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Health Care Leadership on the Edge-Dialoguing and Reflecting on Burning Questions

By Diane L. Dixon, Ed.D.

The Complexity of the Health Care Environment

The current health care environment is faltering on multiple edges. The edge of a new paradigm meaning a fundamental shift in the basic assumptions upon which health care delivery was built. As the ground is figuratively and literally moving the state of health care sometimes teeters on the "edge of chaos" as it attempts to redefine itself in a new age (Zimmerman, Lindberg, and Plsek, 1998, p.265). This is a time of innovation and adaptation. Health care delivery is at the edge of transformation. It is during the edge times that breakthroughs occur moving systems to a new level of being and performance.

Long-standing Problems and Disequilibrium

In the midst of the turbulence, upheaval persists as efforts continue to figure out how to cure a sick system. Long-standing problems such as rising costs, the quality of care delivery, public and private reimbursement, distribution of health services, the number of uninsured, staffing shortages, and physician unrest continue to haunt leaders as they have for several decades (Andersen, Rice, and Kominski, 2001; Jonas, 1998). What we have is a conundrum of seemingly intractable issues that are perplexing and difficult to solve. Added to the current mix are shrinking managed care rates, diminishing Medicare and Medicaid reimbursement, and accelerating pharmaceutical expenditures (AHA, 2001). Further increasing the complexity are the emergence of E-Health and the implications of new technology that will shape health care delivery in ways that we never imagined possible. And as the impact of breaking the genetic code continues to unfold, innovative care delivery protocols bring the promise of curing sick patients but no one is sure at what price. So, the health care delivery landscape presents

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a paradoxical picture of problems and innovation in the context of turmoil and uncertainty as it continues to edge towards transformation.

All of this has been exacerbated by the emergence of terrorism in the United States. Questions are being raised as to whether the health care infrastructure can manage the strains of bioterrorism and the potential of future terrorist attacks (Martinez, 2001). This is a striking example of the need to manage the unexpected. Health care delivery organizations are dynamical systems that are constantly adapting to changes in a highly turbulent environment. However, they have not learned to adapt quickly enough to manage the current shock waves and solve long entrenched problems simultaneously. **Burning Questions: What do health care leaders need to do to help delivery systems become more adaptable in the highly turbulent environment? How do leaders solve long-standing problems in the midst of crisis and disaster?**

System Fragmentation

In a recent Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* it was indicated that "frustration levels of both patients and clinicians have probably never been higher, yet problems remain" (Institute of Medicine, 2001, p.1). Health care delivery continues to be highly fragmented resulting in a lack of systemic change and real progress in addressing quality and cost concerns. Further, according to the IOM report, ineffective use of valuable resources, poorly designed care delivery processes, and inconsistent performance are byproducts of continued fragmentation. Hospitals, health systems, physician groups, ancillary clinical services and insurance companies often still operate in silos. This results in ineffective communication about patients and operational issues. Clinicians and administrators have not been fully trained and developed in competencies such as collaboration and negotiation across departmental and organizational boundaries. These skills are needed to accomplish whole system change.

While one of the goals of integrated delivery systems was to help resolve the fragmentation problem, the reality is that integration has not completely achieved its intended results. In hopes of expanding market share and staying competitive the wave of mergers, acquisitions, and alliances soared in the 90's creating health systems comprised of multiple diverse entities (Marks and Dixon, 1999). Merger mania subsided in the beginning of the new century with leaders questioning how to make fragmented health systems more aligned in a cost-containment environment. Many of these mergers failed to produce the intended results and some have even broken up disillusioned with fractured bottom lines and distressed staff (Bilchik, 2000). In fact, the estimated \$5 billion invested in integration strategies has not demonstrated an equal return on investment (Haugh, 2001, p.134). Integration implemented with a fragmentation mindset is doomed to failure. **Burning Question: Are integrated delivery systems flawed or is the manner in which they were implemented the problem?**

Quagmire of Complex Regulations

Transformational change has been further hindered by the continuing quagmire of complex rules, regulations and compliance procedures such as HIPAA (the Health Insurance Portability and Accountability Act) and the Balanced Budget Act of 1997 (AHA, 2001). These regulations have been used as accountability, management, cost reduction, and quality mechanisms but have not ultimately solved the core problems of health care delivery. The cost of regulatory compliance is high not only in dollars but in time and resources. This high price has taken its toll over time in an even more dramatic way on the organizational culture of our health care organizations. Heavily regulated hospitals and health systems often operate as regulated bureaucratic systems that constrain innovation rather than unleash it. In an increasingly turbulent and unpredictable environment regulations on the surface seem to reduce ambiguity

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and uncertainty but paradoxically have the opposite effect. As change continues to escalate, a vicious cycle of more and more rules for each segment of health care organizations is created. The excess of rules and regulations then defeat their intended purpose because they increase the complexity rather than simplify it. Leaders unwittingly become paralyzed by the system and can not rise above all of the details and view the whole picture; thwarting the hope of seeing new possibilities and a cure for what ails our health care system. **Burning Questions: How can health care leaders overcome their regulation mindset? What do health care leaders need to do to manage the complexity of regulations and compliance more effectively?**

Refraining Health Care Delivery

Defining A Paradigm

Leaders find themselves caught in this vise of regulatory constraints and are often equally trapped in their traditional mindsets that won't allow them to break free. Therefore, achieving real progress in changing health care delivery systems has been very difficult. There has been a great deal of talk about the need for a paradigm shift but there does not seem to be a common sense approach of what that really means in health care. Part of the problem lies in a basic understanding of the definition of paradigm. It is the whole pattern of beliefs, values, techniques, and models shared by a community (Kuhn, 1970,). Within this pattern is a network of assumptions that drives behavior and decisions that leaders act upon consciously and unconsciously. The challenge in health care is that there are multiple communities such as federal, state, and local governments, numerous associations representing a variety of constituencies, and consumers that have their individual beliefs, values, techniques, and models about what health care should be and how it should change. This creates a competing values, beliefs, and assumptions dynamic that makes it very hard to gain consensus on significant transformation in the industry.

Trouble Shifting Paradigms

Based on the author's observations health care leaders get caught in the conundrum of problems and pressing issues. Just trying to keep up with the day-to-day demands can be overwhelming. And in the stress of the moment and in the midst of financial hemorrhaging leaders 'go back' to cost-cutting and belt-tightening as a means of maintaining or regaining control. This is often at the expense of people, process, and purpose. When the going gets tough the same old quick fix behaviors surface. Downsizing, divesting, demerging, reorganizing, and restructuring are painful solutions. This is not to say that these are not viable decisions when aligned with strategic intent and market realities. But when they are implemented at the exclusion or out of balance with people, process, and purpose it is hard to achieve fundamental, sustained solutions. Leaders tend to focus on cost-reduction or innovation, people, process, and purpose. An *'either/or'* mentality persists.

What has been happening is a modification of processes and thinking in some parts of the overall care delivery system but the fundamental worldview has not changed. The financial model prevails. A real paradigm shift will lead to long-term sustainable health care organizations. This would mean changing the "collective consciousness" of health care leaders (Morgan, 2001). That is, altering the conceptual frameworks that influence the way in which leaders create the health care delivery reality. There needs to be some common ground among health care leaders as a community about how to lead, manage, and ultimately change delivery systems in a complex environment. An authentic move to a new worldview will first require bridging the chasms that divide leader's minds and keep them from working together. Part of the great transition work for health care leaders is to become boundary spanners but in a new and profoundly different way than previously espoused. With a collective consciousness and a shift to the paradigm of transformation leaders would collaborate across organizations,

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functions, and departments in the context of continuous change. Negotiation across boundaries to gain a common sense of the collective values, beliefs, and assumptions about care delivery and the most effective methods for affecting change is imperative. A new paradigm must be shared by members of the health care community as a whole. Gaining consensus on a common purpose is no small task but is the gateway to transforming the care delivery system. The Institute of Medicine is suggesting "the entire enterprise of care would ideally be united across these aims by a single, overarching purpose for the American health care system as a whole" (Institute of Medicine, 2001, p. 6). Before this can be accomplished leaders must be willing to open up to learning new ways of thinking. There is a simple reality, *'If you keep looking through the same lens you will see things the same way no matter how hard you try.'* **Burning Questions: What can be done to help health care leaders shift paradigms? What can be done to help leaders from multiple constituencies develop a shared purpose for health care delivery as a whole?**

A New Viewpoint

The real voyage of discovery consists not in seeking new landscapes but in having new eyes.
Marcel Proust

The foundation of Western health care organization is rooted in the functionalist approach based on the sociology of regulation and stability (Burrell & Morgan, 1979). It would be safe to say that health care organizations operate out of a paradigm of regulation and order. This model is based on stability, predictability, and control. In the paradigm of regulation there are numerous rules that are developed in an attempt to ensure order and control. Philip Howard in *The Death of Common Sense* states "Rules elaborate on prior rules; detail breeds greater detail. There is no logical stopping point in the quest for certainty" (Howard, 1994, p. 27). The paradox of all of this is that rather than increasing judgment and common sense it decreases it. This helps to explain why health care is stifled by its incessant quest for control.

In an effort to explain and predict events occurring in both the external and internal environment objectively, cause and effect, linear reasoning is used. Either/or thinking predominates leadership decision-making. From this deterministic viewpoint the environment dictates organizational events. Hence, the organization is in a reactionary mode. This is particularly evident in health care which is continuously reacting to government and regulatory bodies that impose numerous requirements. Looking through this lens alone confines health care leaders and hinders them from seeing problems and opportunities from varying perspectives.

Another aspect of the paradigm of regulation and order is the view that the whole is the sum of its parts with each part having a specific function. This is the origin of the silo mentality that gets played out in so many health care delivery systems and in the industry overall. The fragmented view plagues hospitals and health systems creating logjams in problem-solving and decision-making. Rather than looking at the whole system, changes are made function by function, department by department, organization by organization failing to see the interrelationships and interdependencies. This leads to duplication of effort and ineffective solutions.

Paradigm of Transformation

An alternative view is to see health care organizations as living, adaptable complex systems in which interdependency and interrelationships are key for survival within the context of continuous change (Zimmerman, Lindberg, and Plsek, 1998). Complex adaptive systems can be described as encompassing diverse components interacting with each other and capable of undergoing spontaneous self-organization (McDaniel and Driebe, 2001). From this perspective the entire mindset shifts to a more realistic picture of what organizations are in these times.

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For example, a health delivery system with multiple entities and interdisciplinary teams that must work together to create an effective organization is a complex adaptive system. The conflicts and contradictions inherent in this dynamic environment are accepted rather than constantly minimized by the development of a new set of rules and regulations. There is acceptance that everything is not predictable and controllable. Continuous change, disorder, and turbulence in organizations are the norm rather than the exception. There is recognition that within this disorder there is an inherent ability to self-organize without the authoritarian control. When high levels of change creates great disturbance and disequilibrium the ability to self-organize is central to the organization's resiliency (Wheatley, 1992).

In the paradigm of transformation the whole is greater than the sum of its parts. The collective norms and values are balanced with those of individual health care related organizations, departments, and functions. Therefore, collaborative relationships between the various entities and working as a team becomes a more effective way of doing business. Relationships are continuously negotiated and renegotiated. With this understanding leaders do not attempt to develop more rules and regulations to control every situation but rely on sound judgment and common sense in the moment. They recognize that there are multiple answers and multiple realities rather than single answers to the myriad of problems facing delivery systems. Solving problems is not always a stepwise, linear progression but more often a cyclical, nonlinear process requiring a higher degree of adaptability and flexibility. This perspective reflects the realities of 21st century health care delivery.

Reframing health care delivery requires leaders to reconstruct and redefine some key assumptions upon which these systems were built. The paradigm of regulation and control dominates these assumptions. This dominance has created the vise that keeps leaders from seeing the world differently with new eyes. This revolutionary period demands that leaders have a bigger, broader picture of organizations and how to change them. It is clear that the myopic mechanistic view alone does not work in a complex world. **Burning Question: What methods can be used to help health care leaders reframe their thinking?**

Both/And Mindset

Leading complex adaptive health care delivery systems requires leaders to have a "*both/and*" mindset which means to look at life, the environment, and the organization from many viewpoints. This means reflecting on various aspects of an issue rather than trying to reduce it to a single understanding. For example, analyzing a problem and seeing it from both logical and intuitive viewpoints; thinking of individuals and groups; developing solutions from both linear and non-linear standpoints; and being objective and subjective perspectives. A "*both/and*" mental model enables leaders to consider all sides of an issue and gain the benefit from the interaction of multiple perspectives; the effects of which would not be possible individually. This different mindset may seem counterintuitive to traditional leadership practices which are rooted in health care administration education. It has been noted that health care leaders have not been adequately trained to lead in this complex environment (Robbins, Bradley, Spicer, and Mecklenburg, 2001). There is no doubt that "*both/and*" thinking is more complex and means that leaders will have to learn to manage the inherent dilemmas and paradoxes more effectively. Part of the new work of leadership is learning how to use paradoxes and dilemmas as tools that help solve problems and generate new ideas.

Common Dilemmas and Paradoxes

There are several common dilemmas and paradoxes that challenge health care leaders. They may have seemed easier to manage from the paradigm of regulation and order and an "*either/or*" mindset. Leaders have been conditioned to define away the contradictions inherent in a dilemma thereby eliminating paradox (Quinn, 1988). Hence, more rules and regulations. This type of thinking can keep leaders from seeing other perspectives and becoming "blinded

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by their purposes" (p. 26.). Through the lens of the emerging paradigm of transformation dilemmas are not minimized or explained away but rather embraced. Contradiction is accepted as part of the natural cycle of change. Leaders must become masters of paradoxical demands (Hart & Quinn, 1993). Here are several key examples:

Independence and interdependence

This dilemma can play out on several levels. At the hospital level, for example, decisions are made daily about how independent and interdependent clinical departments must be to deliver care. Decisions are made without broad impact and unintended consequences play out in dysfunctional ways. On a broader health system level the dilemma becomes even more complicated as leaders determine the extent of interdependence and integration between multiple entities. The rise of mergers and acquisitions in the 90's added to the complexity because often the entities involved had different cultures. (Marks and Dixon, 2000). Some mergers have failed so miserably that they have broken up leaving behind even more questions about how to manage this dilemma. The push and pull of independence and interdependence across diverse organizations struggling to reach common goals has raised questions about how much interdependence and integration is practical to attain. But common sense tells us that we need a balance of independence and interdependence to thrive in a continuously changing environment. For instance in a health system, hospitals and other operating units need independence to be able to meet their patients needs within their respective regions. However, they need to depend on the system as a whole for financial support and coordination to achieve the overall system mission and vision.

Short-term and Long-term

The rapid pace of change creates tension between short-term and long-term. There is a tendency to focus on the short-term because the environmental demands keep changing and the definition of long-term is a moving target. However, if leaders only have a "*in the present*" mindset their actions and decisions are more likely to fall into the trap of the quick-fix syndrome. For example, some CEOs thought riding the stock market highs through aggressive investments would solve the bottom-line crunch (Lagnado, 2001). They found out that when the early 2001 stock market slump hit that those quick-fix decisions in the long-term created even bigger financial hemorrhaging. Finding the balance between addressing the demanding present and the long-term creates a dynamic tension that supports positive momentum in the organization.

Mission and Margin

The price of achieving the core mission of delivering quality care is continuing to rise. Achieving a margin is becoming increasingly difficult. The cost of quality remains high. Reimbursement challenges have yet to be resolved. Hospitals that are particularly dependent on Medicaid and supporting the indigent are barely able to survive. Teaching medical centers are also squeezed by decreasing Medicare reimbursement and managed care belt tightening. Technological advances continue to enhance health care delivery but at great costs. Patients are demanding the best care and want more involvement in their treatment. This too comes with increased costs. In the emerging paradigm of transformation the challenge and opportunity is to work towards some level of balance between mission and margin.

Collaboration and Competition

The mantra of the 90's was scale and market share as a means of beating the competition. As health care delivery systems have learned the hard way, competing against each other can be counter-productive. For example, at an unprecedented meeting a couple of years ago, California health care executives faced with dramatic fiscal pressures proclaimed that "the idea that health care industry success derives from shoot-outs where the one still standing is the winner had been tried and had failed" (Emmott, 2000). In essence, there is the recognition

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that the success of one health system does affect the other within a community of care. However, this does not mean that there should not healthy competition to deliver the best quality care. But it is evident that more collaboration is needed. An informal study of CEOs indicated that there are economic benefits from collaboration and as much as \$300,000 to \$20 million in savings annually could be attained (Palmquist, Coddington, and Fischer, 2000). In sum, both collaboration and competition are important.

Top Down and Bottoms Up

Traditional health care organizations have been characterized by bureaucratic, hierarchical cultures that are frequently top-down driven. However, it has been found that a totally top-down leadership style stifles people and sets the organization up for failure (Eisenstat and Dixon, 2001). Some leaders still fall into the trap because they have not let go of the traditional administrative mindset and have not received adequate development in more participatory processes (Robbins, Bradley, Spicer, and Mecklenburg, 2001). Bottoms up leadership means inverting the pyramid and encouraging leadership on all levels of the organization and allows for full participation. However, the extremes of bottoms up with all its good intentions can create problems if leaders at the top do not provide the necessary direction and coordination. Both top-down and bottoms-up leadership need to work together synergistically to create the appropriate balance of employee involvement.

Centralization and Decentralization

As health system mergers and acquisitions grew so did the complexity of the centralize versus decentralize dilemma. Mega health systems with acute, post-acute entities, physician groups and ancillary centers often exhibit a dynamic tension among these disparate organizations. They are seeking some level of unity while simultaneously trying to maintain individual identity. Decisions about human resources, marketing, planning and development, and especially patient care delivery services can be major sources of debate among top leadership teams. Physician leaders used to autonomy and power find the forces of large-scale system change particularly stressful. Deciding how much of a corporate center is needed to adequately coordinate system strategy, structure, systems, staff, and processes is complex. However, what is simple to understand is that a balance of both centralization and decentralization are needed for effective and efficient care delivery systems.

Consensus and Momentum

Figuring out how much consensus is needed to make key decisions and yet maintain the needed momentum to move the organization forward is frequently a difficult task. However, gaining consensus on decisions and actions needed to turn around troubled delivery systems is more important than ever. Moving ahead without gaining input and getting buy-in from key stakeholders creates fragmentation and lack of team work. It also builds resentment.

Consensus means that those involved in the decision-making process may not completely agree with the group but can live with the group's decision. They will commit to acting on it. However, consensus takes time and leaders do not have time for long drawn out processes. Keeping pace with the high speed of change requires maintaining a certain momentum. Finding the right symmetry between consensus and momentum is an ongoing, dynamic process that is affected by the situation.

Each of these dilemmas as well as others that occur can not be easily resolved with quick fix answers. Contradictions and conflict are a natural part of adaptive complex organizational systems. They open the door to a wide variety of issues and opportunities that to impact

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change in health care delivery systems in different ways. The answers to how to manage scarce resources and deliver quality care lie somewhere in the center of these polarities. There is no doubt that this is more difficult to manage because it requires continuously seeking balance among competing ideas and priorities.

Burning Question: What can be done to help leaders to become masters of paradox and dilemmas?

Mandate for Change

"You can't go forward until you get it out of reverse." Hugh Thompson

The mandate for change is clear. Reverting back to the old ways of thinking and acting are no longer acceptable. The recent talk about going 'back to basics' does not reflect forward movement (Haugh, 2001). Health care delivery is on the edge of a new paradigm not yet clearly defined or agreed upon. This time is characterized by uncertainty, unpredictability, and ambiguity. Rather than moving backwards what must happen is to move forward with the leadership and management basics as a foundation and stabilizing force. Transforming health care organizations in complex times requires transforming leadership. The transition to a new age of health care delivery is an uneasy one. Embracing a new time requires letting go of regulated and rule-bound mindsets. The regulated mindset creates a regulated leader that can not innovate. A quote from Lawrence Miller so vividly describes the bureaucratic leader. He states "The bureaucrat will constantly reorganize, searching for the structural solution to the spiritual problem" (Miller, 1989 p.128). So much of what has gone wrong in health care is spiritual in that the very essence of why health care exists as a societal right is being shaken. There is a lack of a shared understanding of the core purpose. The recent Institute of Medicine (IOM) Report states that all health care constituencies must commit to a "national statement of purpose for the health care system as a whole and to a shared agenda" (Institute of Medicine, 2001 p.5). It is with a common purpose and collective wisdom that gives us hope for sustainable change. As different paths and maps are created to lead the way in the continuous reshaping of health care delivery, leaders need to develop a mutual and shared understanding about how health care organizations should to be managed and led in the 21st century.

Burning Questions: What will health care leaders need to be and do to transform health care delivery? What are the key leadership competencies for 21st health care leaders?

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Biography

Diane L. Dixon is an independent management consultant, writer, and guest lecturer. She specializes in leadership development, change management, strategy development, and team building. Diane has more than 20 years of experience in the field of human resource and organization development with specific expertise in health care leadership. Her articles have been published in a variety of practitioner journals on such topics as executive leadership in health care organizations, leadership and culture alignment in partnerships, leadership in health care mergers and acquisitions, and the field of human resource development. Diane writes the monthly Leadership and Organization Outlook Column for Caring for the Ages and serves on the Editorial Board. She has been a guest lecturer and faculty associate at Johns Hopkins University, University of Maryland, and Catholic University. She holds a doctorate in Human Resource Development from George Washington University.

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