to master, reduce, or tolerate the internal and/or external demands that were created by the stressful transaction". The study of coping, according to Dewe and Guest (1990), was fraught with difficulties, because it does not necessarily manifests itself in observable behaviour and included intra-psychic processes that rely on self-report.

Several investigators (Aldwin & Revenson 1987; Lazarus & Folkman 1984) underlined the importance of understanding coping mechanisms; they suggested that coping behaviours minimised the impact of stress and alleviated its negative consequences (O'Driscoll & Cooper 1994). An executive in Hospital One experienced conflicting perceptions regarding his stress and how he displayed his feelings. Initially he stated: "*I, have not experienced a lot of it, largely because I'm really enjoying this – because we're now in control of our own business, our own destiny, making our own decisions – it's our money on the line*". Later the same executive showed signs of stress when discussing a time he was absent from the organisation

for several months: "… *when a few things happened that were threatening the cohesion of the management team, I was a little bit concerned about that when I came back*".

As the executives found, staff stress led to job dissatisfaction and lower job performance. O'Driscoll and Cooper (1994) stated the lack of effective stress management led to significant decrements in well-being, dissatisfaction, feelings of disengagement from the job, and reduced job performance. In all four hospitals, the managers and executives stated that staff dealt with stress differently – but there was an increase in sick leave. In Hospital One, the executives acknowledged that "… *staff deal with stress differently*" and there were more people on sick leave: "… *people who didn't normally take sick leave needed breaks*". Apparently, some staff joked about matters, others had a long weekend, while others just needed to "*blow off steam*". However, no set structure was developed and there was little support for staff during difficult times. Staff worked longer hours than before, sometimes all night, and undertook new tasks that initially created problems. The manager felt that staff coping with unresolved issues was "… *just a matter of sitting and working them out and working out the best way to solve the problem*" – an attitude reported by Folkman and Lazarus (1980).

Within Hospital Two, managers felt that staff did not care what happened because they were so "*frightened and terrified they just stopped feeling"*. One manager stated that "… *within the hospital, communication ceased; staff were walking around laughing one day, and then a few days later the place was like a morgue*". Contrary to management's view of the lack of communication in Hospital Two, many of the staff continued talking about the changes, expressing their upset to each other and to the patients. Many patients were aware of the changes and the distress to staff because the issues were openly discussed. Many staff needed to vent their feelings, and were so resentful they used patients as sounding boards for their anger.

In Hospitals Three and Four stress manifested itself in different ways: some staff resigned, there was increased sick leave, and others were visibly upset – crying during meetings was reported. To overcome the increased sick leave, management developed an employee-assistance service with an external counselling facility for staff. However, management

maintained that most of the coping happened through meetings, where problems were discussed with the staff and a social worker was used facilitate dialogue with the staff about their feelings. According to Seyle (1956), stressors and stress are a natural part of life and suggested there were four variants based on the degree and type of stress. The goal was to develop a balance between overstress (hyperstress) and under stress (hypostress), while maximising good stress (eustress) and minimizing bad stress (distress). The managers' activities in Hospitals Three and Four demonstrated the Seyle's theory.

Seyles' (1956) theory was also demonstrated in Hospital Two where an executive stated that he experienced both good and bad stress during the change period. Bad stress occurred "… *if something is happening and you want to deal with it, but you're unable to – so it's frustration more than anything else*". The managers felt that there was less bad stress during the change, but high levels of positive or good stress. There was "… *an awful lot of work on your plate and a lot of significant function and jobs to get through over a very short space of time, and you had to get them right. Because you could be very proactive – and we have a good team and everybody knew what the plan was – we got through it*".

The majority of management and staff in Hospitals One and Two stated there was an increase in sick leave. However, one manager in Hospitals Three and Four disagreed, and believed that "… *in the early days there was not a lot of sick leave or anything like that, because the staff wanted to be here*". Nevertheless, there was some resistance by Hospital Four staff who would ring in sick when asked to work a shift in Hospital Three. Staff from Hospital Three felt the same way about travelling to Hospital Four for shifts, and nurses from both sites were "*a little bit naughty*" with their shift moves. Management dealt with these issues through discussion and the notion of using communication to solve stress repeatedly appears throughout the portfolio of management tools and techniques in Hospitals Three and Four.

An example of stress management at Hospital Four is seen by this comment of one staff member: "… *the simple thing about a medication chart was to actually resolve it, because it did create conflict within the staff – their communication to each other at times was quite abrupt*". The approach by management in Hospitals Three and Four was that if they could

resolve distressful process problems, then they might assess the staff's ability to cope and eventually get acceptance for the changes (Hann 1993). However in Hospitals One and Two, some staff were not able to cope effectively with the changes and decided to "*self-select*" (resign). Based on Seyles' (1956) theory a good balance of stress did not evolve resulting in staff resignations.

Within stress and coping theory, there are many models available to reduce stress. One is the *person-environment fit* model (Latack & Havlovic 1992). In this model, there were two types of fit between the individual and the environment: i) the extent to which the individual's skills and abilities match the demands and requirements of the job; and ii) the extent to which the job's environment satisfies the needs of the individual.

Within the concept of the *person-environment fit* theory (Latack & Havlovic 1992), a manager in Hospital One felt "*unworthy*" when he did not receive support during the difficult times, and often wondered if he should move to another hospital where staff were "*treated better*". Another manager at the same hospital felt that he would like more support and to be consulted on issues affecting his department; he wanted more involvement in the upper levels of management. He felt being involved would allow for greater understanding of what occurred within the hospital and the role his department played in the change. In this instance, the *person-environment fit* was poor and he suffered from stress because of the limited coping strategies he had in place.

Contrary to the above, yet another manager in Hospital One felt comfortable in her position, as she was responsible for an important department. The doctors supported her and the department; her services and the facilities she managed were required on a regular basis. She was in close contact with the executives, had open and honest discussions with them, and felt her position within the hospital was secure.

During the restructuring in Hospital Two, staff members relied on one another for information regarding the change, despite being encouraged to speak to management about their concerns. However, staff believed the negative rather than the positive. Management felt staff had the

opportunity to ask the questions they wanted through the intranet or normal meetings with management. Within Hospitals Three and Four, communication was the main coping mechanism, as well as an employee-assistance scheme of counsellors. There was an expectation that department managers be "… *pretty proactive in dealing with the stress of staff*", and the notion of *coping*, which formed part of the person-environment transaction model (Latack & Havlovic 1992), was actively used within Hospitals Three and Four.

According to Swent (1983), the individual was the most important variable, and a simple coping technique will not be successful for any one person in all situations. Therefore, it is important for an individual to experiment with alternative coping techniques (Allison 1997). Similarly Bass (1990) stated that leadership that is effective in coping with stress implies leadership that results in rationally defensible, high quality decisions, the appropriate use of available information, skills and resources and the enhanced performance of followers in reaching their goals, despite the threats and obstacles to doing so. Gmelch (1988) stated the solution to reducing stress lay in holistic interventions to combat stressful situations. Heibert (1987) suggested it was sensible to approach stress control from two directions. One approach was referred to as *stressor management* and focused on situational factors and methods of reducing the demands of the situation (the work environment) on the individual. The other approach was the *stress management approach*, which focused on the behavioural, cognitive or physiological components of an individual's response (the person) in an effort to permit calmer responses to demanding situations. As Gmelch (1988) stated, the psychological aspect of stress and coping was important. As examined in the previous element, the sub-theme of the *use of psychologists* emerged. In the following section, the use of psychologists in the four hospitals is discussed.

Sub-theme 4: Use of psychologists.

In all four hospitals, management told staff a psychologist was available for consultation should they require support through the change process, and number of staff took up the offer. The psychologist in Hospital Two remarked: "… *there was a lot of uneasiness amongst the staff, so I availed myself to the new management team and in fact, they were very encouraging*

in my supporting the staff". The psychologist made individual appointments for concerned staff, and made himself available for lunch-hour group consultations.

In Hospital Two, staff actually voiced their concerns about the changes to the psychologist who relayed them to the management team; the managers were open about addressing these concerns. Staff were so desperate to talk that they were unconcerned about this apparent breach of confidentiality. The psychologist also confidentially disseminated information from the executives to specific staff. Research by Dewe and Guest (1990) showed that examining how people cope with stress can help the understanding of the processes by which coping strategies counteract the negative impacts of stress on health and well-being.

As well as the counselling, the psychologist found the "*misery loves company*" coping method was used considerably during the changes in Hospital Two, which he believed was a poor technique. He believed that if staff met and discussed their concerns, and these concerns were given a realistic perspective, they would develop good coping mechanisms. Unfortunately when staff did meet, they fed misinformation to each other and "*wound each other up*". Rumours abounded, and the psychologist attempted to quash the stories and pass on the facts. He found a number of staff were anxious, unsettled, close to tears and suffering from depression – and he suspected that absenteeism had increased.

Despite the availability of the psychologists, an executive in Hospital One stated: "*I don't know how well utilised it is now. In the past, we received feedback from the psychologists about the staff concerns and how they were being dealt with and the levels of stress*". Overall, the psychologists in Hospitals One and Two were not well used by the staff. The case study research found many staff coped using outside networks and confided in colleagues rather than suffer the imagined stigma of seeing a psychologist.

In all four hospitals studied, staff revealed they relied on outside networks to help cope with the changes. As a result, the assessment of stress was often coupled with the assessment of the ability to cope within (Hann 1993). Managers appeared more able to cope with mergers when there was a culture of openness. Similarly, the support of the family was an important

factor in coping, and no doubt time pressures and long work hours were easier to cope with when the family was sympathetic and did not make additional demands on them (Cooper, Cooper & Eaker 1988).

During a major organisational change such as a corporate restructuring, feelings of stress among staff can occur. A manager in Hospital One stated that at the start of the change process there was a lot "*of disgruntlement*". Staff hours, pays and penalties were reduced, and the changes started to impact on "… *staff pockets and hours they work; it really affects them*". Previously, staff had maintained certain hours of work regardless of the amount of work. After the restructure, the hours changed and staff were told to "*go home*" if it was not busy. Those who were unhappy with the hours and pay resigned, and the replacement staff came to accept that "*it's run this way*". However, the manager believed there was still some discontent because of the reduced hours and pay. The pressure created by the change and the uncertainty regarding redundancies had a major impact – and this was reported by all members of staff.

Similarly in Hospital Two, a manager stated that a stressful situation occurred with staff who had been made redundant or had their hours cut. The hospital began rehiring, and previous staff were being "*rung up and asked if they want to come back to work*". While telephoning the ex-staff, managers were abused by family members upset at this treatment. According to the theory, to control a situation such as the one described, Pearlin and Schooler (1978) identified responses that changed the situation, altered the meaning or appraisal of the stress, and ones intended to control feelings of discomfort. Latack (1986) distinguished between three categories: control, escape, and symptom management. Control and escape include both action and cognitive re-appraisal, and in the situation described above, many families abused management as a form of control and escape (Dewe & Guest 1990). This made the reemployment situation difficult for Hospital Two.

Another manager in Hospital Two experienced significant stress because his position was reduced a level along with his pay, and he was removed from many of the hospital committees. His increased worry caused a tight, upset stomach, weight loss, and tiredness. Work became joyless and he no longer felt like going to the hospital, which was "*going down*

the gurgler". He wondered what the executive had done and why. As shown from the research, this manager did not use any coping methods and experienced considerable stress.

To alleviate stress, studies (Latack 1986; Newton & Keenan 1985; Pearlin & Schooler 1978) showed possible coping methods were: rational task-oriented activity; emotional release; some process of distraction; passive attempts to tolerate the effect; and social support. As well, Newton and Keenan (1985) developed six classifications dealing with coping mechanisms and the effects of stress that staff experienced during periods of organisational change: (i) talk to others; (ii) direct action; (iii) preparatory action; (iv) withdrawal behaviour; (v) helplessness and resentment; (vi) other behaviour.

Within Hospital One, one manager found that supporting her staff and "*pitching in when needed with buzzers and medication*" was important for relieving stress among her staff. The manager had a 24-hour coordinator call facility for when the ward was busy. In this situation, the person-environment fit was good (Allison 1997). Here the needs and abilities of the person matched the rewards and demands of the job; the person-environment fit was good. There was little occupational stress and all experienced a high degree of job satisfaction. On the negative side, having staff with the wrong skill-mix of staff caused her the greatest stress, rather than having excess staff on the wards.

Research (Allison 1997) showed staff with higher stress levels tended to cope using more work-related coping techniques, while those who reported limited stress were more likely to use techniques related to their own personal health and well-being. An executive in Hospital One typified Allison's research when asserting that: "*It probably was stressful, but I was busy and it was a new role – I didn't see it as being stressed. I probably get more stress now than I used to 18 months ago, because I get more time to stop and think about what if we get this one wrong – what might happen?*". This executive stated that the change was quite exciting and challenging, and found great pleasure being able to work with appropriate people. In addition, the executives were now able to spend time working on issues that added value to the organisation: "… *my stress level is a lot lower than what it was when I worked for a bigger organisation, because I control what I can do*".

The executives in Hospital One found the financial aspects stressful because "*we don't have a big brother*", and managed the financial budget to ensure everything was working smoothly. According to the executives, that was the only stressful part of running the hospital. As can be seen in this example and according to Bass's (1990) theory, transformational leaders when coping with stressful situations are not easily frightened, disconcerted or thrown off balance, but remain calm and maintain their sense of humour in the face of a crisis.

However, staff and managers who had more extensive coping repertoires were more likely to be in better health and experienced lower levels of stress. If the coping repertoires were increased, the effect of work-related stress declined. According to Gmelch (1988, p 222), "coping with stress is a holistic and polytechnic proposition". Effective coping consists of building a repertoire of techniques equally distributed among all of the coping categories (Allison 1997).

One effective coping technique established in Hospitals Three and Four, emerged from the reluctance of many staff to adapt to the change process. One nurse, who worked in the night shift Emergency Department in the original Hospital Four, was reassigned to work in the new Hospital Four facility. Her attitude in the original Hospital was: "… *we'll just patch up and stabilise and send off patients, to one of the other hospitals and now, we've actually got to deal with the other end of this system of attending to patients*". When she first arrived at the new facility the environment was so significantly different that she could not readily lay her hands on needed equipment – she had been very comfortable in the old environment. However, she was totally overwhelmed moving to a specifically built emergency service unit in the much larger new Hospital Four. To cope, she found it necessary to "… *actually get a trolley and put all the things [she] needed routinely on that shift, and move the trolley around with [her] from patient to patient until [she] adapted to the change*". Management were happy to accommodate her change techniques and way of coping.

The previous example was characteristic of the Lazarus (1966) and Folkman (1982, 1984) models: after deciding the situation demands action (primary appraisal), the decision about

what could be done (secondary appraisal) was determined by how much control the individual perceived there was over the situation. When the situation (Latack & Havlovic 1992) was appraised as being controllable, the emphasis was likely to be directed towards a problem-solving strategy, as the nurse demonstrated. Where the situation was perceived as offering little or no means of control, then the emphasis was likely to be to reduce the emotional discomfort – as occurred with staff resigning rather than accept the changes (Latack & Havlovic 1992).

In Hospital One, a manager felt emotional distress because the changes were *"huge"* and she was uncertain of her ability to complete set tasks. She was new to the organisation, but was partnered with another manager who she had previously known – they established an excellent relationship (Lazarus & Folkman 1984). Both managers coped with stress by debriefing and bouncing ideas off each other: "*… long and hard because of the pressure we were under*". According to the manager: "*There was an enormous amount of pressure to pull this hospital in very quickly because of the financial side of it. As well, I could appreciate that managers have to have the depth of knowledge to understand that you don't compromise patient outcomes at all – because you won't have a good product if you do*". She realised the business imperatives for the executives and found they were "*… manifesting strange behaviour, even though everyone was friendly*".

Uncertainty during the change period was a theme expressed by many of the staff and management in the four hospitals under review. One manager from Hospital One, stated "*…there was considerable stress in the organisation about possible redundancies"*. Staff from a specific department were informed that two positions were being eliminated, but not who would be retrenched. After several months no one had been removed, so the manager pressured the executive for a decision to alleviate the stress and uncertainty for the staff. The reply was: "*There's nothing much we can do, it's a big job. We'll have to get around to it when we can*". This manager was concerned about the handling of the retrenchments and experienced considerable stress. In relation to this example, the theory by O'Driscoll and Cooper (1994) stated that prolonged maladaptive coping may ultimately induce a chronic, highly debilitating form of stress known as burnout (Letier 1991). Because of the stress in this

department, several staff were warned about breaching work ethics, and several left because of the uncertainty of work hours and positions – the workload also increased dramatically.

As shown by theory and research (Seyle 1956), negative appraisal leads to distress while positive appraisal strengthens *good stress* and the feelings of competence and self-efficacy. In Hospital One, negative stress led one manager to claim he was under considerable pressure because he was relatively new to the position. Even after an 18-month tenure, he still felt stressed: "*I've got no one to ask for help – or I feel intimidated if I do ask, because they say I should have known how to do that anyway*". He dealt with his personal stress by calling another manager – or managers at other hospitals – for advice. According to Seyle's (1956) theory, this manager experienced negative appraisal for his work resulting in negative stress.
The managers in Hospitals One and Two felt there was limited coping mechanisms established for handling stress, and the best way to cope was to "*pitch in and help*". They learnt from the lack of support during stressful times that they "… *just have to put up with the stress as there's no other avenue* …" for assistance or guidance. These managers did not receive praise – which could be cited as negative appraisal – and this led to maladaptive behaviour (Seyle 1956). The managers described maladaptive behaviour like avoiding managerial duties to help lower-level staff, and avoiding paperwork and meetings.

Another manager in Hospital One also expressed feelings of negative appraisal and found the change period stressful because of the attitudes of her staffs. She discovered older staff "… *caused more trouble than anything, and I don't know whether they did it deliberately or not*". At lunchtime, there would "… *always be this bitching going on about what was happening and they weren't happy*". For 12 months, working at Hospital One was very depressing, with staff continually making negative comments about the redundancies. The staff went to "… *lunch one day and there would be ten of you; then the next day there would be nine, then eight – and everyone was wondering who would go next*". She felt it was a terrible time for the staff, but thankfully "… *most of the negative people have left and there haven't been any people leaving for a while, so the staff are starting to settle down again*".

Other models for investigating stress and coping techniques (Folkman, Lazarus, Dunkel-Schetter, Delongis & Gruen 1986; Nelson and Sutton 1990) studied problem-focused coping (or managing the sources of stress) where coping can be negatively related to depression and physical systems, and positively related to self confidence. In contrast to the findings on the problem- and appraisal-focused methods of coping (Folkman, Lazarus, Dunkel-Schetter, Delongis & Gruen 1986; Nelson & Sutton1990), previous research found emotion-focused coping for stress was related to negative outcomes. Emotion-focused coping (Lazarus & Folkman 1984) that involved cognitive or behavioural efforts was used to manage the response to stressors being associated with depression and dysfunctional physical symptoms (Billings & Moos 1984), and with high levels of somatic complaints (Latack 1986) and anxiety (Stumpf, Brief & Hartman 1987).

Only Hospitals Three and Four staff used the problem-solving techniques described by Lazarus and Folkman (1984). According to another manager, "*different individuals have different stressors*", and there was always underlying stresses for management. Management always put a positive spin on circumstances, turning negative situations into a "… *positive situation for them, a positive for the community. The new hospital was going to be a challenge, and staff are up to that challenge*". For the staff relocated from the original to the new Hospital Four, there were positive stresses and positive changes. But with this came an expectation that they needed to update their clinical skills to do the new work. To meet expectations and reduce stress, management established competencies for each unit and the nurse-unit managers were regularly reviewed with their teams. This ensured staff confidence in their capabilities as clinicians, and these competencies were reviewed annually. This demonstrated problem-focused coping skills and staff were no longer focused solely on the emotional coping skills (Lazarus & Folkman 1984) as occurred during the changes.

Also in Hospitals Three and Four, there was only a select group of staff in each department able to do certain procedures. With the new annual competency review, staff could undertake a range of procedures to develop their competencies. Management worked out the method of competency assessment by developing a learning package. Once staff successfully completed the package, they were signed off as competent. This program was open to all interested staff

and not restricted to discrete groups, and demonstrated that management had progressed staff interests for the whole profession rather than elitist groups with certain skills. Staff were moved around different departments to use and maintain their new skills. This again demonstrated the use of a problem-focused coping strategy and reduced the emotion-focused coping strategies within the hospital (Folkman 1984).

In general, there was considerable support for staff from both internal and external sources during the changes in Hospitals Three and Four. Staff were offered retraining if they wished to change jobs, and several nurses took the opportunity to be retrained for rural and remote nursing.

When coping with stress, staff and managers were confronted with many different ways of coping, and Allison (1997) described coping strategies that, for the most part, were stress-management techniques. These strategies intended to moderate the effects of stress on the *person,* as opposed to stressor-management techniques (Heibert 1987), intended to reduce the source of stress in the *environment* (Allison 1997).

Allison's research (1997) discovered the most commonly used coping techniques included: (i) practising good human-relation skills with staff; (ii) maintaining a sense of humour; (iii) approaching problems optimistically and objectively; (iv) maintaining regular sleep habits; (v) setting realistic goals; (vi) delegating responsibility; (vii) talking with family members and friends; (viii) engaging in less active non-work or play activities; and finally, (ix) working harder.

In Hospital One, tolerance to change was low, and the managers felt staff had a coping mechanism: "… *they left early, because they were just 100 per cent resistant to the change*". Many of those resigning had worked there for a long time and did not want the hospital sold to the new private company. Others coped by becoming passive and retiring. The manager knew that there were "… *some phenomenal personalities and the staff were a close team, but I knew they had so much potential – but they were just sitting very quiet*". She knew the staff

did not "*know what she was about*" and that she had to gain their trust before pushing them with change

Similar situations occurred in Hospital Three where around half a dozen staff were not prepared to relocate to Hospital Four and decided to leave. The manager felt for the first 18 months of the change there was considerable passive/aggressive behaviour, though staff eventually became more confident because the hospitals honoured its undertakings. However, the manager stated: "… *there were some behaviour issues there*".

In all four hospitals, many staff resigned rather than working to implement and understand the changes, and this passive/aggressive approach by small groups was a common feature of all change programs – they concentrated on emotion-focused coping strategies rather than problem-focused ones (Folkman & Lazarus 1980). They did not tackle the source of stress, (problem-focused), but dealt with stress-induced emotional discomfort by resigning.

As demonstrated in the first two components of *communication* and *team building*, several sub-themes emerged.

Sub-theme 2: use of trust.

Contrary to the research (Dewe & Guest 1990; O'Driscoll & Cooper 1994) into the use of problem-focused coping, emotion-focused coping, mini-vacations, external support and internal support, staff and management found the coping mechanisms used in the four hospitals were not effective if *trust* was absent in the organisation.

A manager in Hospital One stated that the whole issue of change was based around a "*trust thing*", and she found that building trust did not take long. She gave staff time to adjust to the changes rather than using a "*I want this done now*" attitude. Her method was to break the changes into "*smaller segments*" so staff could initially focus on patient care, while she focused on other issues. This gave them "*breathing space, which was what they really needed*". She determined who were her good staff, which staff were ready for change and when they were ready to accept she did not use an authoritarian style. Because of the stress,

some staff were a little brash with their communication, but she accepted that, and stepped back from confrontation. Many of them coped by being a little "*aggressive at times and that was how I supported them*". This manager did not correct the staff, but tried to help them understand the changes and found that many who had been aggressive would come back later and apologise. She believed this was how she built trust within the team and respect for her hard work.

Another facet to be included in stress and coping techniques is the psychosocial aspects of gender influence (Iwasaki, MacKay & Mactavish 2005): the differing ways women and men cope with stress. There was a need to recognise issues of inequality, discrimination and sexism to understand the gendered nature of women's lives. Gender appears to play a key role in explaining how people cope with stress in their daily lives and needs consideration in applying stress and coping techniques.

5.3.2 Summary.

In this current study, the research objective was to understand the processes involved in undertaking organisational change. The previous section provided a detailed discussion of the issues involved in dealing with stress and the techniques used to cope with the stress of change. The research showed that organisations properly managing staff stress would implement change more successfully. Evidence for including this third component of *stress and coping* into the extended framework transformational leadership models has been found.

The current study showed that in all four hospitals there were common stresses for each member of staff and management. There were also common coping skills used in each organisation, such as psychologists and use of rumours. However, staff in the four hospitals used their own external coping mechanisms for reducing stress. Overall, they used limited coping techniques to reduce stress, and the management in Hospitals One and Two – which were private hospitals – provided limited coping tools for staff, where as the public hospital management in Hospitals Three and Four provided significant coping mechanisms for staff.

Overall, it can be seen that the public hospital management employed greater coping skills than the private hospital management. Staff in the private hospitals experienced more stress, uncertainty, and confusion regarding the changes, and consequently experienced increased stress and used greater external sources of support to cope with it. In the public hospitals, staff were provided with strong coping techniques, and kept informed about the changes. Management involved many staff in the changes and this involvement in the decision-making process reduced their levels of stress, while those not involved in decision-making were kept up-to-date by the intranet and specific meetings with management.

As the research showed in Hospitals Three and Four, management undertook successful stress and coping techniques and were able to retain staff during the change process resulting in successful organisational change. In Hospitals One and Two, many staff were retrenched and others left voluntarily because of the stress of the change. A less successful change in Hospitals One and Two was partly a consequence of the leaders not providing stress and coping techniques for staff during the change.

The following section deals with the component of *inter-group conflict*.

5.4 Inter-group conflict

The fourth and final component found from the research was inter-group conflict. The analysis is presented as a summary of inter-group conflict experienced by managers and staff in each of the four hospitals during the organisational change. Following the summary is a detailed analysis of inter-group conflict through an investigation of the literature and interview statements. The methods the leaders, managers and staff developed for dealing with the inter-group conflict was also studied.

The following points highlight inter-group conflict experienced in each hospital and the techniques used by hospital management and staff during inter-group conflict caused by the organisational change.

General inter-group conflict common to all four hospitals.

- All staff felt conflict between groups, especially in departments which merged.
- Communication was not used effectively.
- Managers immediately dealt with conflict in their departments.
- There was upset between in-groups and out-groups in all hospitals.
- To immediately alleviate problems, managers used external third-party interventions.

Hospital One – a large private hospital in the city.

- Managers did not feel that inter-group conflict occurred in their hospital.
- Executives had a passive approach to staff.
- Difficult staff left the hospital rather than overcoming the problems.
- A formal structure was established to deal with conflict when it occurred.
- Significant conflict occurred between managers and staff.
- Staff felt conflict when they moved out of their established work areas and into new work areas.
- A new nursing model of care was established to overcome conflict.
- Personality problems caused conflict.
- Managers deal with conflict by meeting in neutral areas to solve the problems.
- An independent mediator was used.
- Conflict was dealt with immediately by communicating with the staff.
- Conflict was directed towards the executives because of staff ward movements.
- A grievance policy was instigated to solve conflict situations.

Hospital Two – a small private hospital in a rural area.

- Conflict was solved by meeting staff in groups to discuss issues.
- Staff were contacted quickly by managers when conflict was identified.
- A formal structure was implemented for dealing with conflict.
- Conflict was not dealt with at the departmental level, but went to the management level swiftly.

- Staff were moved from established wards to new areas, which created considerable inter-group conflict
- A new nursing model of care was established to help staff deal with changing work areas.
- An independent mediator was used to solve conflict.
- Conflict was directed toward the executives because of staff ward movements.
- A grievance policy was instigated to solve serious conflict situations.
- Staff and managers solved conflict themselves without requiring external mediators for less serious conflict.
- Staff caused conflict by changing structures and plans back to the original system before the organisational change.
- Leaders were removed from existing roles and wards and replaced with inexperienced staff, causing great conflict among the doctors.

Hospital Three and Four – one large and one small public hospital in a rural area.

(Both hospitals need to be studied together as both are controlled by one District Manager).

- In-group and out-group behaviour increased significantly with the opening of Hospital Four.
- Staff in Hospital Three undertook shifts at Hospital Four to overcome conflict between the two hospitals.
- Hospitals Three and Four formed specific committees to resolve conflict, create working parties, and develop new policies.
- Staff and managers found the most effective way to deal with conflict was for groups to meet and discuss their problems.
- Inter-group conflict was reduced by standardising policies and procedures between Hospitals Three and Four.
- To reduce conflict, managers developed an *environment of tolerance* policy and a *skill enhancement* process for staff moving between Hospitals Three and Four.
- Hospital Four included staff from Hospital Three on committees that involved both hospitals.

The following section provides a detailed analysis of the literature and interviewee transcripts and provides evidence for supporting the inclusion of the research question four in the extended transformational leadership models.

5.4.1 Inter-group conflict literature and interviewee reports.

Campbell (1965, p 288) stated in realistic group-conflict theory that "real conflict of interests, overt, active or past conflict, and/or the presence of hostile, threatening and competitive out-group neighbours, which collectively may be called 'real threat', caused a perception of threat". A threat actually existed for a group, or maybe a false perception on the part of group members – but the result was the same. The ability of groups to make decisions and solve problems effectively has long been considered an important factor in the reduction of inter-group conflict (Rempel & Fisher 1997). According to Bass (1990) the transformational leader can manage conflict between employees whilst undertaking organisational change by instilling pride in the past, coupled with a need to meet the challenges of the future.

According to the eclectic model (Fisher, Grant, Hall, Keashly & Kinzel 1990), perceived threat played an integral role in the onset and escalation of conflict. When combined with a competitive orientation, ethnocentrism and mistrust, perceived threat helps induce ineffective communication, inadequate coordination, continuous tactics and reduced productivity – particularly in groups attempting to solve conflict related problems (Rempel & Fisher 1997). This resulted, according to Fisher and Keashly (1990), in an escalation of the conflict. Within the four hospitals analysed, the feelings of threat were evident with all staff. Management found that communication was used and abused when dealing with conflict, and many problem-solving techniques were not used because of the mistrust among staff. However, several managers in Hospital One felt that little conflict occurred in their organisation.

According to one executive in Hospital One: "*I haven't really perceived there being conflict. Any conflict that there's been – in terms of bringing managers in from outside of the pre-existing organisation – has really been fairly passive*". The executive believed their style of management was "*fairly early-grenade type of approach and absolutely take control so that people tend to be a little bit reticent about creating conflict*".

Similarly, another manager in Hospital One believed there was no conflict in her department because of its small size. Through discussions with other departmental managers and staff, she believed that staff who had been confrontational at the commencement of the change program had left. She had a hands-off approach to conflict, and stated: "*… you hear rumours all the time about staff who are having problems, but I don't know any of them, so I don't know if they are true*". This manager believed any conflicts would be managed effectively because the management team and the executive were "*fairly close*". She felt if there were problems on a ward, the ward manager would "*try and deal with it*" before the executive became involved.

Many researchers (Labianca, Brass & Gray 1998) have defined conflict as perceptual rather than behavioural. Researchers such as Coser (1956) and Simmel (1955) noted that perceptual biases and negative images of an out-group increased among in-group members as inter-group conflict increased. As conflict increased, the internal cohesiveness of the group increased, as does group differentiation (Forsyth 1990). Coser (1956) suggested that as conflict between groups increased, group members began to emphasise the differences between the groups rather than focusing on their similarities. An in-group/out-group bias develops and grows more pronounced as conflict grew. Here, two biases are combined: a tendency to favour the in-group, and a tendency to look unfavourably on the out-group and its members, procedures, culture and products (Labianca, Brass & Gray 1998).

Sherif, Harvey, White, Hood and Sherif (1961) believed the perceptual biases which were revealed when conflicting groups attempted to evaluate each other included: stereotypes, the complexity bias, the extremity bias, and the out-group/homogeneity bias (Judd & Park 1988). Because of these biases, individuals based their judgments about an entire out-group membership with whom they have interacted. Biases toward out-groups were perpetuated by perceptual distortions (Darley & Gross 1983), memory distortions (Howard & Rothbart 1980), and other confirmatory biases that prevent in-group members from disconfirming stereotypes of an out-group.

During the pre-structure days in Hospital Two, inter-group conflict was handled in the normal process: management meeting with the groups or individuals in conflict and resolving their differences in an amicable fashion. Bornstein and Gilula (2003) stated that communication between groups was highly effective in bringing about a peaceful resolution if the conflict was motivated by fear, but useless if the conflict was motivated by greed. Management in Hospital Two acknowledged that pre-restructure staff felt somewhat threatened by the way some inter-group conflicts were managed, and used effective communication to alleviate the problems.

However, one manager in post-restructured Hospital Two stated, "*the game has changed*". There was a Director of Employment Relations contracted to Hospitals One and Two. If group or individual conflicts arose, the Director intervened and interviewed the staff concerned. Appropriate action was taken: dismissing a staff member if necessary, counselling staff, or a changing systems and processes if relevant. Conflicts were dealt with in a more professional manner, in terms of the impact on relations, than before the restructuring. Because there was a formal, structured format to deal with issues, inter-group conflict moved quickly to the Director of Employment Relations for resolution.

Takacs (2001) stated that social networks play an important role in the mobilisation of collective action (Oberschall 1973). Previous models did not recognise that individual network ties within and between groups transmit social and cognitive rewards that influence participation in inter-group related collective action. In particular it was widely believed dense in-group relations help the establishment of collective action (Gould 1993; Marwell & Oliver 1993). In the inter-group context, not much was known about why and under what conditions dense in-group and scarce out-group relations supported harmful collective action (Marwell, Oliver & Prahl 1988).

Within Hospital One, the significant conflict was between the staff and management during the change and not between staff – and this could be considered in the context of Takacs social network groups. During the change, staff were asked to move from established areas to work in other areas for cost-cutting reasons. According to management, staff moving from

one area to another had little experience in the new area and found the relocation stressful. The stress was reflected in their work attitudes; they would blame management for the problems saying, "… *management had no right to do this, they don't have the experience*". Again, this supports Takacs (2001) concept of in-group and out-group relations that causes harmful collective action.

Despite the contributions of management towards staff development, individual contributions can be costly and group-beneficial collective action is difficult to achieve (Takacs 2001). The existence of an out-group (Gould 1999) could explain higher contribution rates by staff to discussions, especially if the relation between the groups was competitive. Erev, Bornstein and Galili (1993) believed inter-group competition could be considered a possible structural solution to social dilemmas. The solution within the groups created a social dilemma between the groups and the *self-sacrificial* loyalty to sub-groups created conflicts between them (Caporael, Dawes, Orbell & van de Kragt 1989; Olsen 1982).

In Hospital One, the manager felt that conflict in her department arose because of personality problems, which were dealt with immediately. She told staff members: "*You don't have to like each other, but you do have to respect each other's right to be here*". The manager found that with a neutral, third-party mediator staff who once did not get along, now "… *got support from each other and it's been good*".

Majeski and Pricks (1995, p 623) found groups often communicated a great deal in times of conflict, "… they talk, negotiate, signal, and make threats, commitments and promises". Much of the communication was costless and non-binding "cheap talk" that had no direct bearing on the participant's payoff (Bornstein & Gilila 2003). Insko and Schopler (1987) found that communication between groups was relatively ineffective as a means of resolving conflict, as group decisions were highly competitive – much more so than individual decisions (Schopler & Insko 1992).

Insko and Schopler's (1987) theory was demonstrated in Hospital One where managers felt there was considerable conflict and resistance to every change in specific departments.

According to the manager, staff did not implement the changes, or would slightly modify the changes and restore the old methods. The manager would then "… *go back and have several meetings, communicate with staff down in the unit to try to re-establish new methods*". The manager sensed the resistance and found extensive non-communication in the departments. According to the manager, "… *there was a lot of aggressive communication towards me and I would never be aggressive back. I would just let it go over and just go back into the primary reason of why we're doing this, to explain to them. They couldn't see it; they couldn't see the big picture. Every time we had to do something, it was challenged, and the staff were very impatient as well*". In this instance, Majeski and Pricks (1995) concept of "cheap talk" seemed relevant.

Similarly, communication played a significant part in a manager's role in Hospital One. According to the manager, when there was conflict the management felt the best solution was to immediately communicate with the person and "… *hit it on the head very quickly*". If the problem was too complex to be resolved departmentally, they involved the Human Resource Manager, whose the primary role was to use effective performance management. However, most managers believed that conflict was resolved by keeping emotion out of the situation, as well as good, immediate, and clear communication about the problems.

Labianca, Brass and Gray (1998) investigated the association between the interpersonal relationships of members in different departments and the individual perceptions of inter-group conflict. Although friendships across groups were not significantly related to perceptions of inter-group conflict, negative relationships were associated with higher perceived inter-group conflicts (Nelson 1989). Perceptions of inter-group conflict were also significantly related to indirect relationships through friends.

Nelson (1989) assumed that an increased frequency of interaction would reduce inter-group conflict. However, not all interactions were positive, and negative interactions exacerbated inter-group conflict. According to Darley and Gross (1983), negative relationships in organisations were particularly important, because of the constraints imposed by required interactions in organisations. Whereas one can usually walk away from or minimise

unpleasant interactions in a social setting, it was difficult to sever a negative relationship in an organisation because the relationship either required workflow interactions, or hierarchical, supervisory relationships (Labianca, Brass & Gray 1998).

One manager said there were two major areas of conflict in Hospital Two: the front office (the administration area) and the new medical services area. In the administration area, two departments merged – the day hospital and the ward clerks – and formed the front office staff. Many struggled to cope with the new way of working and moved from one department to another within the merged departments to return to a familiar environment. According to another manager, the original front office manager was "*very dictatorial*", and her opinion of the new staff was: "*I didn't employ them, I don't like them, but I've got to put with them*". This attitude caused conflict and a number of staff left when the situation remained unresolved. According to Labianca et al (1998), an increased frequency of interaction between two groups reduced inter-group conflict. In this department, increased interaction produced severe negative relations between staff without reducing inter-group conflict.

A second area in Hospital Two experienced considerable change when two units were merged to create a new medical services division. Again, negative relations among staff caused inter-group conflict. According to one manager, some nursing staff felt the palliative care patients did not receive enough attention after the two sections were combined. Staff worked across both wards, whereas previously they worked only in palliative care. Trained in palliative care, many now worked outside their expertise and felt threatened by the move. Management attempted to resolve the issues, but many staff reimposed the old divisions without management consent, causing continued conflict for themselves and patients.

Although significant inter-group conflict occurred in Hospital Two during the change, it faded after the changes were complete. In fact, a manager stated: "*When the change was going on, you'd hear a lot from the patients, 'Gee its bad, what's happening?' and obviously staff were talking. Today, all you hear from patients is how lovely it is here, how good the staff are, and patients are saying they use to go to other hospitals in the area, but will only go* to Hospital Two *now*".

Given the constrained nature of interactions within organisations, it seemed likely that negative relationships with an out-group would overwhelmingly predict perceptions of inter-group conflict (Labianca, Brass & Gray 1998). An individual's perception of an entire in-group's level of conflict with an out-group was affected by the number of direct negative relationships between the individual and members of the out-group. If out-group relations were strained, and perceptions of conflict between the groups was high, individuals were more likely to develop negative relationships with members of an out-group. Perceptions of inter-group conflict acted as a biasing frame for interpreting interpersonal actions (Darley & Gross 1983).

The perception of in-group and out-group behaviour was significant in Hospitals Three and Four with the opening of the new Hospital Four in 1997. There was limited communication between the two hospitals and few facilitated group meetings in either hospital when the change was initiated. The staff in both hospitals disliked the other. To reduce the inter-group conflict, there was a change in the corporate governance structure to ensure equal representation from both hospitals on committees. Management used the governance structure as the main mechanism to deal with inter-hospital conflict.

According to one manager in Hospitals Three and Four, the best way to deal with inter-group conflict was through meetings. The manager stated: "*I've found the best way is to get all players in the room and sort things out, as there has been a lot of game-playing by staff through all the issues we've been through over the years*". The manager felt it was not constructive to have staff talking behind each other's back with "*he said, she said type conversations*". Meetings were held where everyone spoke openly and freely about their concerns. The manager stated: "*I always go in with the goal of what we're trying to achieve with the change and keep focused on that. But I let everybody have their say, then go back and say this is where we want to go, these are what your issues are: how can we reach a compromise? I try to get a compromise*".

As with Hospitals One and Two, management found there was conflict directed towards the executives, and inter-group conflict because of unwelcome movements between wards by staff. Individuals had an established skill set in one area and found it difficult to move to other wards and between hospitals. According to the manager: "*Those people who weren't dealing with the ward moves have left, and those people that have managed to deal with it, well, are still moving wards*". Staff in Hospitals One and Two had trouble moving between wards, but were forced to accept the situation to retain their positions.

As stated above, there was still a "*them versus us*" attitude between Hospital Three and Hospital Four. According to one manager, around one per cent of staff believed the two hospitals competed against each other and only a minority of the staff had trouble with the changes – only two out of a thousand were known to dislike both hospitals. So, the majority of staff were happy to move between the two hospitals according to their skill level and the hospitals' requirements. According to Fisher (1986), there were three criteria for evaluating the success of any conflict management method: (i) good substantive outcomes; (ii) improved relationship, so that future differences were handled more collaboratively; and (iii) general efficiency of the method. All three points were demonstrated in Hospitals Three and Four.

Hospitals Three and Four reduced their inter-group conflict by maintaining standards across both facilities (Fisher 1986). They standardised policies, procedures, practices and paperwork and maintained uniformity between both institutions to allow the staff smooth and easy movement between them. This avoided some of the inter-group conflict experienced by staff in Hospitals One and Two. The managers and executives in all four hospitals developed uniform methods of work and procedures, which alleviated many of the inter group conflict situations experienced during the organisational changes.

Ashforth and Mael (1989) stated that an organisation was one comprised of sub-units, in which members of each share a social identity specific to their sub-unit. Social Identity Theory (SIT) assumed that much inter-group conflict stemmed from the very fact that groups existed (Tajfel 1982). In SIT it was argued that:

a) Given the relational and comparative nature of social identifications, social identities were maintained primarily by inter-group comparisons.
b) Given the desire to enhance self-esteem, groups sought positive differences between themselves and reference groups.

According to Turner and Brown (1978) in-group members adopted more extreme positions after comparison with an out-group than with fellow in-group members, and members preferred and selectively recalled information that suggested inter-group differences rather than similarities (Ashforth & Mael 1989).

Managers in Hospitals Three and Four attempted to reduce inter-group conflict by evaluating and alleviating the conflict in an "*environment of tolerance*". The conflicts were discussed at the nurse unit manager level – middle managers – and according to the executives it was "*up to them to manage their teams*". Conflict was resolved not by mediation, but by negotiation, where staff and management attempted to find common ground, and similarities could be found and built upon (Miller & Engemann 2004). Within a new system of service integration (or complementary services) the staff in Hospital Three undertook shift swaps to maintain skills. Management tried the "*skill enhancement line*", whereby staff were located in a department for three months to developed skills in that area, and were then able to successfully move between hospitals. This skill-enhancement process reduced inter-group conflict between departments and hospitals.

To reduce inter-group conflict, Hospital One executives believed "… *you start on a very basic level and then you work up through the management levels*". However, dealing with conflict was more about "*nipping it in the bud straight away*", and talking to the person involved as soon as possible after the incident. Another way of dealing with conflict was through third-party interventions (Keashly, Fisher & Grant 1993). Keashly et al (1993) proposed to de-escalate inter-group conflict by differentiating the underlying assumptions of the members involved. Process-oriented approaches, such as third-party consultation (Fisher 1983), tried to de-escalate conflict by emphasising the subjective and focusing on the basic relationship between parties, their attitudes and their perceptions.

Third-party intervention was used to de-escalate conflict in Hospital One with the development of a "*grievance policy*". According to management, the normal procedure for instigating the policy was "*… if there is a problem, it's between the two staff members, or if a staff member comes to me, I try to deal with it. If there's not going to be a result, then I need to speak to the ER manager who then brings in the person, and the person is allowed to have a union representative there if they need to speak to them, and we try to deal with it that way"*. This manager recalled only one instance where an ER manager was involved: the employee received a warning letter and, subsequently, the union became involved. According to manager, the situation was resolved, but the employee "*wasn't very happy for a while*".

In contrast to the hands-on approach in Hospital One, the psychologist in Hospital Two found that staff cooperated and handled their problems within the departments. He was available to act as a mediator if required (Labianca, Brass & Gray 1998), but noted that the business unit managers were involved in resolving conflict and few situations escalated to the stage where higher authority was involved, or where he was required to mediate.

Keashly, Fisher and Grant (1993) stated that interactions or process-oriented approaches such as third-party consultation (Fisher 1983), took a more subjective emphasis, focused on the basic relationship between the parties, their communication, feelings, attitudes, and perception of each other and of the conflict. It was assumed that a re-evaluation of perceptions, attitudes, behaviour, and priorities facilitated a more collaborative and integrative approach to the resolution of the more objective issues (Burton 1982).

Many theorists (Fisher 1972, 1983; Mitchell 1991) viewed the sources of conflict as both the incompatibility of goals and values (objective or realistic conflict) and the misperception and misunderstanding between the parties (subjective or unrealistic conflict). Misunderstandings (Keashly, Fisher & Grant 1993) between parties can have disastrous consequences as the manager in Hospital Two discovered. The manager lost confidence in the new executive because of conflicting stories told by staff and the executive and staff did not accept their new jobs. The manager found that, staff did "*… take part of the tasks they're given, decide which part of the task they will do, and they will only do it the way they've always done it in there*

old departments". This reluctance to accept new ways of working was found throughout the hospital and caused considerable conflict between management and staff. The manager also found the executive did not support her efforts to change the work structure.

More resentment and insecurity for doctors and staff was caused in Hospital Two when departmental leaders were deployed to other areas in the hospital. The doctors were concerned because experienced staff were removed from the wards and younger staff moved into leadership positions. Many older staff refused to lead the wards on particular occasions due to being removed from their leadership position resulting in no leader actually being in charge. Lanzetta, Haefner, Langham and Axelrod (1954) examined the effect of situational threat on group behaviour. Threatened groups – like the doctors – became less task-oriented, less forceful, and less active in attacking the problem than non-threatened groups. When compared to the no-threat conditions, it was possible that at moderate levels of threat, their problem solving abilities may be enhanced (Rempel & Fisher 1997). The doctors were concerned about the level of experience of many ward leaders, and returned to old work habits because of the risk to patients. For doctors, the situational threat in the wards was extreme, but many managers felt threatened by the unilateral changes made by the doctors.

Theatre staff were another group in Hospital Three who felt threatened and caused anguish for the management. This group were dismayed when they lost their emergency theatre work to Hospital Four and they personalised their anger. To overcome this, management formed a committee and developed a trial for theatre staff encompassing both Hospital Three and Four. Six months into the trial, the theatre staff at both hospitals worked together as a unified team. The development of a new structure eliminated much of the inter-group conflict and many staff were "*happy to staff a list at Hospital Four*".

Janis (1972, 1982) defined group-think as a concurrency-seeking tendency in highly cohesive and insulated groups. There were three antecedent conditions facilitating the appearance of group-think: (i) a highly cohesive group; (ii) organisational structural faults: insulated groups, directive leadership, lack of norms requiring methodological procedures and homogeneous membership; and (iii) a provocative situational context: high stress from external threats, low

hope for a better solution than the leaders could provide and low collective self-esteem. These conditions were proposed to lead to the symptoms of group-think. The symptoms had a negative impact on decision-making, and the result of this sequence was ineffective decision-making performance by the group (Rempel & Fisher 1997). This definition seems to apply to the reactions of the theatre staff at Hospital Three.

Janis (1972, 1982) theory of group-think was also demonstrated by staff from Hospital Three who were originally treated warily when doing shifts at Hospital Four and they reciprocated the treatment with Hospital Four staff. Both managers and staff felt the resistance to move between the centres, and this included the reluctance to transfer patients from one hospital to another. Hospital Three staff felt they had failed professionally by transferring patients to Hospital Four for surgery – they resented and resisted these transfers. Management dealt with their attitude through numerous group and individual meetings. Despite considerable defensiveness from staff, many conflicts were eased. These feelings of resentment and conflict were typical of the findings of Miller and Engemann (2004), and Rempel and Fisher (1997).

In spite of the organisation's efforts to control conflict, management in the four hospitals could not control external situations that influenced the inter-group conflict. Staff and managers behaviour was largely constrained by neighbours, friends and family, regardless of group membership (Takacs 2001). People did not participate in collective action in isolation, but collectively with friends and neighbours (Opp & Gem 1993). When they decided to act, they were assured of the other's participation. If friends and neighbours did not participate, neither did they (Oberschall 1994). This way, each dyadic relation was subject to playing local coordination games, but in a form that was inseparable from the choice to participate in collective action (Morris 2000). If surrounded by extremists, people were highly constrained to participate (McAdam 1986). On the other hand, peaceful friends or friends from a rival group provided enough confirmation pressure to avoid contributing to the harmful collective action. Such a mobilisation process was called *block recruitment* and provided the micro foundation for collective action like demonstrations (Oberschall 1973).

5.4.2 Summary.

The previous section provided a detailed discussion of the issues involved in dealing with inter-group conflict. The current research highlighted that when attempting organisation change programs, success partly depended on the organisation including a mechanism for dealing with inter-group conflict.

The current study showed in all four hospitals, members of staff had experienced, or were aware of, inter-group conflict. Staff were able to recall episodes of inter-group conflict occurring when units were merged, staff were redeployed, and new staff joined the teams. Staff displayed the typical *us-versus-them* attitudes as shown in the literature.

As can be seen from this current research, the four hospitals attempted to solve inter-group conflict by communication and by meeting with the staff involved as quickly as possible. The four hospitals leaders were willing to use the skills of an independent third party when the conflict was extreme. However, management and executives did not establish uniform conflict resolution plans, and managers individually developed their own system of dealing with conflicts. It was important that a more structured approach to deal with inter-group conflict be established in the four hospitals.

Only in Hospitals Three and Four did the managers establish an equal partnership with staff to minimise rivalry and to reduce the inter-group conflict during the organisational change. In contrast, the management at Hospitals One and Two did not include the staff in decision-making processes during the change periods and experienced significant inter-group conflict.

The current research and interviews indicated the need for the inclusion of *inter-group conflict* in the transformational leadership models. It showed how the staff used external conflict coping sources like families and outings, and joined clubs and societies. Staff and managers in all hospitals also stated that, on occasions, they were left to deal with the inter-group conflict on their own and make their own decisions on how to handle it. Often, managers instructed staff to sit together and sort the situation out between themselves. There were few formal structures in place for dealing constructively with inter-group conflict. It is important

in organisations for managers and leaders to develop procedures for solving inter-group conflict.

The following section addresses the additional components that appeared as sub-themes throughout the research.

5.5 Further components

The development of the four components studied involved analysis of a wide range of topics within the one area. The likes of communication can involve not only verbal but non-verbal communication and there are many categories within those wide groupings. As such, it was important to identify any sub-themes that emerged from the research.

The current research from this embedded case study and the reviewed literature demonstrates that within the four components several sub-themes emerged. These sub-themes appeared in each component and were repeatedly voiced by the interviewees. The sub-themes included *trust*, the *use of psychologists, the intranet* and the *use of rumours* within the hospitals. Each of the sub-themes was highlighted within the literature as being important for undertaking successful change and the research demonstrated the need for these additional components. These four additional components should be added to the existing four components as follows:

* communication
* team building
* stress and coping
* inter-group conflict
* trust
* use of psychologists
* use of rumours
* intranet

These additional eight points cover a wider range of issue for leaders to take into consideration to improve their success with organisational change programs.

5.6 Conclusion

The previous four sections provided a detailed analysis of the literature and case study and found support for the potential extension of transformational leadership models. The analysis indicated four components of communication, team building, stress and coping and inter-group conflict could improve transformational leadership that did not currently address these particular issues. Besides the four components analysed the research also discovered an additional four components of trust, psychologist, rumours and intranet to be included in the extension to transformational leadership models. This will result in an additional eight components being included in the extension to transformational leadership models.

In each of the three models analysed, several of the eight components have been referred to indirectly but have not been addressed fully. As such in the Bass & Avolio (1994), model which considered four I's or principles of transformational leadership, that is individualised consideration, intellectual stimulation, inspirational motivation and idealised influence, the eight components would be distributed through the four I's above.

However in Kotter's (1990a), eight-stage process of change leadership very few of the eight components have been addressed and this model could have the new eight components added as Stage 9 and titled *Supporting The Process.*

The Kouzes and Posner (1987, 1995) model could be considered with the new proposed principle called S*upporting the Process*, which consists of the eight new components described above. The inclusion of these eight additions could potentially become an integral component of organisational change programs and the adoption of these components should improve the chance of a more successful organisational change. Figure 5.1 shows the principles of the original Kouzes and Posner (1987, 1995) framework and how by including

Supporting the Process the model could be modified and improved for successful organisational change.

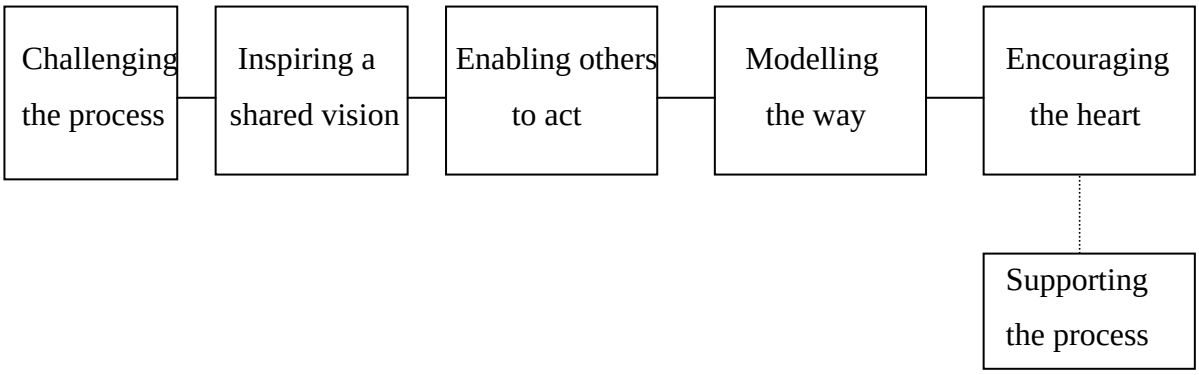

Figure 5.1 Kouzes and Posner (1987, 1995) Original Framework

The final connection in Figure 5.1 can become a solid line to formalise the status of *Supporting the Process* when undertaking a successful organisational change program (See Figure 5.2).

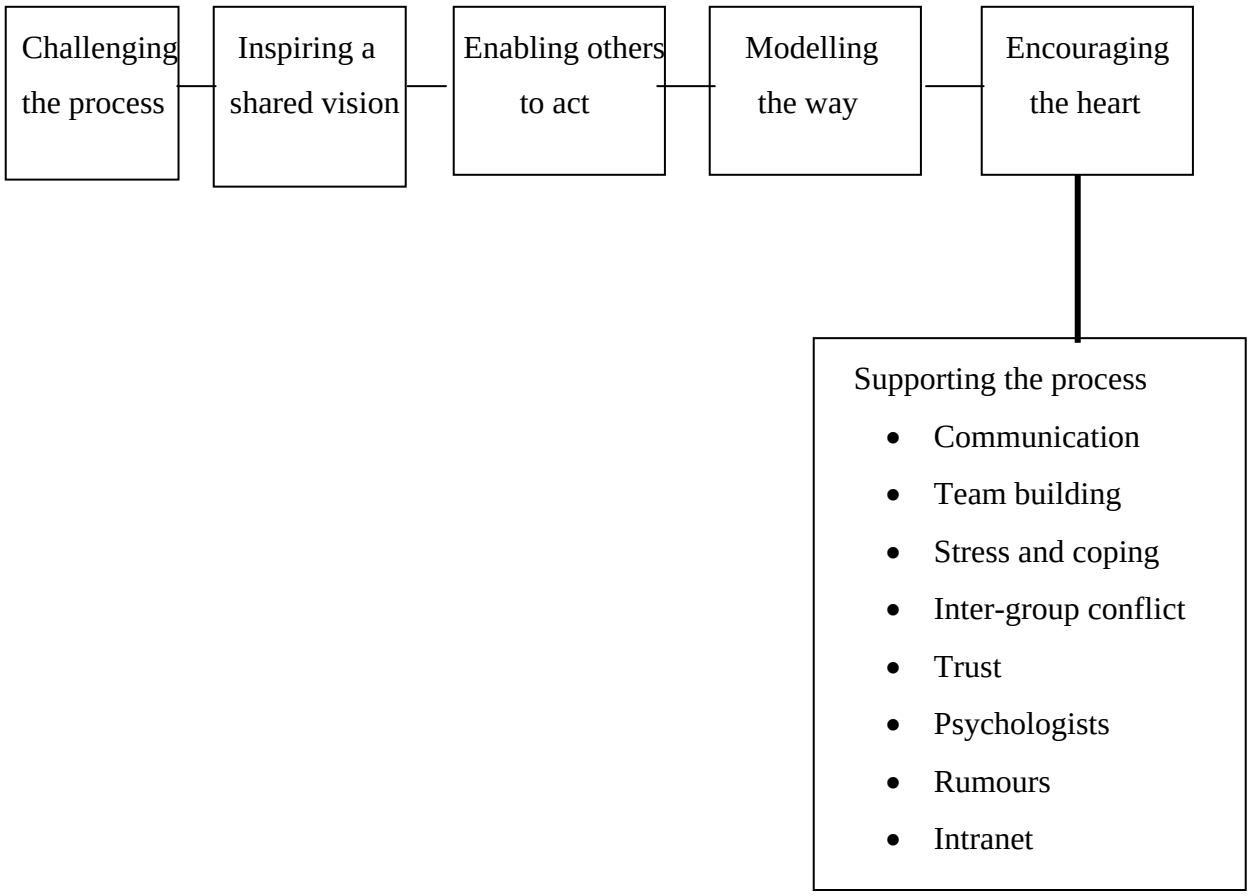

Figure 5.2 Kouzes and Posner Final Extended Framework

As the example has shown the current research revealed compelling evidence to support the inclusion of *Supporting the Process* in extended transformational leadership models. The transformational leadership models when tested showed that when undertaking organisational change, staff and managers were not given appropriate tools for supporting the changes. The current research discovered the missing components required for extending the model to provide a more complete model of change and improved the success of the change. During organisational change, leaders only progressed to the stage of implementing ideas and projects. Once these were reached, many leaders or change experts left the organisation and moved onto the next project. The staff and managers were left behind without support or guidance to continue with the change programs. Often, managers and staff were incapable of

maintaining the changes and the organisations returned to their original ways of operating. To overcome these problems, the research included the concept of *Supporting the Process* with the four components of communication, team building, stress and coping and inter-group conflict. These components add value to the model and provide guidance for leaders to complete the change cycle.

When undertaking this study and developing this new principle, several sub-themes emerged that were not originally considered in the study and they have been included in the new model. These issues show that there are several limitations to the new framework and are to be investigated in the future. The four issues include the use of rumours, the development of trust, the availability of the intranet to staff and the need for psychological support during organisational change.

Overall, this current research revealed that the eight components of communication, team building, stress and coping, inter-group conflict, rumours, trust, intranet and psychologists should be included in the development and implementation for a better chance of a successful change management program.

CHAPTER 6

Conclusion, Implications, Limitations and Further Research

6.0 Introduction

This chapter concludes the thesis by addressing the implications for theory and practice of organisational change, as well as discussing the limitations of the current research and suggested future research. This current study sought to address whether there was a need to include factors relating to the effect on change on people in transformational leadership models.

6.1 Implications for theory

The aim of the study was to answer the following questions:

1. What communication skills do transformational leaders use in the organisational change process?
2. How do transformational leaders foster change in the organisation through team building?
3. How do transformational leaders manage the high levels of stress and coping that occur during organisational change?
4. What do transformational leaders do to manage inter-group conflict during organisational change?
5. Are there other components that need to be added to the transformational leadership models not previously identified?

To find answers to these questions, current theory and practice was reviewed. The research established there were differences between the theory of various models (Bass & Avolio 1994, Kotter 1990a, Kouzes & Posner 1987, 1995) of organisational change and the reality of implementation within the hospitals studied. The existing theories seldom acknowledge the post organisational change support needed for employees hence, this study provides a

contribution to the body of knowledge. More specifically, this present study documents the way executives and managers undertook organisational change in their hospitals and their application or failure to address a number of factors: communication, team building, stress and coping, inter-group conflict, rumours, trust, intranet and psychologists which could be formed into one principle called *Supporting the Process.*

In addition to the contribution to theory, the study highlighted several implications for practice which is discussed in the next section.

6.2 Implications for practice

It is proposed the potential *Supporting the Process* should be incorporated into the extended transformational leadership models to develop a more complete and successful model of organisational change. The eight components of *Supporting the Process* - communication, team building, stress and coping and inter-group conflict, rumours, trust, intranet and psychologists were established as major factors for inclusion in management strategy when undertaking organisational change. The new principle, *Supporting the Process* suggests that employees should be actively supported by the four components while they transit the change process, to increase the potential of a more successful organisational change.

The first component of *Supporting the Process* was *communication*, an important aspect of any successful leadership and organisational change program as indicated by this study. The management in Hospitals One and Two did not effectively communicate with staff, resulting in employees having little understanding of why the changes occurred, or what their role in the change process was likely to be. The staff in Hospitals Three and Four, however, with a transformational leader were involved in the changes with good communication between the staff and the leaders. Staff were allowed to participate in the decision-making and to take responsibility for the implementation of the changes.

The second component of the research involved the development of *team building*. Team building within Hospitals Three and Four was effective because staff were involved in the

planning and implementation of decisions which led to quicker and more successful organisational change. In Hospitals One and Two, staff were denied any opportunity for combined teamwork, with many working as individuals rather than as a team member. This resulted in staff becoming disillusioned about their roles and responsibilities causing increased discontent and staff resignations.

The third component investigated in this study was *stress and coping*. As highlighted in Hospital Two, staff faced significant disruptions with the merging of departments, incorrect information conveyed to staff from management, change of ownership and reduced levels of responsibility for many of the staff. In Hospitals One and Two, the executives provided a psychologist for staff to consult on a voluntary basis. This coping facility was not well utilised resulting in poor coping of stress by the staff. Absenteeism increased, tension increased within the hospital staff which led to considerable patient comment and discontent.

In contrast, the staff and managers in Hospitals Three and Four cooperated to alleviate stress by providing suitable coping methods with special training and support during the changes with staff being able to talk to management, obtain counselling and the development of solid coping techniques. It is evident from the current research that, leaders in the public hospitals Three and Four better supported their staff with more stress and coping facilities, than the private Hospitals One and Two.

Inter-group conflict is the final component of the proposed principle. The leaders and managers in Hospitals Three and Four experienced considerable inter-group conflict during the changes as a result of the merging of departments in Hospital Three and the transfer of staff between the two hospitals. Overall, the leaders in Hospitals Three and Four provided greater support for staff when dealing with inter-group conflict than the leaders in Hospitals One and Two resulting in less conflict with staff in the hospitals and a better outcome to the organisational change.

In addition from the interviews with the staff in all four hospitals an extra four components were discovered. These four components were rumours, trust, intranet and the use of a psychologist and should be added to the original four components in an extension to transformational leadership models.

6.2.1 Summary.

As the research showed, the role of leaders during organisational change has a significant impact on the staff and the degree of success of the change program. Specifically, the components of communication, team building, stress and coping, and inter-group conflict were addressed and evidence found to support their inclusion of these and four additional components of rumours, trust, intranet and psychologists in transformational leadership models.

The next section highlights the limitations of the study and provides suggestions for future research.

6.3 Limitations

The current study had a number of shortcomings. First, the research used only qualitative data. The use of grounded theory was a restrictive methodology as interviewees were left to develop topics and concepts without direct questioning. Also, a broader study – using surveys and undertaking a quantitative analysis – would assist theory development and provide additional evidence to support the principle of *Supporting the Process.*

Second, despite using the grounded theory approach, several direct questions were required to provide a basis for analysis. Once these questions were answered, issues were able to emerge with more general probing questions.

The third shortcoming of the research was the choice of organisations to study. Four organisations were used: one large public hospital in the country; one small public hospital in a rural district; one large private hospital in the city; and one small private hospital in a rural

district. A larger sample of hospitals would have provided greater conformity in the results. Moreover, the study was limited to Queensland, though a broader interstate comparison would provide more in-depth knowledge of hospitals and industries undergoing organisational change- this is subject for further studies.

Fourthly, a limited number of staff were interviewed, and because of the political situation in the Queensland hospital system, only a restricted number of executives and managers were available for interview in the available time period. Further investigation with all levels of staff would greatly assist the findings and theory development in the study.

As stated previously, there are several concepts that have been identified in the current research. These issues will develop the model further and will provide the basis for future research, and is addressed in the next section.

6.4 Further Research

The current study proposed the four components be included as an extension of the transformational leadership models by including the components of communication, team building, stress and coping and inter-group conflict. The current study discussed a set of principles or processes needed to be developed to better manage the four components analysed. These concepts will be studied further using embedded case studies with research into the development of *Supporting the Process* in other industries that have recently undertaken considerable change.

The current research has indicated that besides the four components of *Supporting the Process,* other issues emerged as important issues for undertaking successful organisational change. The other issues included four new components of rumours, trust, intranet and use of a psychologist during organisational change. An issue that repeatedly emerged in each component was that of trust. Employees referred to losing trust, losing faith, or needing to develop trust again in management to successfully complete the changes.

In addition to a component of trust, the use of rumours was a recurrent theme throughout the interviews and indicated that staff and managers depended on receiving and supplying information about the changes through the rumour mill and from external sources.

The new *Supporting the Process* framework should include the eight components of communication, team building, stress and coping, inter-group conflict, rumours, trust, intranet and use of psychologists.

6.5 Conclusion

This chapter discussed the implications of the study in both theory and practice for executives and managers undertaking an organisational change program. Following a discussion of the theory and practical applications to a change program, the limitations of the study were highlighted as well as the conclusions and areas of possible future research identified.

In summary, the current study showed that an organisation undertaking change needs a transformational leader who can inspire staff with vision, ability and words of encouragement. Leaders require effective and appropriate communication as a major component for change as well as developing teams, solving inter-group conflict, and reducing stress through suitable coping strategies.

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Appendix 1

Thank informant for making the time to participate in the interview. Tell informant that the interview should take about 1 hour.

1. **Introduce Researcher:**
    - CJ is undertaken this research as part of a Doctor of Business Administration Degree through Southern Cross University.

2. **The title of the thesis** is "The Human Face of Organisational Change" and I am interested in the communication, inter-group conflict, stress and coping techniques and team building characteristics of the change that has occurred in your organisation.

   Following the interviews I will be documenting my research findings and I will forward a copy of these to you for your comments.

3. **Consent Issues –** The Informed Consent form and the Information Sheet I have given you detail a number of areas I would like to go through before we start the interview.

   (Go through all sections of both documents with the informant)

   Are there any specific questions you have?

   Once all questions have been answered ask the informant: Are you happy to progress with the interview?

   If the answer is no, address issues of concern until the informant is happy to proceed. If agreement cannot be reached to proceed, thank the informant and close the discussion.

   Once the informant is ready to proceed ask them: I'd like to get the Informed Consent form signed by both of us before the interview starts. Could you sign here on both copies (point to the appropriate space) and then I will sign. I will give you one copy to keep for your records and I will keep one.

4. **Tape Recorder**. I'd like to tape record what you say so I don't miss any of the interview. I don't want to rely on my notes and miss something that you say or inadvertently change your words somehow. So if you don't mind I'd very much like to use my recorder. If at any time during the interview you would like to turn the tape off, please advise me and I will stop the tape.

   The tape will be labeled with a code only and will be stored in a safe place in my office. The tape is for my purpose only and will only be heard by me. Following the transcription of the tapes and the completion of the research, the tapes will be kept securely locked away for five years then destroyed.

Are you happy for me to use the tape recorder?

5. **start questioning.**

6. **end of interview.** Can you please summarise your key points

7. **Thank informant.** I'd like to thank you for being so generous with your time and your thoughts today.

   I'd like to reiterate that everything you said will remain confidential and any the only person who listens to the tape and the tape will be destroyed on completion of the research and acceptance of the thesis.

Key issues raised

Thoughts/reflections

Appendix 2

Interview Planner

Researcher: Camille Jackson Date:_____

Time Interview Started: _____ Time Interview completed: _____

Informant name and job title: _____

Company Name:_____

Code on Tape:_____

Summary to be completed following interview

What were the main issues or themes that arose during this interview?

Summarise the information gained in each of the key areas

- Communication
- Inter-group conflict
- Team building
- Stress and coping

Anything that stuck me as important, interesting, illuminating or salient in this interview?

Appendix 3

SOUTHERN CROSS UNIVERSITY
INFORMED CONSENT FORM

My name is Camille Jackson and I am studying for a Doctor of Business Administration at SCU. I am researching the effect of organisational change on an organisation and its employees. I am investigating change in general and then four specific aspects of change namely communication, inter-group conflict, stress and coping and team building. These aspects are a continuation of a study I conducted several years ago for my Masters Degree and I am currently adding new dimensions to the model to improve its applicability to the procedures used by executives undertaking organisational change. Consequently I have titled the project The Human Face of Organisational Change. Thank you for participating in the study and if you are happy with the study could you please read and sign the consent form provided.

Name of Project: The Human Face of Organisational Change.
You are invited to participate in a study of communication, intergroup conflict, teamwork and stress and coping techniques. I hope to learn how each of the techniques were used and how they impacted upon your work environment and you personally. I also hope to discover what techniques the leader of the organisation used to alleviate any problems you may have had during the change process.

Procedures to be Followed:
I will be asking several open ended questions which will allow full and honest answers from you. The interview will be approximately 1 hour in length and will be tape recorded if you agree. The interviews will be conducted in your office at the organisation where you work. If you would prefer to move from your office to be interviewed, a meeting room will be used in the organisation. I will be tape recording the interview and a transcript will be provided to you if you wish to see the interview. All tapes and transcriptions will be securely held for a period of five years and all identifying aspects will be removed from the transcriptions. It is possible that a follow up study may need to be undertaken 6 months later after my collation and analysis of the results of all the interviews.
No remuneration will be provided to you.

Possible Discomforts and Risks
There will be no possible discomforts or risks to you as the interviews will be anominous and the organisation will not have access to your name or any details of the interview. The only inconvenience to you will be your absence from your duties and the necessity to have another person cover for you during the interview. As participants you will not be leaving your place of employment for the interviews. If you do not have you own office, then a meeting room will be used for the interviews.

Responsibilities of the Researcher

Any information that is obtained in connection with this study and that can be identified with you will remain totally confidential and will not be disclosed to any other member of your organisation.

Interviews will be tape recorded only after obtaining your approval. As participants in the study I am advising you that the tape will remain in the possession of myself and will be transcribed personally. Tapes and their transcriptions will be locked in a secure and safe location. The tapes will be erased at the conclusion of five years and the transcriptions shredded, the time period determined by the ethics committee of this university.

Responsibilities of the Participant

I would appreciate it if you would fully disclose any information you feel is relevant to the research without fear of your identification within the organisation. As a participant in the study your identity will be confidential and your superiors will not be notified of who is participating in the study. All tapes will be transcribed by myself and the transcribed documents will be kept in a safe location away from the organisation and executives of your organisation.

Freedom of Consent

If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. As this study is of a voluntary nature and as a participant in the research you have decided to volunteer your time and assist in the research. I want you to clearly understand that your participation in my research program is purely voluntary and can you assure me that you have not been coerced to participate in any way.

Inquiries

If you have any questions, please feel free to contact me.

Supervisor Details

Associate Professor Stewart Hase, Southern Cross University, shase@scu.edu.au, : 02 66203166

Researcher Details

Camille Jackson, 02 66203166, or email, shase@scu.edu.au, who will be happy to answer any queries you may have.

OR if you have any problems associated with this project, please contact:
Mr John Russell
Ethics Complaints Officer
Graduate Research College
(02) 6620 3705
jrussell@scu.edu.au

Please sign below to signify your agreement to participate in this research and return it to me. You will be given a copy of this form to keep.

I have read the information above, and agree to participate in the study entitled “The Human Face of Organisational Change”. I am over the age of 18 years.

Name of Subject:

Signature of Subject:..... Date: .....

(Signature of parent or guardian if subject is under 18 years of age)

Name of Witness *(who shall be independent of the project)*

Signature of the Witness: ..... Date: .....

I certify that the terms of the form have been verbally explained to the subject, that the subject appears to understand the terms prior to signing the form, and that proper arrangements have been made for an interpreter where English is not the subject's first language. I asked the subject if she/he needed to discuss the project with an independent person before signing and she/he declined (or has done so).

Signature of the researcher:..... Date*:* .....

Appendix 4

Southern Cross University
Information Sheet

Organisational change, leadership, communication, team building, stress and coping and inter-group conflict.

Description of the Research Project

The Human Face of Organisational Change

Research is being conducted in a number of hospitals who have undertaken change in the last few years.

This is a leading edge independent research project that will provide valuable and up to date information on leadership and organisational change techniques available. The project will look specifically at the roles of communication, inter-group conflict, team building and stress and coping techniques used in the organisation.

Participation

You are invited to participate in this study. Participation is entirely voluntary. You are free to withdraw your consent and to discontinue your participation.

Researcher

The research project is being conducted by Camille Jackson as part of a Doctor of Business Administration degree, with the thesis title being shown above.

The study is supervised by Associate Professor Stewart Hase from Southern Cross University. We are both happy to answer any questions you might have about this study and can be contacted on the following numbers:

Camille Jackson
(02) 6620 3166

Associate Professor Stewart Hase
DBA Coordinator and Director of the Southern Cross Institute for Action Research
(02) 6620 3166 or 0417 255 995

Procedure

The study will be conducted through interviews with a number of executives in each of the research organizations. Each interview should take approximately one hour.

To conduct a number of interviews with executives, the participation of the executives within the organisation will be co-ordinated through the contact nominated by the Chief Executive Officer. No executive will be contacted without prior approval. If the organisation has specific approval mechanisms that need to be adhered to then all necessary steps will be taken and permission gained prior to any contact.

The interviewees are asked to make themselves available for an interview at their convenience, during October, November 2004.

The researcher will work through one main contact within each organisation to ensure that the organisation is kept up to date with the activities at all times.

Confidentiality/Privacy

The names of all interviewees and the participating organizations will remain confidential and will not be disclosed to any third party. In addition, the contents of each particular interview will remain confidential between the researcher and the interviewee.

Any reports on the research findings will be labeled as 'Executive A', 'Executive B', 'Organisation A', 'Organisation B'.

Feedback to Participants

Following the research the interviewees will receive a report of the findings from the research and will be asked for their feedback and comments.

Your interest in this research project is very much appreciated.

Appendix 5

14th October 2004

PO Box 2033
ASCOT 4007
QUEENSLAND

Chief Executive Officer

Dear Sir,

I am a Doctorial student at the Southern Cross University and my thesis has been developed from my Masters of Management research at The University of Queensland. One of the requirements of my Doctorial research is that it is a real world application rather that an academic one.

My area of research and interest is around Leadership and Organizational Change and in particular I am researching four aspects which I believe to be missing from the traditional Kouzes and Posner framework.

These are:

- Communication
- Team Building
- Intergroup Conflict
- Stress and Coping.

In addition to the above four hypotheses I have developed, I will also be testing the original leadership framework developed by Kouzes and Posner. In previous research this model has been a very successful tool for leaders to implement an organizational change program and improve organizational efficiency.

I am writing to you to request your permission to undertake the research within your hospital. This will be undertaken by me in the form of interviews lasting around one hour with appropriate executives and staff.

The Ethical permission granted to me requires me to maintain complete confidentiality and I will be the only person dealing with the information. No names or identifying company details will be contained in the thesis and no third party will have access to the information. I will, however, be happy to provide you with a summary of the findings of my study if you wish.

I would very much appreciate your assistance in my research of Organizational Change.

I will phone you in several days to discuss your organizations participation in my study.

Yours sincerely

Camille R A Jackson
BA (Psych); BComm; MBA (advanced); MMan.

Ph: 07 3268 2383
Fax: 07 3268 3791
Email: camillejackson6@aol.com

Appendix 6

Can you tell me about the organisational change your hospital has been through in the last 12-18 months?

I am looking at how your hospital handled communication, intergroup conflict, teambuilding, stress and coping during your recent organisational change. Could you tell me how the hospital has undertaken those four topics?

Probe questions if needed.

How has this change been communicated to you?
Tell me about intergroup conflict during the organisational change?
Tell me about your teams and teambuilding in the organisation during the change?
How did your organisation handle stress and how did you cope with that stress?

Round two interviews:
To be determined after analysis of round one.