Potential Extensions to Transformational Leadership Models

CRA. Jackson

Follow this and additional works at: https://scholars.fhsu.edu/alj

Part of the Educational Leadership Commons, Higher Education Commons, and the Teacher Education and Professional Development Commons

Recommended Citation
Available at: https://scholars.fhsu.edu/alj/vol7/iss4/23

This Article is brought to you for free and open access by FHSU Scholars Repository. It has been accepted for inclusion in Academic Leadership: The Online Journal by an authorized editor of FHSU Scholars Repository.
Academic Leadership Journal

Review of Transformational Leadership Literature

The view adopted in this research was that transformational leadership (Bass 1985; Burns 1978) could be characterised by an ability to bring about significant change in an organization, and that transactional leadership above 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.

To understand the leadership of change there are numerous key issues for excellence in change leadership. To clarify the roles and responsibilities of a leader a number of theories (Hersey & Blanchard 1982; House 1971; Vroom & Yetton 1973) provide useful frameworks for understanding the leadership of change and the concepts of vision, values, leading by example, communication, rewards and empowerment.

According to Sosik and Megerian (1999), the leader of an organization undergoing change needed to maintain five components: self-awareness; emotional control; motivation; empathy; and social skills. To be effective in organizations Kolb, Rubin and McIntrye (1971) stated leaders must be educators. They lead staff by helping set goals, communicating those goals widely throughout the organization, taking the initiative in formulating means of achieving the goals and finally inspiring members of the organization 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 organization (Weisinger 1998). The research (DuBrin 1998; Kotter 1999a) showed the necessity for a leader to be visionary and transformational when undertaking organizational change, while Kotter (1999a), believed 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).

To undertake major change an individual who already had a track record for leadership should be appointed (Kotter & Heskett 1992). The new leader creates a team that establishes a new vision and set of strategies for achieving that vision. Each new leader succeeds in persuading important groups and individuals in the organization to commit themselves to that new direction and then energises 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 can lead to similar confusion for others within the organization and role ambiguity being a major obstacle to the improvement of organizational
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 organization, 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 and at the same time, develop 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 behavior and these actions were seen to give critical credibility to their words.

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 organization and the vision of the leader were internalised (Carlson & Perrewe 1995).

To understand the role of transformational leadership and organizational change, research by Bass and Avolio (1994), Kotter (1996), and Kouzes and Posner (1987, 1995) will be reviewed as these theories of the behaviour of the transformational leader analyse the transformational leadership styles involved in undertaking organizational change.

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 organizations. 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). Followers and colleagues were developed to successively higher levels of potential (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 (1991, p14)
3. **Inspirational motivation**: Transformational leaders behaved in ways that motivated and inspired those around them by providing meaning and challenge to their follower’s work (Avolio & Bass 2002). Personal accomplishments, the development of communication skills and role modelling created the potential to inspire others.

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).

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 organization (Bass & Avolio 1994). When trying to promote cultural change in an organization, 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).

Transformational leaders changed their organizational culture by understanding it first and then realigning it with a new vision, amending its shared assumptions, values and norms (Bass & Avolio 1994). The Bass and Avolio (2002) frameworks provided a strong basis on which to build a change program and provided a starting point for change leaders 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.

**Kotter (1996) frameworks**

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.

According to Kotter (1996), at stage 1 the leader needed to establish a sense of urgency. For stage 2, Kotter (1996) stated that managers should engage a strong, guiding coalition of people with position, power, expertise, credibility and leadership skills. While at stage 3, Kotter (1996) suggested leaders develop a vision and strategy where the vision was 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 when undertaking organizational change.

According to Kotter (1996) at stage 4, managers communicated the change vision and in most organizations, managers under-communicated and often inadvertently sent inconsistent messages and resulted in “stalled transformation”. In stage 5, managers revealed their ability to empower a broad-based action plan and to empower numerous people by removing barriers to the implementation of the change vision.
In Stage 6 generating short-term wins (Kotter 1996) as a major change process built credibility and sustained managers’ efforts with the staff. While in Stage 7, leaders needed to consolidate gains and produce more change. In the final stage 8, the challenge was to anchor new approaches in the culture and develop shared values among managers.

Through his case studies, Kotter (1995, 1996) argued that successful organizational 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.

As the analysis demonstrates, Kotter’s models (1990, 1995, 1996) provided an extensive range of concepts, processes and tools for leaders undertaking organizational 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 current literature review demonstrated there were still gaps in these change models, but the Kouzes and Posner (1987, 1995) model of change could provide a more complete framework for transformational leaders.


A third framework, the Kouzes and Posner (1987, 1995) model provides a set of principles which examine the behaviour of transformational leaders. 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 organizational change. Kouzes and Posner (1987, 1995) established a model of five principles of change.

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

- challenging the process,
- enabling others to act
- modelling the way
- encouraging the heart
- inspiring a shared vision

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 organizational change.

However, the above literature demonstrated there were several potential components missing from the transformational leadership models and this research tested and provided evidence for the potential missing components of communication, team-building, stress and coping and inter-group conflict.

**The Case Study**

The research was conducted in four organizations and used an embedded case study approach with in-depth interviews. The four hospitals were chosen because of the major changes they had experienced. The hospitals also represented two geographical and financial differences which increased the opportunity for comparison between the private major city hospitals and the regional government managed hospitals. The interviewees were asked four questions and a strict 60 minute interview time was allowed. The same questions were asked of each of the 26 interviewees.

Interviews were with the Chief Executive Officers, senior management and team leaders in the four organizations. The decision to interview only the most senior members was made as they were directly involved in making decisions regarding organizational change and then the implementation of the change.

**History of the organizational change in the four hospitals and the Findings based on the potential additional components to transformational leadership models**

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. Other changes 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).

Hospital Two was 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 Hospital One management purchased the hospital management rights. 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. 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.

Hospital Three was the only medium-sized public hospital in its region and was originally the base hospital for the surrounding district, with over 300 beds servicing outlying rural areas and the local city. 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 Three has had large upheavals because of changes in policy, nurse training methods and government legislation. The hospital was also a major teaching hospital with up to 300 students at various times.

Hospital Four was a new, purpose-built, medium-sized public hospital in a neighboring region located some 30 minutes drive from Hospital Three. It was originally built to replace Hospital Three, and the older original Hospital Four. 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. It was anticipated that, in the future, Hospital Three would close with Hospital Four becoming the main hospital for the region.

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 pediatrics department.

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.

The major focus of this case study was upon the transformational leadership displayed by the leaders and managers during the change process. Their behaviors were analyzed using the theoretical frameworks of transformational leadership and the proposed elements of communication, team building, stress and coping and inter-group conflict missing from the leadership frameworks are now reported.

There were five research questions asked of each interviewee, with four specifically relating to the missing components being investigated and a final question was asked which sought to identify if any other components were missing from the Kouzes and Posner (1995) framework which stated:

**Questions 5:** Are there other elements that need to be added to the Kouzes and Posner (1995) framework not previously identified?

The following sections will address the four research areas of communication, team building, inter-group conflict and stress and coping.

**Theme 1:** The use of communication

**Research Question 1:** What communication skills do transformational leaders use in the organizational change process?

An important aspect of any successful leadership and change role in an organization was communication (DuBrin 1998). Transformational leaders communicated their vision, goals and
directives in colorful, 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. 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 organization, 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. 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 organization; and second, to learn how to communicate themselves.

Introducing change within an organization 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 organization to the rank-and-file managers was often found to be ineffective (Coch & French 1948).

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 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. 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.

Communication was the spearhead for ensuring that successful change took place (Proctor & Dukakis 2003). It helped to overcome ambiguity and uncertainty; it provided information and power to those who were the subject of change. As the literature (Coch & French 1948) stated 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”. In Hospitals One and Two communication was obtained through emails, department heads’ meetings and from other lower-level staff members. 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.
In contrast in Hospitals Three and Four the grassroots changes (Proctor & Doukaks 2003) were communicated very well because the manager met with all staff in both hospitals through various focus-group meetings with specific departments, such as the birthing facilities. Management facilitated the changes by establishing a management advisory group and decisions were made after considerable consultation with staff and management teams. Staff from every level were considered and represented and two-way communication was exceptionally good at Hospitals Three and Four.

In the final report developed by staff, it was recommended that a trial be started, or “a district model of care” be established. Incorporated into the model was a team staffed from across the district. Those staff on the teams who developed the model worked at both hospitals and management discussed the models of care openly with staff. Staff were pleased with the consultation process and the outcomes for the potential patients 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.

To improve the communication availability throughout the four hospitals a number of different communication techniques were employed by the change leaders. Most of the communication tools used by executives from the top directly to all employees was through new technologies: an intranet and extensive use of email (Proctor & Dukakis 2003).

In Hospitals One and Two a highly successful communication tool was a communication board which involved the use of the intranet and email. According to one manager: “They (Management) 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”. Staff were pleased with the facility, and believed information was provided at a consistent rate with little misinterpretation by staff.

The communications board was utilised regularly by staff and management in Hospital One with few problems as most staff had access to the intranet. However, early in the change process, 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. Management in Hospital Two ensured all emails were printed and posted in the staff areas, particularly in wards or units in a dedicated communications book. These printed emails originally appeared to have enhanced the communication processes and improved morale amongst staff.

Unfortunately, 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 and removed the book. Once it was removed, morale increased and the complaints decreased.

In contrast to Hospitals Two experience with the communications board and book, in Hospitals Three and Four, email was made available to all staff. The purpose was for staff to communicate with most hospitals in the district, as well as being connected to a hospital-based electronic site where meeting minutes were placed and accessible to the district staff. 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 and email was accessible to the majority of staff and used daily which staff found a positive and useful tool.
Overall, the current research has shown 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.

The 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. 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 organizational change. Good communication is essential to the development of a change program, its implementation and its ultimate success.

**Theme Two: Team Building**

**Research Question Two:** How do transformational leaders foster change in the organization through 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 characterized 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 organizational knowledge. Clarke, Amundson and Cardy (2002) theorized 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 organization, and took many forms including financial, technical, traditional and emotional. In some organizations, the main challenge was the removal of a hierarchy and building an effective team-based environment (Weick & Roberts 1993).
many organizations, 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 from one department (see Denison, Hart & Kahn 1996). Weick and Roberts (1993) highlighted that organizations 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 organization. In contrast, Conner and Prahalad (1996) stated that successful organizations with teams fostered learning at both individual and organizational levels; they invested in human and technical resources, while developing tools and methods to support them. 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.

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 organizations to the wider acceptance and reliance on team collaboration, and this was found in Hospitals One and Two.

In Hospitals One and Two there were few attempts by the executives and managers to develop teams despite the necessity for teams within these two hospitals. 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 organization.

In an attempt to create teams management in Hospital One hoped that a new team nursing model would overcome the team development problems. Many organizations 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”. Thus managers 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.

Within Hospital Two, team building became an important post-restructure issue according to the
Within Hospital Two, team building became an important post-restructure issue according to the manager, and an issue the hospital considered seriously and team building started in both a horizontal and vertical manner.

The managers 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 improving teamwork by developing a formal corporate governance procedure as the mechanism for people working together. Consequently, the manager was not aware of any dysfunction needing external intervention or requiring the reinventing of groups within Hospitals Three and Four.

The District Manager was particularly visible as he is a transformational leader in Hospitals Three and Four 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 and 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”. Specialist units with many levels of staff being present had unique representation: for example, in maternity, midwives were invited to join the steering committee and participate in brainstorming workshops. These corporate governance structures resulted in Self Managed Work Teams (SMWT) being developed.

A significant SMWT was created in Hospitals Three and Four because of community outrage at the closing of the maternity department in Hospital Three. To deal with this backlash, a specific SMWT advisory group was formed, to develop a mode of care to meet the clients’ needs for a continuum of care for the staff and expectant mothers. Also, the advisory group undertook the development of a new model of staff training where staff were able to maintain their professional skills, 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. 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.

In Hospital Two, management 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), ii) surgical and ICU services; iii) the remainder (including the intensive care unit and a number of wards).

With the non-clinical programs in Hospital Two, there were designated managers in individual departments, with their own team meetings and departmental meetings. At these meetings, staff learnt about changes at the strategic level and formed larger, more strategic response units at a higher department level. Building general and cross-functional work teams was important in this department and reduced conflicts in Hospital Two.

As can be seen from this current study, there were some similarities in team development between the four hospitals. However in Hospital One there was limited use of a formal structure for team building, and managers mainly left it to staff to develop their own teams. While Hospitals Two, Three and Four undertook more formal team development through self management work teams and a formal corporate governance procedure.
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 organizational 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.

**Theme Three: Stress and Coping**

**Research Question Three:** How do transformational leaders manage the high levels of stress and coping that occur during organizational change?

Bennis and Nanus (1985) found many organizations underwent unparalleled levels of organizational change in attempts to overcome debt problems, improve efficiency and competitiveness 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 organization, 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 organizational change required both individual and organizationally managed responses, according to Pearlin and
Schooler (1978). In response to large-scale organizational 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 organization (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 organizational culture. Case studies have revealed that managers and staff used a variety of coping strategies during organizational 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).

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).

In the four organizations reviewed, there were mergers of some sort. Each organization 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.

In all four hospitals, the managers and executives stated that staff dealt with stress differently – but there was an increase in sick leave despite all four hospitals management having agreement and disagreement regarding the level of sick leave occurring. In Hospital One, the executives acknowledged that “… staff deal with stress differently” and: “… 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.

As well in Hospitals Three and Four managers found there was an increase in sick leave. However at the commencement of the change, managers 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 in Hospitals Three and Four 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.

As a result management in Hospitals Three and Four, found that 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 to facilitate dialogue with the staff about their feelings.

As stated above the four hospitals studied employed a mediator or counsellor for the staff when they needed to talk through any crises they were experiencing. Also staff utilised outside coping mechanisms to deal with their stress during the change processes.

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.

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. 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. 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. The psychologist found a number of staff were anxious, unsettled, close to tears and suffering from depression.

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).

Surprisingly only the staff and managers in Hospitals Three and Four used the problem-solving
techniques described by Lazarus and Folkman (1984). According to one manager, “different
individuals have different stressors”, and there was always underlying stresses for management and
staff. As a result management tried to 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”. As an example for the staff being relocated from the
original Hospital Four 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.

The current study showed that in all four hospitals there were common stresses for members of staff
and management. There were a few common coping skills used in each organization, such as
psychologists and use of rumours. However, staff in the four hospitals found it necessary to use 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.

It can be seen that the public hospital management provided 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
organizational 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.

Theme Four: Inter-group conflict

Research Question Four: What do transformational leaders do to manage inter-group conflict during
organizational change?
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 organizational change. 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 organization, the introduction of new technology, and changed lines of responsibility and authority as found by Jackson (1999). 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 organizational 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 organization’s mission, vision, and strategy – and the link between them needed to be clear. Employee resistance to management initiatives was generally associated with negative organizational outcomes, including those associated with job dissatisfaction and grievances (Kirkman, Jones & Shapiro 2000).

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 organizational change by instilling pride in the past, coupled with a need to meet the challenges of the future.

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 despite knowing that there was conflict, several managers in Hospital One felt that little conflict occurred in their organization. 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 organization – has really been fairly passive”.

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. The 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.

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 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.

In all four hospitals inter-group conflict was widely seen when wards and departments were merged and staff moved to these new areas. Within Hospital One, significant conflict was between the staff and management during the change and not between staff. During the change, staff were asked to move from established areas to work in other areas for cost-cutting reasons. Staff were moved from one area to another with 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”.

To overcome many problems managers quickly communicated with staff 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 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.

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.

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.

Within Hospitals Three and Four the perception of in-group and out-group behaviour was significant 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 stated above, there was still a “them versus us” attitude between Hospital Three and Hospital Four. To overcome the “them versus us” attitude leaders and managers in 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
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 organizational changes.

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 develop 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.

Another process to reduce inter-group conflict was to develop intervention procedures within the four hospitals. According to a Hospital One executives to reduce inter-group conflict “… 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.

Dealing with conflict through third-party interventions, Keashly, Fisher & Grant (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 were 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”.

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 organizational 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 organizations for managers and leaders to develop procedures for solving inter-group conflict.

The current research demonstrates that within the four components several sub-themes emerged in each component and 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 additional eight points cover a wider range of issue for leaders to take into consideration to improve their success with organizational change programs.

**Conclusion**

The current research has 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 organizational 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 organizational change, leaders only progressed to the stage of implementing ideas and projects. Once these were reached, many leaders or change experts left the organization 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 organizations returned to their original ways of operating. To overcome these problems, the original research included the four components of communication, team building, stress and coping and inter-group conflict.

When 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 in a new concept entitled Supporting the Process. 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 organizational 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. The eight new components could be titled *Supporting the Process* and incorporated into transformational leadership models in the future.

**References**


and validating a diagnostic model
. Academy of Management

The resolution of conflict: Constructive and destructive processes. New Haven: Yale University Press.


Fisher, R.J., Grant, P.R., Hall, D.G., Keashly, L., & Kinzel, R. (1990). The Development and testing of a
strategic simulation of intergroup conflict.

Folkman, S., Lazarus, R.S., Dunkel-Schetter, C., Delongis, A., & Gruen, R.J. (1986). Dynamics of a
stressful encounter: Cognitive appraisal coping and encounter outcomes.

Gaughan, A.C. (2001). Effective leadership behaviour: leading “the third way” from a primary care
group perspective – A study of leadership constructs elicited from members of primary care group
management boards.
Journal of Management in Medicine, Vol 15, iss 1, pp 67-94.

Hann, N. (1993). The
assessment of coping, defence and stress. In Goldberger, A., & Breznitz, S.

Hatfield, J., & Huseman, R. (1982). Perceptual congruence about communication as related to
satisfaction: Moderating effects of individual characteristics.
Academy
of Management

Management of organizational behaviour:

Administrative


Lawrence, P.R., & Greiner, L.R. (1970). How to deal with resistance to change. In Lawrence, P.R., & Greiner, L.R.(eds), Organizational change and Development. Homewood: Irwin.


VN:R_U [1.9.11_1134]