

Chapter Four

CULTURAL FACTORS: THE EXPERT CULTURE AND THE COLLECTIVE CULTURE

Great discoveries and achievements invariably involve the co-operation of many minds.

Alexander Graham Bell

He who has a "why" to live for can bear most any "how."

Friedrich Nietzsche

CORPORATE CULTURE IS the personality of the organization. Just as all human beings have personalities, all organizations have a corporate culture. Whereas personality is the basis for our behavior and decision making, corporate culture is the context for organizational behavior and decision making. Our personalities are the result of a long process of socialization typically begun by our parents, who had a set of beliefs or values that they felt were important for us to learn and use to guide our life's decisions. Our parents systematically taught us these values through lessons and experience reinforcing those specific behaviors that were consistent with their values and disciplining behaviors that were different from their views of good.

Essentially, our personality is the sum of experiences that reinforce or weaken behaviors that reflect someone's notion of good and bad, respectively. The degree to which our behavior is consistent with a set of espoused values equals the strength of our personality. A human being should have only one personality; the more personalities a person possesses, the more dysfunctional the individual is in society. The dynamics of personality development shares many similarities with the creation of a corporate culture.

CORPORATE CULTURE

All organizations have at least one corporate culture—the challenge is to have just one culture, not multiple corporate subcultures. Organizational behavior defines the culture of the organization. In its simplest form, corporate culture is the way things are done. Healthcare organizations each have a set of espoused values. The degree to which the behavior displayed on a daily basis by all, or most, employees demonstrates the strength of the corporate culture. Therefore more corporate culture is *espoused values demonstrated by behaviors*. The Walt Disney Company exemplifies a company with a strong corporate culture. Regardless of whether you visit Disney in Florida or California, the level of service of the staff is consistent and predictable.

Behavior is driven by a set of values. If the organization's values are not strong enough to drive individual behavior, the individual's value set is the only basis upon which to define and control desirable behavior. Values, manifested by behaviors, define the strength of the culture. However, intangible factors come into play when creating or strengthening a corporate culture.

TANGIBLE AND INTANGIBLE ELEMENTS

All healthcare factors can be sorted into tangible elements and the intangible elements. Tangibles are those things that are fairly easy to measure. Intangibles are those elements that are more

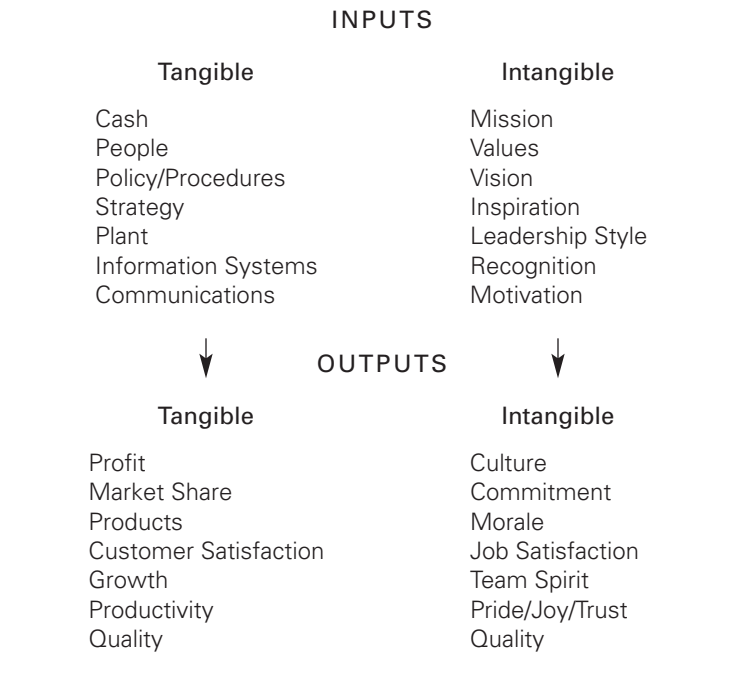
elusive to common measurement but more critical to organizational success. These tangible and intangible factors can be subclassified further into inputs and outputs. For example, on the tangible side, profit is an outcome—you cannot do a “profit.” When the business systems are structured so that you spend less than you make, a profit is realized. Another important dynamic among these factors is when the outputs are not at the level you wish (e.g., profit is less than desired), you must go to the inputs that most affect the particular outcome to discover how to alter them to arrive at the desired level. The same fundamental dynamics are imbedded in the intangibles.

Figure 4.1 shows the relationships between and among the main tangible and intangible elements of an organization. Intangibles have both inputs that directly and indirectly affect outputs. Culture is an outcome. You cannot do an outcome—you cannot do corporate culture. The input elements of mission, values, and vision, as processed through leadership, are the most critical. If mission, values, and vision are the ingredients in the recipe for a strong corporate culture, leadership is the quality of the chef who uses the ingredients. Without a great chef the best of ingredients will not come together for a delicious meal. Without the great leadership, the best mission, values, and vision statements cannot come together to produce a strong corporate culture. Leadership is the key and the bridge between leadership and the mission, values, and vision statements is *trust*. Figure 4.2 shows how trust holds the culture together.

TRUST

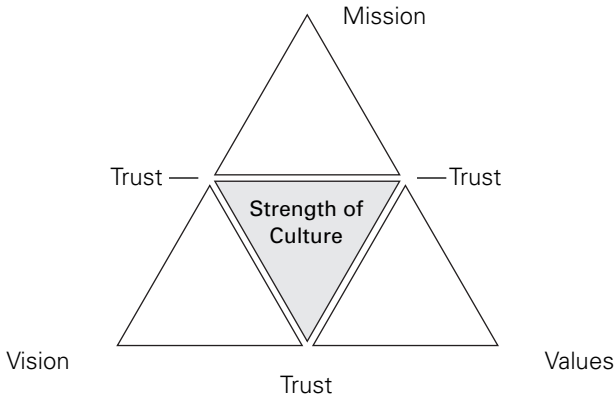
Trust is the glue that holds organizational culture together. Trust is defined as *the perception of honesty, openness, and reliability/dependability*. Trust takes a long time to develop and can be broken in a heartbeat. Trust increases as a function of meaningful interactions. The more frequently any group meets over those issues of importance to all, the more trust will be engendered.

Figure 4.1 Relationship Between Tangibles and Intangibles



Leaders involved in managing change with physicians consider trust as so important that they view it as a major strategic imperative. Trusting someone does not mean that you like or care for that individual. There is no correlation between seeing someone as honest, open, and reliable and liking that person. When trust and caring are feelings you have toward an individual, a nice combination results. But liking is not a prerequisite to trust. When dealing with physicians in the change process it is very important that trust be the focus of the interactions. If everyone ends

Figure 4.2 Trust and the Strength of Corporate Culture



up liking each other, that is wonderful, but not critical to the outcome. Trust is treated differently within collective cultures and expert cultures.

COLLECTIVE CULTURES AND EXPERT CULTURES

The most important factor in understanding how to manage change with physicians and other healthcare providers is the difference between collective cultures and expert cultures. Healthcare systems are comprised of both of these, and many times the difficulty in change management, and even conflicts, can be traced to the fundamental differences between these two cultural phenomena.

COLLECTIVE CULTURES

The collective culture is comprised of highly affiliative staff who embrace the mission, values, and vision statements of the organization. Each of these statements answers a question that is important to those who are collective by nature. The mission statement answers the question, What is our business? The values' statement answers the question, What beliefs underlie our decisions? The vision statement answers the question, Where are we going and how do we know we have arrived? These questions are important to healthcare professionals who are dominated by the motivational profile of affiliation and have progressed in their profession by working in a collegial manner with others. Nurses, therapists, administrators, and many support staff fall into this classification. Highly affiliated people tend to enjoy work environments that put others ahead of self, are trusting, and value loyalty. These professionals like to work in groups, tend to avoid conflict, are not high risk-takers, and tend to be very thin-skinned (i.e., easily injured psychologically). Collective cultures are most discussed in change management literature. However, healthcare has a very important and powerful group that does not conform to the definition of collectives. This group behaves like experts and prefers the expert culture environment. This group is physicians.

EXPERT CULTURES

Expert cultures possess very different characteristics and dynamics from collective cultures. Expert cultures do not need mission statements or value statements. Trust may or may not exist—indeed it usually does not exist outside a very narrow range of clear expectations for performance. Expert cultures are found in engineering firms, architectural firms, multispecialty law firms, and the profession of medicine. Expert cultures are characterized by individualized behavior that is motivated primarily by self-interest.

Unlike collective cultures, wherein affiliation is the major motivational influence, expert cultures are dominated by the motivational influences of accomplishment and power. The reasons people are attracted to collective or expert cultures are found in their respective socialization experiences. Physicians are experts, whereas, for the most part, other clinicians are collectives. Their chosen professions require very different work-life experiences.

Characteristics of an expert culture individual. Starting at a very early age, children who wish to become doctors compete for grades. Grade school and high school become opportunities to demonstrate academic and leadership potential. Selection to a prestigious college becomes an obsession. The choice of medical schools in turn will determine to a large degree the resident match. After completing residency and the medical boards, the decisions of where to practice and in what specialty has a lot to do with professional and financial success. There is no place or time in this more than 20-year process where success resulted from teamwork. At each point, success was determined by outperforming the competition. Achievement, risk-taking, stamina, intense focus, quick decision making, and personal accountability were some of the main characteristics that were consistently reinforced. Consensus building, interdependency, following orders, and sacrificing self-interest for the greater good are not often found in the socialization process of experts. A simple metaphor shows the difference between the expert culture and the collective culture.

A mythical description of physician team building potential is “herding cats.” A better description of an effective physician team is a golf team. The only way for the United States to win the Ryder Cup is for each member of the team to perform at his personal best. Compare this to winning the NBA championship. The Los Angeles Lakers were comprised of outstanding basketball players for many years before Phil Jackson took over as coach. However, until they learned to suppress their expert needs for

interdependency, they did not perform at their highest potential. Healthcare delivery is comprised of both experts and collectives. The challenge of leadership is to create an environment in which both cultures can manifest their needs for the greater good—serving the healthcare needs of the community. This means that change management strategies for collectives must include group work that is contextualized in mission, values, and vision. The change management strategies for experts (i.e., physicians) need to focus on a shared vision wherein the physician can see his or her self-interest manifest in the successful achievement of the vision. Self-interest versus group interest delineates the expert culture from the collective culture. An unusual example may be instructive—The Dennis Rodman Syndrome.

The Dennis Rodman syndrome. Former professional basketball player Dennis Rodman is an extreme example of how the expert's need to feed self-interest is his or her main motivation. Any other motivational interventions that do not incorporate personal (or in Rodman's case narcissistic) needs will fail. Dennis is an expert at one thing—collecting basketballs off the backboard.

When Dennis played with the San Antonio Spurs, the coach attempted to motivate him by trying to have him behave using the values of David Robinson. David Robinson is a wonderful human being—very caring and giving. Trying to make Dennis use the same values as David was doomed from the start. When Dennis moved to the Chicago Bulls, a very different approach was used by coach Phil Jackson. Coach Jackson understood that the only way to motivate an expert is to engage his or her self-interest. He told Dennis that if he collected basketballs off the rim and gave them to his teammate Michael Jordan, he would be paid an obscene amount of money. Phil Jackson never incorporated values into Dennis' motivational formula. The formula to motivate Dennis is the only one that works with experts: identify a common, shared vision in which the expert sees his or her self-interests being met when the vision is achieved.

Figure 4.3 Comparison of Collective and Expert Cultures

Collective—High Affiliative	Expert—High Power
Thin skinned	Thick skinned
Very sensitive to injury	High risk
Injure: commission or omission	Must win or L-L
Long memory for injury	Insensitive to collectives
Risk averse	Results versus process
Process versus outcome	Fast “clear” decisions
Change causes “FUD”	Self-interest first
High need for recognition	Like to lead
Conflict resolution motif	Conflict motif
<ul style="list-style-type: none"> • Denial • Passive aggression • Explosion 	<ul style="list-style-type: none"> • Direct confrontation
Malignant = Cynic/Victim	Malignant = Narcissism

NEITHER CULTURE IS RIGHT OR WRONG

Figure 4.3 outlines the differences between collective and expert cultures. An important point vis-à-vis collective and expert cultures is that there is no right or wrong with either of these motifs. A common reflex is to denigrate the experts’ desire to see their self-interest in the shared purpose and support those who work in groups with shared values. They are both unique to the socialization of the expert or the collective. These behaviors are “hard-wired” into the person. Wishing they were different is useless. Change leaders understand, and respect, the unique dynamics of both cultures and use the interactions that most fit the needs of the expert and the collective. Corporate culture is the context in which any change is perceived as good or bad. This

Figure 4.4 Culture Characteristics

	Aligned	Misaligned
<i>Collective</i>	Values-Based Behaviors Openness Innovation Joy and/or Pride Customer Satisfaction	Fear Uncertain Doubt Small Sub-Culture Minimum Behavior
<i>Expert</i>	Vision-Based Focus Collegiality Feel Respected Feel in Control Collaboration	Egocentric Economic Focus Personal Autonomy Conflict Anger

perception is a function of whether the individuals' motivation is influenced more by affiliation (collective culture) or accomplishment and power (expert culture). The main goal of leadership is to align the collectives and the experts. Figure 4.4 describes the reactions of aligned and misaligned culture.

CULTURAL FACTORS AND MERGERS

Problems often arise when trying to merge healthcare corporations that have different cultures. Too often merger decisions are based only on tangible elements such as increased market share, economies of scale, and decreased competition. However, while most mergers are executed on the basis of the tangibles, most failed mergers are the result of the intangibles—most often a clash of corporate cultures. Merging cultures is difficult when collective behaviors are the only behaviors considered. Mergers

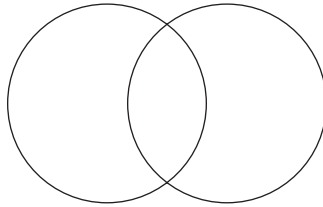
that include medical staffs and medical groups present a complex dimension to the process.

Collective cultures must create new mission, value, and vision statements. The merging entities must design ways to communicate these new statements in ways that increases trust. An unpleasant history of failed healthcare mergers just in the last decade has emerged. Each of these failures can be traced to conflicts in one or more intangibles. A significant number of mergers have had some success in merging the collective cultures but have yet to make any, or just minimal, progress with the expert physician culture. Following are some models and examples that may help explain why mergers succeed or fail, as well as some models that address the differences between collective and expert cultures.

MERGER MODELS: COLLECTIVE AND EXPERT CULTURES

THE EQUAL BLEND MODEL

Figure 4.5 shows the scheme that most merger plans use. Two relatively equal hospitals (many times a Catholic one and a community one) create a new, coequal entity. The new entity is very often given some new name that makes sense only to the people who created it (e.g., Intergalactic Health System). The underlying myth of this approach is that everything should be equal and the physicians and the community will understand clearly the new mission, value, and vision statements. The structure of the equal blend model requires that half of the board members be taken from one entity and half from the other. The executive team and middle managers are selected using the same “Solomonesque” technique of half-and-half. The parity mentality, while very easy to design and consistent with good democratic values, seldom works. Rather than creating an efficient new healthcare delivery entity, gridlock results. Highly affiliative

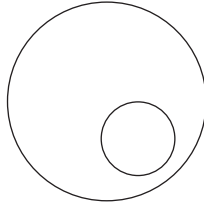
Figure 4.5 Equal Blend Model

persons are attracted to this model because it seems so fair. Problems begin to emerge when difficult decisions need to be made about service realignment, staff adjustments, and new business development. Pleasantries turn to frustration at the decision-making point because the leaders are so embedded in their initial hospital loyalty. Physicians during this process are usually very verbal about how bad the merger idea was in the first place, negating any hope of engaging them in building a new future.

THE BIG DOG–LITTLE DOG MODEL

The merger model in Figure 4.6 is really a take-over model. No matter what euphemisms are used to create the notion of a partnership, the fact remains that the larger or smaller in size but more aggressive organization will determine the culture. This can be an efficient method for creating the desirable culture. That is, the merger tells the mergee the decision rules. If the mergee does not agree, it is replaced. This model is more common in non-healthcare industries, for example, banking and manufacturing. The model, although efficient, poses many dangerous problems,

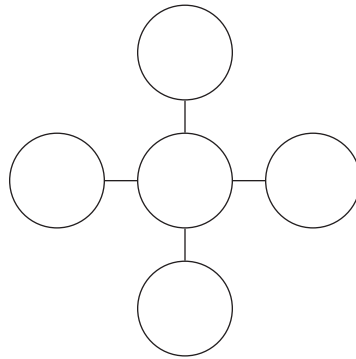
Figure 4.6 Big Dog–Little Dog Model



especially for healthcare. The model requires an autocratic, non-engaging approach.

Autocratic approaches have some predictable dynamics. Their biggest problem is that they reinforce the autocratic. The people in charge actually think they have done something and have done it fast. The fact is there may be some immediate, observable changes in the tangibles elements of structure, such as the number of full-time employees, the amount of pay, etc. However, while the autocrat is pointing to these changes with pride, a furtive and powerful dynamic is at work—passive aggression. Autocratic change methodologies always produce passive aggressive behavior and passive aggression will *always* destroy the merger in the long run. It is the silent killer.

This model is especially ineffective with buying or merging physician practices. Physicians are motivated to a large degree by accomplishment and power. Autocratic techniques to control physician behavior never have and never will work. A great enthusiasm for buying practices existed for a period of time. There were (and still are) seminars on controlling physician practice behavior. The autocratic attempts at merging expert cultures have

Figure 4.7 Satellite Model

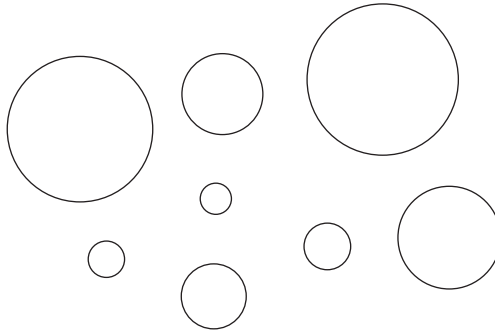
proved to be a fool's journey. You do not control experts—you engage them in a process of mutual self-interest.

THE SATELLITE MODEL

The model in Figure 4.7 works for both collective and expert cultures. Mergers are designed to improve economics through the benefits of size. Most mergers are designed to create a new or strengthen a current economic engine. Multicorporate health-care delivery systems seldom seek to create a single corporate culture across all entities and sites. However, this runs counter to the common thinking: we are one organization, therefore we need one set of mission, values, and vision statements.

Newly merged entities are designed to improve the financial and business aspects of care delivery. These corporate entities do not see patients, and rarely find a physician or nurse at the corporate office. Corporate offices should not try to create a single

Figure 4.8 Chaos Model



culture; they should use some of their resources to increase the strength of the local cultures currently in place.

Variations on this model can be incorporated into planning depending on the special factors of a specific system. The most common variation is to have a common mission and values statement across the system but allow each entity to create its own vision statement or at least its own strategic plan. This promotes corporate consistency and permits the unique aspects of the various sites to be expressed in strategy. This model incorporates the accomplishment and power needs of the experts as well as the group needs of the collectives.

THE CHAOS MODEL

Chaos is the most common response to mergers (see Figure 4.8). The staff at the merging entities have little trust in the new corporation. The enthusiasm displayed by the senior executives for

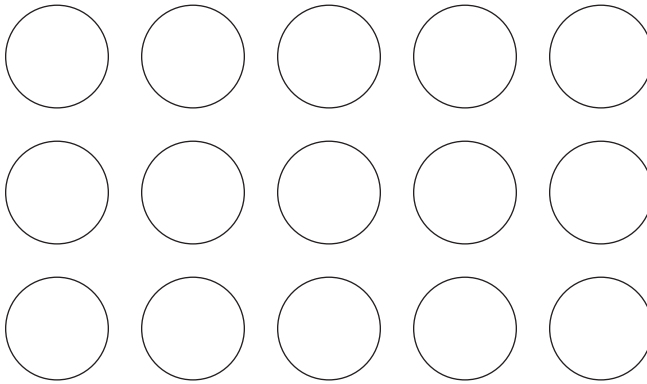
the new corporation is met with fear and distrust by those who do not know if they will fit into the future of the new entity. They default to what they are sure of—their personal value systems. Chapter 3 discussed the notions of egocentric and rolocentric responses to unknown change processes. The chaos model predictably elicits these dynamics. The challenge for leadership is to anticipate these behaviors and create a communication system that helps the staff understand how they fit into the new entity. However, the major difficulty is that the merging entities divide themselves into multiple subcultures.

Sometimes it is useful to remember that the whole body of knowledge about cultures began with the study of tribes. The chaos model of organizational behavior reflects some of the basic understandings about tribal behavior. When threatened, people tend to cluster around those with similar values and concerns. During the chaos stage of organizational transformation, tribes emerge. Tribes may include nurse tribes, doctor tribes, administration tribes, and so on. These tribes become the base for individual decision making. The thinking goes something like this: I have no idea what *they* are up to therefore; I will stay with those I trust and wait to see what happens. Tribal behavior is very common during a massive change like a merger. It is the behavioral reflex to perceived chaos. Although it is predictable, effective leaders try to move from the perception of chaos to commitment to the new entity, from tribes to a focused work force, as soon as possible. The longer the tribes are allowed to exist, the more difficult they are to change.

THE EXPERT MODEL

The expert model of cultural formation is best illustrated by a series of circles lined up in orderly rows (see Figure 4.9). The lesson of this model is that the integrity of the individual is protected along side coequals, all of whom wish to achieve a predetermined goal.

Figure 4.9 Expert Model



The key to making this model work is the time spent engaging the experts in the creation of a goal that they all see as important to their personal interests. The issues of shared mission and core values are not the factors that make this model work. In fact, emphasis on mission and values will contaminate this model to the point that it may not work at all. The only cultural element that makes the expert model work is shared vision. The dynamic which makes the expert model work is allowing the expert to control the process as it relates to his or her practice and respecting his or her judgment in terms of ongoing decision making. Experts respond well to change processes when they feel in control of the decisions that most affect them and feel professional respect throughout the development and implementation of the process.

THE POWER OF VISION

All visions have three characteristics. They are inspirational, they are directional, and they are manageable. The more effective

vision statements tend to be short. However, some people, in an attempt to be efficient, convert their vision statements into slogans. Slogans differ from vision statements in that they are inspirational but not directional. For example, a good slogan is Nike's: Just Do It! While this statement can be very inspirational, the direction is anything you want "it" to be. And, how do we measure "doing it?"

Visions inspire, drive strategy and tactics, and can be measured to determine the degree of achievement. The military is very good at creating clear, inspirational, and measurable visions. One example of a good vision is the operation in Desert Storm. The vision for Desert Storm was to get Iraq's army out of Kuwait. Vision drives strategy. The strategic plan was a multinational military intervention. Strategy drives tactics. The tactical plans were defined by the combat and support units. Tactics drive individual performance. The plans were so precise that each military person knew exactly what had to be done to achieve the goals of the plan. Vision to strategy to tactics to individual performance is the power of visions. They convert overall corporate expectations to precise individual behaviors. The people who must make the vision real understand their contribution to overall success. Their behavior is contextualized in a greater good rather than personal self-interest or survival.

Organizations without a vision. Organizations that do not use vision as the context for change default to retrovisioning (i.e., tactical reactions and survival behaviors) and tactical responses. This behavioral pattern is more reflected in the military action in Vietnam. The espoused vision of the war in Vietnam was to *Stop Communism*. While this statement may have had an inspirational effect on some in Washington D.C., there was no direction.

The vision was too vague to drive a comprehensive strategic plan and the tactical plans seem to be reactive. The result of these factors was to create a combat force that had no greater good to

inspire them and, therefore, defaulted to survival. This same dynamic happens far too often in healthcare organizations. The vision either does not exist or is too vague to inspire individual behavior toward a greater good. The staff default to retrovisioning. They do not know how they fit into the future, so they reproduce past behavior and hope that they keep their jobs. This predictable reaction to an uninspiring workplace is very toxic. Staff members are tired, stressed, and frightened. These are good people who want to do the right thing but are in an environment that forces them to be egocentric.

The Desert Storm and Vietnam examples convey many lessons for physician partnerships. Desert Storm was the coming together of many countries with very diverse cultures, many of whom could not speak each others' language. Some of these countries were historic enemies. All the separate, diverse, country-specific issues were subordinated to the greater good as perceived in a common, shared vision. Unlike Vietnam where, even though the forces were mainly from the United States, and therefore spoke the same language as well as having a shared history, the lack of a shared vision forced the military personnel into holding actions. Whether behavior is egocentric, survival focused, decentered, or outwardly focused is a function of the degree to which people see their contribution to the greater good. This greater good possesses obvious benefits to all involved. Self-interest and corporate interest are aligned and obvious. Keep in mind that "liking each other" and even "trust" are not necessary when bringing experts together to achieve a shared vision.

Long-term behaviors. The final lesson from Desert Storm that is consistent with expert cultures relates to long-term behaviors. When the vision of removing the Iraqi army from Kuwait was achieved, those involved returned to their homelands. The biases and prejudices that existed before the war were back in place. Little if any positive carry-over occurred. The same is true with

expert culture dynamics. Just because a group of physicians came together for a particular strategic thrust in which they saw their needs being met does not, in any way, suggest that the next effort will be supported. The difference between collective and expert cultures is that collective cultures have a common mission, values, and vision and build trust on the basis of successful results. Expert cultures are successful only in connection with a specific vision wherein self-interest is obvious. Each time you wish to engage a group of physicians (or other experts), it's like starting over. You cannot generalize from one successful venture to the next. The dynamics of collaboration more suit experts in a change process than the transformational efforts that are effective with collectives.

CONCLUSION

The definition of collaboration is a mutually beneficial relationship with clear roles that is entered into by two or more individuals and/or corporations to achieve common goals. Collaborative efforts are successful when there is a clear understanding of relationships and goals; a jointly developed structure and shared responsibilities; authority and accountabilities are accepted; and, a mutually developed vision in which each member sees his or her self-interest.

To attempt collective culture change techniques with experts is frustrating and, in fact, counterproductive. The main difference between expert techniques and collective techniques is the respective roles of vision and values. Experts will support any change effort wherein the goal or vision includes their self-interest. Collectives, on the other hand, are more concerned about shared values. Collectives, like experts, want to see how they fit into the future, but more importantly, collectives want to align with a group with similar beliefs. Experts do not make shared values a prerequisite for commitment. When experts share the

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corporate values, the change process has less tension but shared values alone will not mobilize experts. Successful leaders focus on a shared vision for both experts and collectives and spend time on shared values for collectives.

