Physician as Leader II: From Theory to Practice Regarding Blended Leadership Styles

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Mindi McKenna and Perry Pugno (2006) believe that the current problems in American health care require that physicians step forward more often in a leadership role. They offer two recommendations that provide a foundation for the book they have written about physician leadership (McKenna and Pugno, 2006, pg. 1):

> Regardless of the motivation behind this growing demand for physician leadership, two things are certain. First, physicians are being called upon to help lead significant 'transformational improvements in healthcare, and are being called to do so more urgently than at any previous point in history. Second, until physicians are able to lead others, they will be unable to bring about significant improvements in healthcare.

What then is the best way for physicians to provide this leadership? In the first essay I have offered in this series, I propose (along with McKinna and Pugno) that there are actually three fundamental styles of leadership that might be appropriate for physicians to embrace—as presented in the DISC model of leadership (DISC, 2024), in my own Leadership Spectrum model (Bergquist, Sandstrom and Mura, 2024), and as described by multiple physician leaders who are quoted in McKenna and Pugno's book.

In this second essay, I move beyond the three fundamental leadership styles to consider ways in which these styles might be blended. I also introduce the fourth (compliance) DISC style and consider ways in which it relates to and provides a broader perspective on the Rainbow style of leadership (which blends all three fundamental styles in the Leadership Spectrum model). I first consider this interplay between Compliance and the Rainbow.

The Rainbow Leader of Compliance

The fourth style identified in the DISC model requires highly disciplined performance on behalf of an agreed upon way of operating an organization. Emphasis is placed in the Compliance model of leadership on adherence to a high standard of performance. A regular routine should be established and followed under the leadership of someone who is oriented toward compliance. The question becomes: is there a comparable style to be found in the Leadership Spectrum model? I would say that there is compatibility; however, it comes in the blending of several different styles and in the founding of a compliance model of leadership on skillful navigation of intricate team dynamics.

What about these compliant leaders who blend several styles. When they are effective, these leaders “mix it up” with other people and seek to engage in collaborative leadership. They wish to generating ideas, intentions and information through carefully orchestrated discussion and dialogue. In seeking to lead teams that operate at a high level, the Compliant leader may choose to use all three leadership styles and even to find a way in which to integrate all three. When they are ineffective, compliant leaders can readily be bound by specific procedures and traditional ways of operating. While they may pronounce an openness to diverse perspectives and practices, the Compliant leader can actually be

reticent to engage in any activity that leads away from "smooth running" and toward controversy (and disruption).

While DISC provides a compelling description of four different leadership styles, it is in the blending of several styles that some of the greatest insights can be gained regarding effective leadership. I assign the full color spectrum—the Rainbow—to the Compliant leaders. The rainbow, in turn, requires collaboration among several elements and ultimately a beautiful integration of these elements. What are the three elements: a rainbow is created when there is sufficient heat (Ruby Red), light (Golden Yellow) and sky (Azure Blue). This, however, is not enough. There must be a precipitating (excuse the pun) event--a convening challenge if you will. This event is rain. When the challenge is being met, the rainbow appears and is cause for our appreciation of the wonders of nature.

The Rainbow Relationship

Those with a Rainbow orientation thrive in a team setting—especially when they had significant influence regarding its operations. One of McKenna and Pugno's (2006, p. 137) points specially to the Mayo Clinic tradition and to recent broader trends of working in clinical teams:

> More and more there is a realization within medicine (It came later to us than to most people in business) that we can accomplish far more through teamwork than we could ever accomplish alone. This concept is well established in the Mayo Clinic practice. [Monte L. Anderson, MD, Gastroenterologist and Hepatologist, Mary Clinic Scottsdale]

In alignment with recent studies that demonstrate the greater "intelligence" of a team than any one member of the team (Arima, 2021), the Compliant Rainbow leaders acknowledge the strength of a team.

Compliant Rainbow leaders also tend to acknowledge the value of establishing diversity in the teams they establish and in which they work. This is where their Azure Blue joins with their Ruby Red (forming what I will soon identify as a Royal Purple commitment to advocacy leadership). This diversity can include bringing administrative staff together with physicians. McKenna and Pugno (2006x, p. 106) turn, as they often do in their book, to recommendations offered by Dr. William Jessee as President of the Medical Group Management Association:

> Only by working together in physician-administrator teams can we bring patients the needed diversity of skills and perspectives. Only by working as teams can we respond quickly to changing demands, reduce over-dependence on individuals, be willing to take risks, and enhance results.

I would add to what Dr. Jessee has suggested by noting that administrative staff often come to the table with a different set of perspectives and values than the physicians. Together with two colleagues, I have written about differences that exist in the managerial culture and professional cultures that exist in contemporary American health care system (Bergquist, Guest and Rooney, 2004). Given that both of these cultures are powerful and highly influential when it comes to patient care they must be represented at the table. Doctors like William Jessee recognize the need for both set of perspectives and values. Compliant Rainbow physician leaders can play a major role in ensuring that this diversity is to be found at the table and to help facilitate the effective engagement of this diversity.

There is a second constituency that must also be included in any planning for successful patient care. This constituency consists of the many knowledgeable nurses that operate in contemporary health care systems. In search of valid and useful information regarding patient care, Compliant Rainbow leaders have turned to their Golden Yellow and Azure Blue styles (forming the hybrid Verdant Green style of leadership to which I will soon turn). McKenna and Pugno (2006, pp. 72-72) offer insights delivered by one of their physicians. He identifies the values inherent in bringing nurses to the table (and the needs of nurses being addressed by their participation):

> Nursing doesn't have a lot of career advancement or trajectory like medicine does. It is important for nurses and doctors to work together. Nurses are often good facilitators of teams given their clinical background. Some nurses co-lead quality improvement teams with doctors. To address quality we must begin by seeing the problems for what they are. Many doctors don't see it. [David G. Fairchild, MD, MPH, Internist, Chief of General Medicine, Tufts - New England Medical Center]

I would add the bridging function that nurses often provide between the professional culture of physicians and the managerial culture of health care facilitators. They are effective facilitators not only because of their clinical background (working extensively and closely with patients), but also because of their extensive and close work with both the physicians and administrators (Bergquist, Guest and Rooney, 2004) Nurses can provide valuable information and strategical insights in planning for and engaging high quality and cost-effective patient care. The Compliant Rainbow leader is engaging the Golden Yellow (information) and Ruby Red (engagement) (forming the hybrid Tangy Orange mode of leadership to which I will soon turn).

Compliant Orientation

At the heart of this commitment to teamwork and diverse, is the Compliant Rainbow leader's enjoyment in relating to and working with other people. Among those Compliant Rainbow leaders who are most effective, the relationship itself is important. Often displayed an "Extraverted" (Jung, 1971) personality preference, this leader gains energy from their interactions with a wide variety of people (as opposed to the draining of energy by Introverts in their daily interactions with a diverse set of people). The relationship itself doesn't have to lead to any great outcomes. It is energizing even if the desired outcomes are not achieved. A supportive relationship can be established even when the participants are not in agreement with the Compliant Rainbow leader about certain important matters. Under ideal conditions, the Compliant Rainbow leader and team participants don't even have to share values. If these leaders have found success in their work and are comfortable with the way things are operating, Compliant Rainbow leaders may wander into foreign territory and gain a fuller understanding of and even eventually support alternative perspectives and practices.

As I noted in the first essay regarding the three fundamental styles of leadership, a set of characteristics (managerial strengths) regarding the Compliant leadership style is provided on the DISC website (2024):

> high expectations and insistence on quality
>
> ability to look at ideas and problems logically
>
> faces challenges head-on
>
> ability to exercise caution and manage risks

interest in developing systematizing tasks

persistence in finding and analyzing solutions

lays out expectations objectively

These managers often need help appreciating that to grow as a leader, they'll need to embrace the humanity of their direct reports on a deeper level. By understanding other perspectives, they see that the people they manage often need praise, excitement, optimism, camaraderie, or risk-taking at a much greater level than they do.

I would also note that there are limits to the Compliant Rainbow leader's heart-felt, extroverted enjoyment of other people. This is where the corrective insights offered by DISC are of great value. The use of "Compliant" as the DISC title for the fourth managerial style is telling. The Compliant Rainbow leader is energized and effective as long as there is a smooth operating procedure in place. I already mentioned that these leaders can be effective and flexible if they are comfortable with the way things are operating. Some of the leaders quoted by McKenna and Pugno (2006, pp.169-170) suggest that many health care leaders are not comfortable with things not going right—especially when there is confrontation:

> Nearly all physicians feel that we are good communicators - it's what we do all day. Very few of us are good at confrontation. We are used to an unbalanced power structure that does not leave much room for confrontation. We have learned to avoid troublesome, patients, staff, colleagues, or dissention on committees. Of course, that doesn't mean we don't complain about it. We need to learn how to deal with confrontation, and how to assert ourselves in inherently asymmetric power structures - say, when dealing with a Chief of Staff, or health plan insurers, the head of the medical group practice or the senior partner. [Bridget McCandless, MD, Internist Medical Director, Jackson County Free Clinic]

DISC used the label "compliant" because these leaders like to "follow the book." They want solid procedures to be in place so that there are NOT major confrontations. While diversity is welcomed, it is only welcomed because everyone agrees to a set of rules and norms of conduct. "We play nice or not at all!" emerges from the memory of these leader regarding what their mother told them. This golden rule still holds true for these compliant leaders.

There is not just an upside to Compliant Rainbow leadership. Unconscious assumptions that C-style managers sometimes make can get them in trouble. Some of the inappropriate uses of the Compliance Style are based on a set of assumptions identified on the DISC website (DISC, 2024).

If I make a mistake, I'll lose my credibility.

If people haven't gotten negative feedback, they will assume they're doing a good job.

We need all the information before we make a big decision.

It's undignified to show intense or tender emotions at work.

Time spent relationship building is largely frivolous.

My judgment is completely objective and unbiased because I use logic.

Emotions have no place in decision-making.

There's one best way of doing things.

If my feedback is objective and fair, I don't need to cater to people's feelings.

I need to consider all the variables before I decide.

You should keep emotions to yourself.

If I make a bad decision for the group, it will never be forgotten.

I've thought this through and there's no better way to see it.

Like the other three leadership styles, the Compliant Rainbow leadership style can be overused or misused. The Rainbow leader can get caught up in a primary concern for group/team process rather than outcomes. The group is "perfectly run"—but no productive work gets done. Participants might learn more about themselves and about how groups function, but they might leave having "wasted their time" when it comes to the achievement of a tangible outcome. There is also a tendency toward interpersonal neediness. The Rainbow leader is always looking to other people for self-confirmation and assurance that things are being done "in the right way."

What are the major challenges for the Rainbow: being asked to be consistent (a request often brought up by a Golden Yellow) and being asked to be more principled and less expedient (often brought up by an Azure Blue)? The Ruby Red offers their own challenge: they ask the Rainbow leader to help get it done immediately and not overdo the "perfect" group facilitation. The existential threat for someone with a Rainbow orientation is to be left alone without support, information or guidance—and to be ineffective in their interpersonal or group relationships. The effective Rainbow leader is someone who will adapt to changing conditions by moving through all three domains (information, intentions and ideas). Effective Compliant leadership requires a balance between or even an integration of the three different domains.

The Pot of Gold: Collaboration

Effective Compliant Rainbow leadership is something more than just "doing a good job." The Rainbow leader dreams of the mythic pot of gold to be found at the end of the rainbow. This pot of gold, however, is elusive--especially when it requires Integration and Collaboration. Perhaps that is why it exists in myth but not often in reality. The pot of gold is elusive because collaboration is often hard to achieve—easily becoming collusion—and because Integration often falls apart under conditions of anxiety and uncertainty (we tend to regress to a deeply-held preference for one of the three primary styles).

How do we move to sustained collaboration? It begins with acknowledgement and appreciation for all three of the primary styles of leadership and interpersonal preferences associated with these styles. We need Ruby Red, to ensure that we don't get stuck in analysis paralysis (Golden Yellow) or become too dreamy (Azure Blue). We need Azure Blue so that we might be clear about the direction in which we are headed. We don't want to leap out of the foxhole without knowing the cause for which we are willing to give our life (or at least devote our time and energy) (Ruby Red).

Furthermore, we need to know what kind of information we are collecting and for what purpose—valid information is of no use if it is not goal-specific. The Thoughtful Golden Yellow is also important and must be engaged (even if those with this orientation are reticent to get engaged in these collective endeavors). Without Golden Yellow, a group can be charging out of the foxhole without adequate ammunition (Ruby Red) or can remain in the foxhole or never get to the foxhole while espousing a dream of peace that is unrealistic and unattainable (Azure Blue).

A clear articulation of the contributions to be made by each perspective, as well as recognition of the other two-color blends (to which we turn shortly) help to make the Integration possible. An even more important set of three strategies are required. They come from the writing of Watson and Johnson (1972) regarding the important role played by reform in structures, processes and attitudes when bringing about improvement in the functioning of a human system.

Structure

The foundation for effective team operations resides in the design of this team as it is situated in the system where it will operate. McKenna and Pugno (2006 pp. 106-107) turn once again wisdom offered by Dr Jessee:

> . . . we must beware of the frequent challenges faced by teams. Namely, lack of accountability for performance, using the team for all issues rather than being selective, placing too high a value on individual autonomy, stereotyping team leaders or members, or simply going through the motions with 'pseudo teams.

I wish to expand on these insights offered by Dr. Jessee regarding the environment in which an effective team operates in a health care setting. Specifically, I attend to the four spans within organizations that Robert Simons (2005) suggests play an important role in determining the effectiveness of teams. These four spans are: (1) control, (2) accountability, (3) responsibility and (4) support. Each of these spans can be narrowed or widened. Each span relates in a somewhat different manner to one of the three fundamental styles of leadership.

Two of the spans measure the *supply* of resources the organization provides to project teams. The span of control relates to the level of direct control a team has over people, assets, and information. The span of support is its “softer” counterpart, reflecting the supply of resources in the form of help from people in the organization.

The other two spans—the span of accountability (hard) and the span of influence (soft)—determine the team’s *demand* for organizational resources. The level of a project team’s accountability, as defined by the organization, directly affects the level of pressure on team members to make trade-offs; that pressure in turn drives the team’s need for organizational resources. The team’s level of influence, as determined by the structure of the team and the broader system in which the team is embedded, also reflects the extent to which team members need resources. We typically have substantial control (internal locus of control) with regard to two of the four elements (Control and Influence) but have very little direct control (external locus of control) with regard to the other two elements (Accountability and Support).

Span of Control: [Internal Locus of Control] [Supply Element]: This first span defines the range of resources—not only people as resources but also assets and infrastructure—for which an employee or

team is given decision rights. The team is held accountable for performance resulting from deployment of these resources. To narrow the Span a leader reduces the resources allocated to specific positions or units, while **t**o widen the Span, the leader allocates more people, assets, and infrastructure.

I move beyond what Simons has provided by identifying both formal and informal versions of each span element as they operate in both teams and individual jobs. At a fundamental level, control resides in the *Authority* that is invested in a team or job. This is the amount of *Formal Authority* held by a team or in a job. This span concerns the resources which an individual employee or team "owns" or has been officially assigned to and provided for this project.

A team or individual employee is more likely to be successful if it gains access to substantial resources in the organization--though with more substantial resources come increased expectations (a dimension of one of the other spans). There is also *Informal Authority* that influences span of control. This occurs when attention is given to the *Patronage* which operates in organizations. In this case, resources to which employees and teams have access are officially "owned" by or assigned to others in the organization.

Span of Accountability: [External Locus of Control] [Demand Element]: This second span concerns the range of trade-offs affecting the measures used to evaluate a team's achievements. The setting of this span is determined by the kind of behavior the team's supervisor wants to see. As Simons (2005) noted, the span of control and span of accountability are not independent. They must be considered together. The first defines the resources available to a team; the second defines the goals the team is expected to achieve.

By explicitly setting the span of accountability wider than the span of control, leaders can force an employee or members of a team to become more entrepreneurial. In order to narrow the Span, a leader standardizes work by using measures (either financial, such as time-item budget expenses, or non-financial, such as head count) that allow few trade-offs. To widen the Span, a leader typically uses non-financial measures (such as customer satisfaction) or broad financial measures (such as profits) that allow many trade-offs.

I would suggest that residing at the heart of this span is an often-elusive factor called *Expectations*. An employee or team is more challenged if the expectations of others in the organization are higher (though higher expectations often come with greater authority over and access to organizational resources). There are *Formal Expectations.* These are the designated and assigned outcomes for the employee or team. *Informal Expectation*s often come in the form of *Hope*. These are the often unacknowledged, but shared, expectations regarding the outcomes of work done by an individual or team members if they are highly successful. We are likely to be more challenged if the expectations of others in the organization are higher (though higher expectations often come with greater authority over and access to organizational resources).

Span of Influence: [Internal Locus of Control] [Demand Element]: The span of influence, according to Simons (2005), corresponds to the width of the net that a team needs to cast in collecting data, probing for new information, and attempting to influence the work of others. Leaders can widen the span when they want to stimulate their employees and teams to think outside the box to develop new ways of serving customers, increasing internal efficiencies, or adapting to changes in external markets. Leaders can widen a team's span of influence by redesigning the task assigned to this employee or project team.

For instance, the team can be encouraged to enter into a cross-functional relationship with another team.

Leaders can also adjust an employee's or team's span of influence through the level of goals they set. Although the nature of a team's goals drives its span of accountability (by determining the trade-offs team members can make), the level or difficulty, drives her sphere of influence. As Simons (2005) observed, a team that is given a stretch goal will often be forced to seek out and interact with more people and other teams than a team or person whose goal is set at a much lower level. Finally, leaders can use accounting and control systems to adjust the span of influence (e.g. assigning indirect cost allocations to the team).

Leaders can narrow the Span by requiring members of their organization to pay attention only to their own jobs; do not allocate costs across units; use single reporting lines; and reward individual performance. Conversely, they can w*iden the Span by i*njecting creative tension through structures, systems, and goals. For example, the leader can form cross-unit teams, matrix structures, and cross-unit cost allocations.

We can once again move into the heart of this third span —and we will find *Motivation*. In this case, it is all about motivating other people —we influence them by increasing their desire to (and potentially ability) to achieve some important (shared) goal. A job holder or team members are likely to gain much more support in an organization (yet also increase expectations) if they hold the potential of influencing (motivating) other projects in the organization.

At the formal level, we find *Enablement* and *Assistance* —which makes for *Tangible Influence:* This is the direct way in which an employee or members of a team can benefit others in the organization and, more specifically, contribute to the success of other projects. At the informal level we find *Encouragement* which is a form of *Intangible Influence:* These are the indirect ways in which individual employees and teams can be champions or ever-present "colleagues" to others in the organization. These valuable members of an organization can be motivating cheerleaders and admiring observers on the sidelines.

Span of Support: [External Locus of Control] [Supply Element]: This fourth span concerns the amount of help a project team can expect from teams and individual people in other organizational units – how much commitment from others the team needs in order to implement strategy. Simons notes that wide spans of support become critically important when customer loyalty is vital to strategy implementation or when organizational design is highly complex because of sophisticated technologies and a complex value chain. Teams cannot adjust an employee's span of support in isolation —for the span is largely determined by people's sense of shared responsibilities, which in turn stems from an organization's culture and values. For a leader to narrow the Span of support they can use leveraged, highly individualized rewards, and clearly single out winners and losers. For them to widen the Span, leaders must build shared responsibilities through purpose and mission, group identification, trust, and equity-based incentive plans.

True and enduring support in an organization comes not just from connecting with and receiving tangible or intangible support from other people, another project, another initiative or another agency in the organization. It comes from a *Triangulation,* wherein both you and the other entity link positively with a third entity (a shared mission, a shared vision, a shared commitment to and capacity to enable a more general and critical project in the organization). A triangulated structure is always stronger (able to

withstand powerful external forces) than a structure with only two anchor points (or two sets of anchor points: a four-sided structure).

We find formal levels of support in acts of *Investment.* This is the way in which *Tangible Support* is offered. Unwavering and specific contributions of resources arrive from elsewhere in the organization to you and your work. At the informal level, support is offered through *Encouragement.* This form of *(Intangible Support is conveyed through the* sustained and honest best wishes of others in the organization for your success in your current job or team.

Process

While an effective team will be journeying toward the pot of gold by operating in an organizational environment with appropriate levels of control, accountability, influence and support, a way of operating is also critical to the success of this journey.

Finding Truth in Dialogue: Specifically, I would suggest that the process of dialogue (rather than debate or discussion) is an essential ingredient regarding the way a team operates. I am not alone in making this recommendation. One of McKenna and Pugno's (2006, pp. 161-162) leaders speaks eloquently and at some length about this critical use of dialogue in building effective health care teams:

> Authentic leaders communicate candidly and constructively with others, and help others become respectful, honest, effective communicators. Using effective dialogue skills, leaders help others solve problems and move forward. The Greek roots of the word 'dialogue' could be loosely translated as 'meaning flowing through.' Dialogue is the respectful, two-way, open-ended flow of communication that balances listening and speaking for the purpose of learning. Other forms of communication - debate, directing, discussing - may influence or control people, but are unlikely to maximize productivity or effectiveness to the extent possible through meaningful dialogue.
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> Authentic leaders create dialogue by asking effective questions that lead to enlighten and engage others. Effective questions are often open-ended; for example: 'What do you think about this idea?' "How would you solve this?" "What other factors should we be considering?' 'What do you see as the obstacles we face?"
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> To respond, others are required to share their thoughts and ideas. The discussion should flow naturally. You may begin, for example, by inquiring about the person's hopes or intentions: 'What do you want to accomplish?' This leads to problem identification: 'What problems are you encountering?' which can be followed by assistance in exploring solutions: 'What do you see as your options?' The leader can then encourage action, by asking, for example: 'How do you plan to proceed?' and offer support: 'What can I do to support you?' [Francine R. Gaillour, MD, MBA, FACPE, Internist, Founder and Director of Creative Strategies in Physician Leadership™]

It is at this point that Dr. Gaillour acknowledges the reticence of many physicians to confront other people. He goes on (as someone who coaches physicians) to recommend a set of questions which physicians might engage that further the dialogue and provide constructive confrontation (McKinna and Pugno, 2006, p. 162). He has identified what is often referred to as a confrontation script (Bergquist and Mura, 2011, pp. 227-239):

> Many physician leaders squirm at the thought of 'confronting' colleagues about inappropriate behavior. Focus on the behavior, not the person. Be aware of any bias you may harbor because of behavior style differences between you and the other person. Speak frankly, without anger or judgment. Don't settle for simply 'd fusing' such situations - seize them as opportunities to help others achieve their full potential. Here is a seven-step discussion format I often suggest to the clients I coach:
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> 1. Describe the observed or reported behavior and the effect it had on others.
> 2. Probe for additional information.
> 3. Probe for acknowledgment of the event and the effect.
> 4. Suggest or request a new behavior.
> 5. Ask for agreement.
> 6. Encourage the person to develop skills to address the behavior in the future.
> 7. Agree on next steps for follow-up.
>
> Authentic leaders are respectful, honest communicators, and help others communicate effectively as well. By communicating and collaborating, leaders help others overcome challenges and achieve results. Francine R. Gaillour, MD, MBA, FACPE, Internist, Founder and Director of Creative Strategies in Physician Leadership™]

There are many process-based interpersonal and group tools and strategies that help to create and maintain effective team functioning. These include the cluster of communication tools involved in Active Listening (Bolton, 1986; Bergquist and Mura, 2011) and strategies that encourage the generation and integration of diverse perspectives—such as those associated with Bohm dialogue (Bohm, 2004).

In agreement with Dr. Gaillour, I propose that the fundamental feature of any effective team process is centered on the engagement in dialogue. As Ken and Mary Gergen (2004) proclaimed, "truth is only found within community." More specifically, they would suggest that truth is found in trusting relationships: "constructivism favors a replacement of the individual as the source of meaning with the relationship." Even more to the point, truth is found in dialogue – and disagreement. There is an insistence that we respect and learn from other people: "one is invited into a posture of curiosity and respect for others." Of greatest importance is the respect we show for the distinctive expertise which people from all backgrounds bring to the dynamic construction of a desirable future. According to Ken and Mary Gergen (2004), a constructivist framework:

> is . . . likely to favor forms of dialogue out of which new realities and values might emerge. The challenge is not to locate "the one best way." But to create the kinds of relationships in which we can collaboratively build our future.

Balint Method: One of the variants on dialogue that I find to be particularly effective in the functioning of a team comes out of the world of clinical supervision. Michael Balint applied a set of psychoanalytic perspectives to his work with physicians and other professionals. When engaged, the Balint Group Method (Otten, 2017) typically involves the identification of various internal voices that are operating when a specific physician encounters a particularly difficult and elusive clinical issue. This method can also be applied when a team encounters a challenging issue—clinical or nonclinical. Members of team will find that they are "hearing" multiple voices themselves regarding this issue. The diverse

perspectives to be found among team members are identified and articulated. Diverse, often contradictory and at times "shadowy" voices are identified by members of a Balint-oriented team. Members of the team are then assigned specific roles, with each member taking on one of the voices. An enactment of the internal conversation among the voices then takes place with each member of the group verbalizing the voice they have been assigned. They then interact with the other voices in a rich and often insightful dialogue regarding the presenting issue.

The person presenting this issue (or leader of the team) listens to the dialogue and when it is finished reflects on what has been learned. The external enactment of the internal dialogue can be a rich source of learning for members of the team. Critical (often collective) discernment can take place in a supportive, public setting. Personal perspectives are now explicit. No longer held in a tacit manner, personal viewpoints, hopes and fears can now be viewed in a new way by members of the team. I would suggest that this Balint process can be of value when engaged in many settings. I have found this to be the case in my own work with the Balint Method as a process that invites dialogue (Bergquist, 2014).

Attitude

The structure and process of a team resides in the head of those who lead the team and those who work alongside the leader of the team. There is also the matter of heart. How do members of the team feel about working with one another. In the tension-filled world of contemporary health care it is particularly important that members of a team not only support one another but also fully appreciate and utilize the strengths and insights offered by other members of the team.

This perspective on the value and strength inherent in other people is articulated by one of McKenna and Pugno's (2006, pp. 244-245) leaders who identifies two antithetical management styles:

> I have read a few books on management styles, and they tend to fall into two categories. Either you are trying to make employees or coworkers fix their weaknesses, or, the philosophy I agree with. manage to strengths. I think you can get a lot more value from managing to someone's strengths than by trying to correct their weaknesses. I like to look at both employees and colleagues, and determine their strengths and what they really like to do. If they like to manage people and if they like to take on complicated tasks, you should give them more and more of that type of project to do. But you should identify early that there are some people who are better followers than leaders, and the leaders lead using different styles. If you can identify the styles and position it within your organization, I think that you can get a lot more out of people. [Daniel S. Durrie, MD, Ophthalmologist, Durrie Vision Center]

What then is an attitude of appreciation? First, it is important to note that attitudes concern the way in which we see the world in which we live and work. Our attitudes guide the narrative we construct about this world and our reason for being in this world. This narrative can be embedded (and stuck) in the past and in the barriers that make an attractive future seem impossible to achieve. The narrative can instead be constructed around a desirable future to which our collective energy and expertise can be directed.

Effective narratives emerge from and cluster around something called an *Appreciative Perspective* (Bergquist, 2003; Bergquist and Mura, 2011). What is the nature of such a perspective? In essence, an appreciative perspective concerns a willingness to engage with other people from an assumption of

mutual respect, in a mutual search for discovery of distinctive competencies and strengths—areas of expertise-- with a view to helping them fulfill their aspirations and their potential. This simple statement might at first seem to be rather naive and idealistic, but at its core it holds the promise of helping to encourage and make use of collective expertise. Furthermore, this perspective comes in several different forms and has several different meanings that build on one another.

Understanding Another Person: Appreciation refers first to a clearer understanding of another person's perspective. We come to appreciate the point of view being offered by our colleague and with this understanding, we can receive and build on their expertise. The tools of active listening are engaged to enable this understanding to take place. We offer a paraphrase of what another person has said so that we might not only benefit from what they have said, but also gained greater insight into their own perspectives by testing the accuracy of what we have heard (as processed through our own perspective).

This appreciative tool arises not from some detached observation, but rather from direct engagement. One gains knowledge from an appreciative perspective by "identifying with the observed." (Harmon, 1990) Empathy is critical. One cares about the matter being studied and about those people with whom one is collaborating. Neutrality is inappropriate in such a setting, though compassion implies neither a loss of discipline nor a loss of boundaries between one's own perspectives and those of the other person. Appreciation, in other words, is about fuller understanding, not merging, with another person's perspectives. It is about being open to, not necessarily uncritically embracing, another person's apparent expertise.

Valuing Another Person: Appreciation also refers to an increase in worth or value. A painting or stock portfolio appreciates in value. Van Gogh looked at a vase of sunflowers and in appreciating (painting) these flowers, he increased their value for everyone. Van Gogh similarly appreciated and brought new value to his friends through his friendship: "Van Gogh did not merely articulate admiration for his friend: He created new values and new ways of seeing the world through the very act of valuing." (Cooperrider, 1990)

Peter Vaill recounts a scene from the movie *Lawrence of Arabia* in which Lawrence tells a British Colonel that his job at the Arab camp was to "appreciate the situation." (Vaill, 1990) By appreciating the situation, Lawrence assessed and helped add credibility to the Arab cause, much as a knowledgeable jeweler or art appraiser can increase the value of a diamond or painting through nothing more than thoughtful appraisal. Lawrence's appreciation of the Arab situation, in turn, helped to produce a new level of courage and ambition on the part of the Arab communities with which Lawrence was associated.

When we seek out a fuller and more accurate assessment of another person's perspective—though the use of active listening—then we are "valuing" what they have to contribute. When we fully appreciate our colleague's unique perspective in the engagement and use of collective expertise, then we have raised their worth as contributors to this collective effort. Furthermore, we may have seen them, understood them, and valued them in ways that neither our colleague nor other participates in this collaborative effort might have seen them before—thus opening new vistas for their growth and further maturation of the collaborative venture. Paradoxically, at the point that someone is fully appreciated and reaffirmed, they will tend to live up to their

newly acclaimed expertise, just as they will live down to their depreciated sense of expertise if constantly criticized and undervalued.

Recognizing Contributions made by Another Person: From yet another perspective, the process of appreciation concerns our recognition of the contributions that have been made by another person: "I appreciate the efforts you have made in doing research regarding this matter." We are "catching people when they are doing it right" (rather than catching them "when they are doing it wrong"). This tool of appreciative requires not only that we note that what they have just said or done is helpful on behalf of the collective venture, but also an articulate statement regarding Why it has been helpful: "When you said XYZ, I noticed that we have become more CDE and have achieved QRS). Appreciation is not only about what, but also about why. We learn more about the ongoing process of a team when the impact of a specific statement or action is traced. The collaborative team learns from this appreciative tracing of cause and impact.

Appreciation is exhibited in a more constructive manner through the ongoing interaction between those engaged in the building of collective expertise. It involves mutual respect and active engagement, accompanied by a natural flow of feedback, and an exchange of ideas. More specifically, appreciation is evident in not only the processes being engaged, but also the attitudes accompanying these appreciative tools regarding the nature and purpose of work done on behalf of building collective expertise.

These are the three most common uses of the term appreciation. We appreciate the expertise offered by other people through seeking to understand them, through valuing them, and through being attentive and thoughtful in acknowledging their ongoing contributions to the organization. The appreciative perspective can also be engaged in three additional ways that are distinctive—yet closely related to the first three. These three appreciative strategies offer a bridge between expertise-enhancing processes and expertise-enhancing attitudes.

Establishing a Positive Collective Image of the Future: Appreciation can refer to the establishment of a positive image of the future among those engaged in the building of collective expertise. We grow to appreciate our collective effort by investing it with optimism. We invest it with a sense of hope about its own future and the valuable role potentially it plays in our organization or society. Effective appreciative participation in a collaborative venture must be "not only concerned with what is but also with what might be." (Frost and Egri, 1990) We come to appreciate our own role and that of other people with whom we are participating regarding the contributions we make jointly in helping to realize these images, purposes and values.

An appreciative perspective is always *leaning into the future*. There is consistent and frequent attention to what will happen (anticipation) and what should happen (aspirations) in the days and years ahead. Rather than focusing conversations on reconstructed narrative of the past, the conversations are directed toward construction of a new narrative concerning the future. While we appreciate that which has been successful in the past, we don't dwell with nostalgia on the past, but instead continually trace out the implications of shared expertise, acquired wisdom and past successes regarding our vision of the future. We will have much more to say about this appreciative perspective in the next section of this chapter—for it provides the foundation for an expertise-enhancing attitude as well as being a key to expertise-enhancing processes.

Recognizing Distinctive Sources of Expertise: Appreciation in a collaborative setting also refers to recognition of the distinctive expertise and potentials of people working within this setting. Even in a context of potential competition, appreciation transforms envy regarding the other person's expertise into learning from this expertise. Personal achievement and individual contribution of expertise is transformed into a sense of overall purpose and the collective valuing of this expertise. The remarkable essayist Roger Rosenblatt (1997) revealed just such a process in candidly describing his sense of competition with other writers. He suggests that the sense of admiration for the work of other writers can play a critical role in his own life:

> Part of the satisfaction in becoming an admirer of the competition is that it allows you to wonder how someone else did something well, so that you might imitate it—steal it, to be blunt. But the best part is that it shows you that there are things you will never learn to do, skills and tricks that are out of your range, an entire imagination that is out of your range. The news may be disappointing on a personal level, but in terms of the cosmos, it is strangely gratifying. One sits among the works of one's contemporaries as in a planetarium, head all the way back, eyes gazing up at heavenly matter that is all the more beautiful for being unreachable. Am I growing up?

An appreciative culture is forged when an emphasis is placed on the realization of inherent potential and the uncovering of latent strengths rather than on the identification of weaknesses or deficits. People and organizations "do not need to be fixed. They need constant reaffirmation." (Cooperrider, 1990)

Acknowledging the Value of Diversity: A final mode of appreciation is evident in a collaborative setting when efforts are made to form complementary relationships and recognize the mutual benefits that can be derived from the cooperation of differing constituencies and the valuing of varying sources of expertise. This appreciative strategy requires not only the recognition of diverse perspectives and differing backgrounds, but also the engagement in processes (such as Bohm-based dialogue) that brings about a search for common understanding, non-judgmental acceptance, and potential integration of diverse perspective and accompanying practices.

Yet another paradox is found in the engagement of this appreciative strategy. A culture of appreciative diversity actually provides collective integration (the glue that holds a system together) while the organization is growing and differentiating into many distinctive units of responsibility (division of labor) and geography. (Durkheim, 1933; Lawrence and Lorsch, 1969) The appreciative perspective is particularly important in the era of diversity, when there are significant differences in vision, values or culture among people participating in a collective venture. (Rosinski, 2010)

The Blending of Leadership Styles

While the Rainbow orientation and style of leadership brings together all three of the primary orientations and ways of being a leader, there are combinations of two orientations that yield interesting and important variations on the four other styles. We have once again borrowed from the

color spectrum in identifying and describing each of these blends. Orange is constituted of red and yellow. Green is produced by combing yellow and blue. When red and blue are combined the color, purple is produced. I will briefly describe each of these three blends and even suggest ways in which there are slight variations on a specific blend depending on the proportion of each color (style/orientation) in this blend. We begin with Tangy Orange.

Tangy Orange: Purposeful Thought and Action

As a combination of Ruby Red and Golden Yellow, the Tangy Orange style of leadership and the Purposeful Tangy Orange orientation to the world of organizational life is focused on moving to action (Ruby Red) in a thoughtful, data-driven (Golden Yellow) manner. It is a "tangy" orientation because it can be a bit pungent and bitter—given the challenge of engaging action in the midst of a world that is often volatile, uncertain, complex, ambiguous, turbulent and contradictory (VUCA-Plus). A Residency Program Director put it this way (McKenna and Pugno, 2006, p. 203]:

> Managers must make quick decisions, often on the basis of complex and insufficient data. And so, our medical education can be quite helpful, because physicians, too, must by necessity become comfortable with making difficult decisions quickly. The key difference has typically been in the degree to which decisions are made independently (in medicine) or collaboratively (in management). Either way, good communication skills are essential.
>
> Consider, for example, what all of us want from our physicians and our managers. We want them to listen to us, to understand us, to clearly convey to us what we should do. We want to believe that they are focused on our best interests; we can discern that by what they say, as well as by what they do. [Deborah S. McPherson, MD. FAAFP, Family Physician Associate Director, Family Medicine Residency Program, Kansas University Medical Center]

We see the Tangy Orange orientation of Dr. McPherson displayed in her emphasis on the quick decisions that must be made in contemporary health care systems (Ruby Red) balanced off with careful and clear communication (Golden Yellow). To be both Fast and Clear is indeed quite tangy.

The tanginess is also evident in the dynamic integration of thought and action in the world of Tangy Orange. In this world, change does not just occur by pushing forward (Ruby Red) or by preparing a ten - page document in which the steps to be taken are identified (Golden Yellow). Managed change involves the blending of thoughtful planning with a commitment to action. One of McKenna and Pugno's (2006, pp. 208-209) leaders offers her own suggestions concerning this Tangy Orange management of change:

> Physicians need to be in active management of change. Particularly with respect to the implementation of technology, change needs to be planned and implemented in advance of the implementation. The use of change management strategies at an early stage might save a great deal of money and organizational pain. In order to implement technology or any health-care strategy successfully, physicians need to involve din that change. The best technology in the world will be ineffective if system planning is not accomplished by careful attention to change management. . . . [C]omprehensive staff orientation and training prior to initiation should include open communication about the technology, clear understanding of the goals, administrative support and leadership should be visible, and get buy-in from the users from the beginning. Every attempt should be made to avoid being cryptic or secretive. Physician leadership is a crucial element to change management because the physician is able to

> encourage, guide, and support the successful implementation from its inception to its completion. [M. Susan Kraft, MD, CRO, Family Physician, Baptist-Lutheran Medical Center, Goopeert Family Medicine Residency Program]

At the more Golden Yellow end of Tangy Orange, we find advocates for longer-term strategic planning with an emphasis on the systematic collection and organization of data to achieve specifiable and measurable goals. At this end of Tangy Orange, we also find an emphasis on being realistic about what can actually be accomplished given limited time, resources and energy. Priorities need to be set and tough decisions need to be made regarding what to set aside. We have to "cut down some trees" (McKenna and Pugno, 2006, p. 220):

> I have an analogy I use. Every time I plant a tree in my garden, I know that it is going to frow and eventually the branches from each tree are going to run into each other. So every few years, I have to cut down a tree or two and no longer do one or two of the activities. I either pass it on to someone else to do, or just narrow my focus. [Daniel S. Durrie, MD, Ophthalmologist, President, Durrie Vision Center]

Conversely, at the Ruby Red end of Tangy Orange we are likely to find advocates for short term tactical planning with an emphasis on "just-in-time" data gathering and analysis. For these Red-leaning Tangy Orange leaders, there is not time in a VUCA-Plus health care environment to engage in extensive data gathering. They would declare: "This data is likely to be outmoded in a few days and we can't wait for slow-moving thoughtful analyses given the immediate challenges we are facing." This orientation toward immediate use of data and information is to be found not only in the Tangy Orange leader's interaction with others in their organization but also in their interaction with patients (McKenna and Pugno, 2006, p. 95:

> I know that using computers, I could better help patients know warning signs, what to expect, what to do next. The computer was the obvious way to do all that. So I used a word processor to create patient handouts on paper. [Randall Gates, MC, Family Physician, Founder and President, Docs, Inc.]

I suspect that this leader would be delighted with the prospect of Artificial Intelligence (AI) further assisting the "just-in-time" physician-patient relationship. Fast AI analyses would be welcomed by the Reddish Tangy Orange leader—and not welcomed by those who worry about the loss of a "human-touch" in health care (especially the Azure Blue leader who is concerned about the nature of a physician's influence on patients).

The just-in-time strategies are often accompanied by a focus on "action learning" (a perspective that I previously described regarding the Compliant Rainbow orientation). The emphasis in a reddish Tangy Orange orientation is on Action—contrasting with the Compliant Rainbow's emphasis on Learning. A wonderful example of "just-in-time" Orange leadership is to be found in the introduction of the "third alternative" by Dr. Daniel Durrie (McKenna and Pugno, 2006, pp. 217-218):

> One thing I learned . . . is what I call the "third alternative" theory. [It involved] a discussion between two parties – two physicians, two employees, or perhaps even two groups of people – who were having trouble making a decision because they had opinions which seemed to be at odds. The topic could range from an office expansion, hiring of employees, patient flow alterations. [One] would enter the group discussion as a leader and . . . come up with another

alternative that neither one of the parties had considered and get them to entertain discussion on this third alternative. It was fascinating to watch, because as people discussed the third alternative, they always came back and resolved the issue they had been discussing before. Maybe the third alternative was the best way to proceed, and the original arguments were discarded, but most of the time, they would return to their original arguments, but now having broken down some of the barriers, and they were able to make a decision and move ahead, and not be at a road block. . . . I use this method all the time, because I don't like conflict, and so if I come into a room and an argument is going on, I am quite uncomfortable, so I use this method, and the easiest thing to do is to get them a little bit off their original subject, discuss a new alternative, and let them come back around to the original discussion. It works great. [Daniel S. Durrie, MD, Ophthalmologist, President, Durrie Vision Center]

We see a magical blending of thought (proposing a new idea) and action (intervening in a dispute) in the third alternative strategy engaged by this physician leader.

For those oriented toward Purposeful Tangy Orange, the major source of joy (and energy) comes from building this effective plan (be it strategic or tactical). The Tangy Orange leader is likely to focus their attention and the attention of others with whom the work on finding the resources to get a job done. Whatever the latest planning fad--it will be cheerfully employed (be it an old-fashion GANTT chart, a much newer OKR template or deployment of Hoshin-Kanri software). During the last couple of decades, a planning "fad" called process re-engineering was often promoted and used by those who were disposed toward Tangy Orange leadership (McKenna and Pugno, 2006, pg. 99):

> Rick O'Neil was a physician leader in a medium sized internal medicine practice near St. Louis. One day he read *The Goal* – an excellent book by Eliyahu Goldratt having to do with the science of improving efficiency through h process engineering. He began wondering what constraints and bottlenecks were typical in the medical practice of internists and what might be done about them. He recognized that the most expensive resource is the clinician, but they often spend their time during work which lower paid staff could do just as well. So using process re-engineering and informational technology, he completely redesigned his practice. [J. Peter Geerlofs, MD, Family Physician, Chief Medical Officer, Allscripts Healthcare Solutions, Inc.]

The strength that a Purposeful Tangy Orange Leader provides to an organization is seeing the perils and pitfalls underlying any plan (Golden Yellow), while also encouraging the organization to move forward with this plan (Ruby Red). We often find that those leaders who are oriented toward Tangy Orange are historians of health care. They recognize the opportunities along with the challenges (McKenna and Pugno, 2006, pp. 215-216):

> I think if you look at the role of physicians historically, it is not too surprising why we are in the situation we are in today. Back in the 1920s and 1930s, the system was very simple. There were patients who needed care and there were doctors—providers—who could provide that care. There was a very close partnership in decision making between the patient and the doctor on what to do—medication, therapy, surgery—and the cost of the are needed. The doctor was well aware of the inconvenience or cost of the procedure or medication, and together they made the decision. Then medicine began to get a more complicated. We need specialized facilities to be able to provide care. Hospitals became more sophisticated. So now patients were not only treated at home or in hospitals. But at a specialized facilities like nursing homes or even

> disease-specific facilities such as TB sanitarians. So now the system had three parts, the patients, the providers, and the facilities. That worked very well, and it was still a direct patient-to-provider relationship. . . . The next things that happened was the development of the third party payer system. Healthcare was getting more expensive and a safety net was needed. . . . The process became quite complicated and doctors were willing to give up some of that decision making, either because of their lack of knowledge in management or because of the lack of leadership skills in the overall healthcare system, and that leadership need was provided by insurance companies, government, third party payers and hospitals. . . . Now there are five players in the healthcare system of today: patients, providers, facilities, insurance companies, and payers (employers and the government0. Who has taken over the decision-making power? Instead of the patient and the doctors making decisions, the power has shifted to the hospitals, insurance companies, and the payers. [Daniel S. Durrie, MD, Ophthalmologist, President, Durrie Vision Center]

The case is being made for the physician leader to be at the table—a case being made as well by the Compliant Rainbow leader. With this knowledge of present-day complexities in health care, it takes courage to move forward. A full heart is required given full knowledge of the challenges that are likely to be faced. In many ways, the Tangy Orange leader stands with the Compliant Rainbow leader as the most courageous of the various types we have identified. Both leaders tend to feel uncomfortable with conflict, yet they move forward with the thoughtful engagement of change.

The challenge for a Purposeful Tangy Orange leader is being asked to keep the end point always in sight. This concern about lost end points is often voiced by Influential Azure Blue leaders. There is the excitement of planned and managed change—but for what purpose? This excitement is manifest in the statement offered by one of McKenna and Pugno's (2006, p. 90) leaders. Dr. Geerlofs offers the following observation and recommendation:

> I know many physician executives who manage but do not lead They're prevalent in health plans, integrated delivery networks, and large medical clinics. They're fulfilling their day-to-day roles, but not making innovative transformative change happen. In fact, executive roles can actually incline people to be more conservative, so the most creative ideas often come from others who are working outside the context of large organizations, . . . We need to help physicians and others catch a glimpse of what a transformed healthcare system can be, what it can mean to patients and the professionals who work within it. We need leaders with passion. [J. Peter Geerlofs, MD Family Physician Chief Medical Officer, A!lscripts Healthcare Solutions, Inc.]

While the challenge offered by Dr. Geerlofs is compelling and very timely given the contemporary crises in many health care systems, one might ask Dr. Geerlofs to identify the desired outcomes to achieved in bringing about "innovative transformative change." He suggests that physicians need to catch a glimpse of what the outcomes of this change can be—but doesn't indicate what he thinks this outcome will be. Like many other Tangy Orange leaders (and similar leaders in other systems) emphasis is placed on the process of change rather than the outcomes of this change. Education and Training is needed—but to what ends? New technologies are to be engaged—but what will they improve?

The threat for a Tangy Orange leader is based on an understandable fear of failing to take all relevant factors into account —which is especially likely to occur under conditions of VUCA-Plus. It is a matter of

learning from our mistakes rather than never making a mistake. Without this action-learning orientation, the Purposeful Tangy Orange leader is inclined to never move forward—despite being courageous. As Dr. Tim Munzing declares: "Avoid paralysis by analysis - don't miss opportunities waiting for all the information when you have a sufficient amount to make a good decision." [Tim Munzing, MD, Family Physician Kaiser Permanente - Orange County] (McKenna and Pugno, 2006, p. 203)

Verdant Green: Analytic Compassion and Visioning

Verdant Green is a combination of Golden Yellow and Azure Blue. Ideally, it brings together the thoughtfulness and data-based orientation of Golden Yellow with the caring, service-oriented orientation of Azure Blue. We find this orientation to be abundant in the human service sectors of our society and in the human relations divisions of contemporary organizations. It is also prevalent in certain sectors of health care – especially those sectors that push for expansion beyond the traditional confines of allopathic medicine and for a focus on the motives and concerns of both those providing health care and those receiving it.

Verdant Green is about opening the options for action (once again contrasting with the tendency of Ruby Reds to close off the options too quickly). The term Verdant is used because this is a Green that is fully alive (perhaps even overgrown) with abundant foliage (choices). These choices often are articulated in a desire among Verdant Green leaders to bring multiple disciplines into the perspectives and practices of the medical profession. Many of these leaders are particularly inclined to recommend advanced education in management among those who wish to address the complex issues of contemporary health care. A physician in the Mayo system offers just such a recommendation (McKenna and Pugno, 2006, p. 252):

> Why are dual degree programs becoming so prevalent? The practice of medicine is vastly different today. In the past, administration was mostly ignored by doctors who wanted to do their own thing. For example, when the U.S. government began funding medical care, the repercussions weren't quickly appreciated. When the government became the largest payer for medical services, it wasn't long before Washington began to dictate prices and standards. For better or worse, medical care in the United States was changed forever.
>
> Another example is evidenced in technology advances. Doctors today must know about the business and the law of medicine. Pharmacists face similar challenges. They are scientifically oriented and running a pharmacy is a complex business. Many medical schools still avoid business topics - except as an option perhaps. [Monte L. Anderson, MD, Gastroenterologist and Hepatologist, Mayo Clinic Scottsdale]

His sentiments are echoed by another physician leader that McKenna and Pugno (2006, p. 252) frequently site:

> I think these days it is not a bad idea for physicians to pursue an MBA along with their MD. A program for this is being developed in the Kansas City area, and I think that is great.
>
> When we commit to medicine as a profession, we are also committing to some or all of the following roles: mentor, team leader. partner, employer, small business owner, accountant, and community leader, to name a few. Perhaps training for some or all of these roles should be included in the medical school curricula. But until that happens, those of us already in practice

> need to share our knowledge and experience with our younger colleagues. Perhaps doctors in training today will be better equipped to be leaders as well as physicians. [Daniel S. Durrie, MD. Ophthalmologist, Durrie Vision Center]

McKenna and Pugno (2006, pp. 252-253) offer their own perspective on this matter of multi-disciplinarity:

> Successful physician leaders maintain competence in their ever-advancing clinical specialties even while developing competence in the art of leadership and the science of management. Doing so often involves mastery, or at least minimal comprehension, or management knowledge with regard to topics such as
>
> - Accounting: budgets, income statements, balance sheets, cash flow projections
> - Finance: capital investments, lease vs. buy decisions, profitability and liquidity
> - Economics: supply and demand, allocation of resources
> - Law: legislation and regulation, contract law, liability
> - Ethics: professional, organizational, social rights and responsibilities
> - Marketing: attract and retain customers, strategies to grow and compete
> - Information Technology: automation, decision support, data storage/transmission
> - Operations: scheduling, facilities, procurement, resource utilization, quality control
> - Human Resource Mgmt: hiring, training, compensation, performance management
> - Leadership: setting direction, building commitment to achieve shared objectives
> - Organizational Behavior: innovation, change, teamwork, job design, policies, values

I find this embracing of multiple options and multiple disciplines uniquely evident in the wishful pronouncements of a leader quoted by McKenna and Pugno (2006, p. 148). She serves as both a physician and church deacon:

> I want the way we provide care to return to the pre-enlightenment time when body, mind and spirit were recognized as being inseparable. Ancient practices across two thirds of the world saw the spiritual component as much a part of healing or wholeness as the medical science component. They acknowledged the emotional, spiritual, and relational ramifications of a person's physical disabilities. [Reverend Pamela S. Harris, MD}

Dr. Harris is particularly concerned about the introduction of this integrative approach into health care, and about the bridge that should be bult between the medical profession and the church (McKenna and Pugno, 2006, p. 148-149):

> I want doctors to incorporate this awareness into the treatment plans and care they offer. I want the church to be one of the best sources of legitimate information for people seeking health and wholeness. In church, we not only minister to the soul, we honor the body as well. As a Deacon, I'll be ordained to serve, to bring the concerns of the world to the church, and to empower people in the church to use their gifts in service to the world. This is the bridge from head to heart to hands. A pitcher, basin, and towel (reminiscent of Christ's washing the feet of his disciples) are the symbols of Deacons - they remind us that whoever would be great must be a servant. [Reverend Pamela S. Harris, MD]

The garden that Drs. Harris, McKenna and Pugno envision would certainly be verdant and filled with multiple perspectives and practice. This is a garden of diversity and divergence. Verdant Green leaders look at the world and one's place in this world from multiple perspectives. One of the benefits residing in this diversity of perspectives is the capacity to "think out of the box" (McKenna and Pugno, 2006, p. 251):

> I'm a fan of Clayton Christiansen's ideas about disruptive innovation. I highly recommend both of his books - The Innovator's Dilemma and The Innovator's Solution. A professor at the Harvard School of Business, his theory describes how large, successful enterprises often are unable to successfully keep up with innovation, because most of their effort is on incremental changes requested by their demanding customer base. As a result, their products become ever more complex and expensive. This leaves room for tiny companies to do an end run around the larger business by producing products which are simpler, cheaper, and more in line with what the market as a whole, who can't afford the sophisticated products of the large company, wants. I'm greatly oversimplifying an elegant business theory-but the bottom line in my opinion is that healthcare needs disruptive innovation to transform itself quickly. This requires that physician leaders learn how to think out-of-the-box, getting beyond the delivery paradigms we have been living with over the past 30 years. [J. Peter Geerlofs, MD. Family Physician Chief Medical Officer, Allscripts Healthcare Solutions, Inc.]

Diversity shows up in many ways. The Verdant Green leader enjoys engaging in a wide variety of relationships—both inside and outside medicine. They remain curious regarding the perspectives and practices of physicians working in other areas of medicine and might even encourage rotation of physicians between areas—which makes no sense to those physician leaders (like the often-quoted Dr., Durrie) who are more Ruby Red in their orientation (McKinna and Pugno, 2006, p. 81):

> It isn't uncommon for healthcare organizations to rotate physicians through medical staff leadership roles every couple of years. Thus physicians end up in the role whether they're good at it or not, whether they're interested in it or not. That doesn't make much sense to me. [Daniel S. Durrie, MD, Ophthalmologist, President,, Durrie Vision Center]

Cross-cultural experiences are a source of great excitement rather than dread. There is often wide-ranging interest in books, music, theater and any other venue that offers something new and different regarding the human condition. To quote one of McKenna and Pugno's (2006, p. 257) leaders:

> My advice to physicians who aspire to make leading contributions in healthcare? Read a lot! Especially early in your career. Many wonderful thought leaders have published some very good books and articles. [Ronald N. Riner, MD, Cardiologist President, The Riner Group]

In keeping with their multi-disciplinary orientation, many Verdant Green leader also strongly recommend lifelong learning and participation in a wide variety of education and training program (McKenna and Pugno, 2006, p. 257):

> . . . [S]eek formal training courses-through professional organizations, universities, and other educational institutions. I'm not an advocate of MBA degrees for everyone, but I do believe many physicians will benefit by attending two to five day workshops in order to learn a particular aspect of business, management, or leadership that you need." [Ronald N. Riner, MD, Cardiologist President, The Riner Group]

This diversity and multiplicity of perspectives and practices is evident even inside the world of Verdant Green leadership. At the Golden Yellow end of Verdant Green, we find perspectives and practices that are highly rational and systematic. The Verdant Green leaders who are leaning toward the Golden Yellow end of the spectrum tend to look for evidence of effective service throughout the history of medicine: (Mckenna and Pugno, 2006, p. 70)

> I'm a history buff so I enjoy reading about physicians from years gone by. There are so many upon whose shoulders we stand! Understanding their accomplishments shows us how easy we have it today. For example, Icgnaz Semmelweiss, who discovered a way to prevent childbed fever, was ridiculed mercilessly throughout his career. When I began training as a gastroenterologist, none of us really knew what caused ulcers nor did we have any very effective treatment. An Australian physician, Barry Marshall, announced that he concluded from his studies that bacteria can cause ulcers. To say that some of our leaders were skeptical is an understatement. Now we know his insights to be true, and that took place in the 1970s.
>
> The 1988 book Dopors: The Biography of Medicine by Sherwin Nuland, MD - Professor of Surgery at Yale - profiles over a dozen doctors. The book is not exhaustive, but it illustrates clearly what I've been saying. For example, the book features a French military surgeon named Ambroise Pare who worked with Napoleon's Army back when the accepted treatment of large wounds consisted of cauterizing them with hot oil. The patients would spend their nights in agony. One day the supply of oil was exhausted, and Pare noticed that his patients fared better. So he became a 'minimalist surgeon: performing only necessary interventions. Another good book is The Doctors Mayo written by Helen Clapesattle. I am inspired by reading about these people and their great contributions to the tradition of medicine." [Monte L. Anderson, MD, Gastroenterologist and Hepatologist, Mayo Clinic Scottsdale]

It is interesting to note that Verdant Green physician leaders resemble Tangy Orange leaders in their interest in history. However, this interest resides among the Tangy Orange leaders in finding quick solutions to the medical problems they are facing. By contrast, the Verdant Green leader is more inclined to look back at the history of their field as a way to inspire their own search for new and better medical treatments.

Similarly, both the Tangy Orange and Verdant Green leader is committed to learning from mistakes that are made. A Verdant Green leader put it this way (McKenna and Pugno,2006, pp. 243-244):

> I don't chart a course for the next five years, or do formal long range planning. I do, however, reflect on what I've accomplished (and what I haven't) as well as what I've learned. For example, reflecting on the email guidelines I've disseminated, I appreciate the impact they are having. Reflecting on the website I created about electronic communication in patient care, turned out to be, I believe, a good move. On the other hand, I regret not having spent more time writing.
>
> I learn from my mistakes. I've come to realize that I'm not very deferential. I'm frank with people. I say, 'This isn't working well, can we talk about how it can be better?' I make it a habit to be positive. Some people are sourpusses constitutionally. They have to work especially hard because nobody likes a sourpuss or downer.
>
> [What] about mistakes I've made. Years ago, I sent an open letter to our CIO, pointing out that he was a scoundrel and a liar (not my exact words) for diverting promised resources from a

patient safety initiative in IT. I later regretted doing that, because it was not politically savvy. I should have said those comments lace to lace (! had, but apparently not strongly enough), or in a private letter; sending the open letter was not the right thing to do. It was a rookie move that came from inexperience. [Daniel Z. Sands, MD, MPH, Internist, Faculty, Harvard Medical School Chief Medical Officer and Vice President, Clinical Strategies, Zix Corporation]

Once again, Verdant Green and Tangy Orange leaders tend to diverge in how they attend to mistakes and the ways in which they learn from the mistakes. The Verdant Green leader will tend to use their own personal history when exploring lessons learned from mistakes. As was the case with Dr. Sands, they usually focus on flawed interpersonal relationships. By contrast, Tangy Orange leaders tend to engage in historical analyses that involve mistaken plans and flawed systems rather than personal foibles.

The Verdant Green and Tangy Orange leaders also share a commitment to reflective practice (McKenna and Pugno, 2006, p.241:

> All of us are 'brainwashed' in that we've adopted a view of the world that seems true and natural to use. We fail to see our own conditioning and cultural indoctrination. There is a paradox here in that we are most fulfilled when we strive for the truth and reality. However, there is not a single or true reality. Each of us creates our own reality.
>
> We must ask ourselves: 'What am I doing? Does it work? Do the results reflect my intent? Is it meeting my needs?' In the end, this is really about asking, 'What meets the common good? If this doesn't, then what would?' We need to be willing to step back, throw out all our assumptions, and take a fresh look. [Randall Oates, MD, Family physician, Founder and President, Docs. Inc.]
>
> Culturally, most physicians have a tremendous victim mentality. That's what creates a lot of the craziness in medicine. We need leaders to help us get out of that mindset. We are in charge of our well-being and our life's experience.

Once again, there are differences in the use of reflective practice among Verdant Green and Tangy Orange leaders in health care. Those with a Tangy Orange orientation are primarily concerned with the outcomes of a specific medical strategy or practice. They engage in “just-in-time-learning” that comes from immediate feedback (“this isn’t working!”) By contrast those, like Dr. Oates, with a Verdant Green orientation are concerned not just with the outcomes but also the level of alignment of these outcomes with the original intentions associated with this strategy or practice.

While there is a commitment to real-time learning by those with a Verdant Green orientation, this learning is linked not so much to just-in-time correction of a specific medical practice, but instead to better understanding of over-arching theories and concepts of medical practice (McKenna and Pugno, 2006, p. 264):

> I believe formal training is best when nested in a real-time work environment. That way people can apply the theories and concepts they're learning into their actual work experiences, and draw from their work experiences to better understand the concepts and theories. [Jeannette South-Paul, MD, Chair of the Department of Family Medicine, University of Pittsburgh School of Medicine]

Bringing in the distinction offered by Daniel Kahneman (2011), the Verdant Green leader is using history and reflection to think slowly and thoughtfully about medical practices, whereas the Tangy Orange is using history and reflection to think quickly about a pressing medical issue so that correct action can be taken immediately. Both the Verdant Green and Tangy Orange physician turn to the Golden Yellow side of their leadership preferences—but for differing reasons.

We can turn to the other end of the Verdant Green perspective to find a leaning toward Azure Blue. At this end we find a deep concern for the motives and aspirations of physicians (McKenna and Pugno, p.171):

> No one can really 'lead' doctors. To motivate doctors, one must understand the world they live in. Real leaders understand perfection isn't possible. Physician leaders understand that doctors are just as wounded and flawed as anyone else, but are sensitive of their need to protect the mindset that they lack flaws and wounds. Docs typically have a strong need for achievement and independence. How do you herd cats? You get out the tuna fish. Anyone who aspires to lead physicians must figure out what will motivate physicians at a gut level. [Randall Oates, MD, Family Physician Founder and President, Docs, Inc.]

From this Verdant Green perspective, the matter of "authenticity" becomes of prime importance (McKenna and Pugno, 2006, p. 188).

> Authentic physician leaders recognize our responsibility to model the communication and interpersonal skills we want others to exhibit. We ask ourselves: 'How well have I communicated? How clearly have I set expectations? How consistently have I been modeling the behaviors I want others to adopt? How appropriately have I been holding myself and others accountable?'

Physicians must gain insight about themselves if they are to effectively serve other people. Self-knowledge blends Azure Blue and Golden Yellow. This blending is deeply embedded in the Verdant Green perspective. (McKenna and Pugno, 2006, p. 188):

> [Authenticity] requires us to know ourselves - to separate who we are and want to be from what the world thinks we are. No one can teach us how to become ourselves, to take charge, to express ourselves. Only we can do that. We do so by engaging in honest reflection to increase our awareness of ourselves and those around us - of our deepest hopes and concerns, our needs and aspirations.
>
> We uncover our personal power through self-reflection, by taking in the lessons we've learned from failures, by aligning our action with our values. We lead authentically as we allow ourselves to be guided by a higher purpose, to speak and behave in a manner consistent with our values, to project our very souls into our work. This requires an honest assessment of our underlying values and natural gifts, and a willingness to fully express them, rather than letting fear hold us back. [Francine R. Gaillour, MF, MBA, FACPE, Internist, Founder and Director of Creative Strategies in Physician Leadership)

Regardless of the place they reside on the spectrum between Azure Blue and Golden Yellow, the Verdant Green leader wants to be helpful. They would like to know how best to deliver this assistance—which leads them toward thoughtful interpersonal relationships. They wish to be open-minded

regarding alternative perspectives and authentic in their relationships with other physicians (and other members of the healthcare community. They are gratified when gaining insight into the complexity of human relationship and the human development process. Verdant Green leaders are often quietly observant about the people with whom they interact and are careful in the way they care for other people.

The primary challenge for those with a Verdant Green orientation occurs when they are asked to be less "sensitive" and more concerned with the bottom line (a concern often voiced by a Ruby Red). The primary threat in their life is associated with the fear of losing their freedom (enneagram: Five). They worry that the options are closing for them. The nightmare is that they will be forced to accept a tunnel vision of the world (the preference of an extreme Ruby Red).

Royal Purple: Equitable Compassion and Visioning in Action

Royal Purple is a blending of Azure Blue and Ruby Red. For those with a Royal Purple orientation the world is one in which a pathway must be forged toward social justice. Referring to a comment made by Cecil B. DeMille (the Hollywood producer of epic films), one of McKenna and Pugno's (2006, p. 134) leaders provided the focus to be found among the Royal Purple leaders in health care:

> In Dr. Stephen Covey's book *The Seven Habits of Highly Effec*tive *People*, Cecil B. DeMille observed that 'It is impossible for us to break the law. We can only break ourselves against the law.' Of course he is referring to laws or basic principles of personal character that have governed social behavior forever. Covey goes on to mention basic characteristics such as fairness, integrity, honesty, human dignity. Certainly leaders of the health insurance companies of the early twenty-first century seem to be losing sight of these basic principles as they strive to increase their short-term 'bottom line' quarter aft quarter. Their behaviors may be interpreted as driven by 'greed" in some quarters. I think we (physicians) must work hard to remain aware of these powerful, enduring principles as we negotiate with powerful partners in the healthcare arena. [John M. Pascoe, Pediatrician, Professor and Chair, Wright State University]

As Dr. Pascoe has noted, the Royal Purple leader believes that they are needed in the current health care industry because of this pervasive "greed" and the powerful forces operating on behalf of this greed. As a counterweight to this greed, the Equitable Royal Purple serves as an advocate for the underserved and for the welfare of all patients (McKenna and Pugno, 2006, p. 223):

> For me, physician leadership is all about serving as an advocate for patients – helping my patients access quality healthcare. As a practicing physician, I found myself in a position of responsibility, and I realized my patients were looking to me for help in more ways than just treating their medical problems. Many patients don't know how to navigate the health care system. They need someone to assist them—to be their advocate.[Alma Littles, MD, Associate Dean of Academic Affairs, Department of Family Medicine and Rural Health, Florida State University]

As the final hybrid form of leadership, Royal Purple blends the Azure Blue concern about human beings and about envisioning a compelling future with the Ruby Red concern for moving to action. When you are in trouble, there is no one better to have on your side than a Royal Purple leader. Just ask Dr. Gary Morsh to join you. As noted by McKenna and Pugno (2006, p. 144), Dr. Morsch launched "Does Who

Care" (a temporary physician staffing company), "Priority Placement" (a physician recruiting service) and "Heart to Heart International" (a humanitarian organization).

This orientation to leadership is identified as Royal because it is all about power and authority: who has the power and who has the authority? Are they the right people to represent the interests of all people? If not, then we need to act! The Royal Purple leader is often concerned with their own position on the health care hierarchy and their presence at the table where important health care decisions are being made. Dr. Andrew Schwartz put it this way (McKenna and Pugno, 2006, p. 183):

> I believe the commitment of medical staff leadership to the hospital is enhanced by making physician leaders part of the hospital board. This, I believe, helps maintain continuity between the hospital board, administration, and the physician leaders. The incentive for taking on leadership responsibility should be the desire to see your institution thrive. This is simple, but in many hospitals not realistic. As more physicians seek liberation from non-physician owned medical facilities, physicians and hospital administration must be ready to share the helm in order to assure smooth sailing and that their port of call remains vibrant. [Andrew M. Schwartz, MD, Cardiac Surgeon Vice President, Medical Staff Shawnee Mission Medical Center]

At times, this might even mean accepting an assignment within an institution that the Royal Purple leader might consider their adversary (McKinna and Pugno, 2006, p. 104):

> I was very motivated to join 'big pharma' (the pharmaceutical industry) because I believed that I would have impact on a broader and much deeper plane. The sphere [of] influence is greater . . . [Charle Jaffe, MD, Ph.D., Director, Medical Information, Astra-Zeneca Pharmaceuticals]

Royal Purple sits at the opposite end of the Leadership Spectrum from Golden Yellow. Royal Purple leaders often detest those who sit back to thoughtfully assess and critique what is going on in the industry of health care. One should join Big Pharma and work for its reform rather than side back on the sidelines and cry for reform: "this is no time to sit on the sidelines and keep score. This is a time to be engaged!"

Equitable Royal Purple leaders truly care about those who are looking to them for leadership and do not stop caring or acting until some level of social justice is achieved for all people. Whether serving the urban poor or the rural inaccessible, the Royal Purple is there to lend a hand at any hour of the day (McKenna and Pugno, 2006, p. 146):

> I've always had a strong commitment to justice and a strong drive to reduce suffering. In our town, if someone was really sick, they would call the doc off his ranch to come help. We would wake up the pharmacist in the middle of the night if someone needed medicine right away. I saw community care at its finest. We all helped each other. [Reverend Pamela S. Harris, MD Physical Medicine and Rehabilitation Physician Kansas City Veteran's Administration Hospital and Minister of Health United Methodist Church of the Resurrection.]

Their concern for the welfare of underserved patients may take the Royal Purple leader to all corners of the Globe—as exemplified in the work of Doctors-Without-Borders. The leader whom we just quoted points to work done by one of these global healthcare "missionaries" (McKenna and Pugno's (2006, p. 76):

> Paul Brand, MD, was a physician missionary to India until he passed away in 2003. He was a true pioneer in medicine. As a surgeon, he restored hand function. Dr. Brand significantly advanced our understanding of the pathophysiology of leprosy. In his book The Gift of Pain with co-author Philip Yancey, Dr. Brand explained that pain is good by sharing an example from his work with lepers in India. Because the patients were unable to feel pain, they didn't realize when rats ate off their fingers and toes in the middle of the night. So Dr. Brand hit upon a practical alternative. He used kittens to ward off the rats, an approach now referred to as 'kitten therapy.' That approach, combined with visual inspection to identify infection, enabled earlier treatment and helped many leprosy patients avoid preventable Joss of digits." [Reverend Pamela S. Harris, MD Physical Medicine and Rehabilitation Physician Kansas City Veteran's Administration Hospital and Minister of Health United Methodist Church of the Resurrection.]

It is an unending task for many with the Royal Purple orientation whether serving the underserved in a rural American community or lepers in Indian. The overwhelm can easily lead to fatigue, burnout and ultimate disillusionment for those with this public service commitment. Alongside the potential burnout come the rewards associated with successful advocacy. The primary source of joy for the Equitable Royal Purple leader is ensuring that justice is done, and appropriate services are being delivered to those who are often underserved. As Dr. Morsch (the previously identified founder of three major health care initiatives) has declared meaning in life can be found in providing service to other people (McKenna and Pugno, 2006, p. 144): “those who serve others are more likely to know themselves and to accomplish their purpose.” This joy and sense of purpose often can offset the burnout.

A major source of energy is the questioning by Royal Purple of those in authority; do the ends justify the means? Does “might always lead to right” or (as King Arthur declared in Camelot, does “right create might?” The Equitable Royal Purple focus of attention is on defending the weak and disadvantaged by ensuring consistency in policies, procedures and actions. This can occur in one’s society or even in one’s organization—with attention being given to such issues as sexual harassment and gender or racial discrimination. David Kolb (1984) describes the process of assimilation whereby a set of rules and procedures are firmly established to ensure consistency in organizational behavior.

For the Royal Purple leader this assimilation focuses on the creation and implementation of fair and consistent policies and procedures leading to equity and justice. This often means that a position of leadership is taken in the realm of public health. The table at which the Royal Purple leader sits is often one involved not with the care of individual patients or even the operation of a specific clinic or hospital. It is often a table that is situated inside a public institution (at the local, state or national level). Royal Purple leaders are often advocating not just for the welfare of patients, but also the fuller engagement of physician leaders at this public policy table (McKenna and Pugno, 2006, p. 120):

> Healthcare professionals are increasingly asked to weigh in on the issues of medical structure, straining public safety nets, and limited resources. To date, the public debate has been shaped by those other than direct care providers. For years, most doctors believed that even the mere discussion of money in the setting of patient care was a betrayal of the tenets of medicine. By keeping the practice of medicine pure, clinicians have neglected the disparity between scarce resources and an increasing menu of diagnostic and therapeutic options. There is no right answer or one right way to solve the problem. What is clear is that the system now in place is not working. The costs of delaying care and prevention cut to the core of our economy, standard

of living, and life expectancy. [Bridget M. McCandless, MD, Internist, Medical Director, Jackson County Free Health Clinic]

The strength of Equitable Royal Purple leadership often resides in this leader's compelling articulation of these overarching public policy issues.

> "The 'elephant in the room' is looming larger than ever. Healthcare delivery simply doesn't work the way its consumers and payors need and want, but many physicians are too overwhelmed to do anything about it. That's a large part of why I'm so passionate about the potential for a new breed of physician leaders. Even with managed care and the advent of large practices and IDNs, healthcare remains largely a cottage industry - with each organization or clinic operating as though it were an island. Physician leaders must help physicians grasp how infinitely better healthcare could be if we changed our minds and decided to operate as regional and national teams on behalf of our mutual customer - patients!" [J. Peter Geerlofs, MD, Family Physician Chief Medical Officer, Allscripts Healthcare Solutions, Inc.]

There are declarations and demonstrations regarding the failing health care system. Elegant and heroic gestures express the deep feelings underlying the actions that are taken. There are no borders when it comes to caring about care.

An accompanying challenge takes place when the Royal Purple leader is being asked to be less "deep" and to live more often in the real, expedient world (this concern is often voiced by a Golden Yellow). The Thoughtful Golden Yellow member of an organization (or society) might agree that social reform is a good thing; however, "can't we take it a bit slower and buttress this reform with some evidence of the injustice that has actually been done?" The important, existential threat for someone with a Royal Purple orientation is being judged as someone who is trivial, unimportant or unoriginal. To be ignored or taken lightly is the ultimate curse for someone deeply involved in the work of reform in an organization or society: "rather you fight against me then not even notice that I exist."

Conclusions

As I noted at the end of the first essay in this series, where I offered portrayals of three fundamental leadership styles engaged by physicians, stereotypes can easily be elicited, and constructive behavior can often be misunderstood. This can occur even with regard to leaders who incorporate several of these fundamental styles. Yet, the dialogue must take place regarding these hybrid as well as the fundamental leadership styles. Hybrid styles are of particular value in furthering our understanding of the world in which we live—especially the complex and dynamic world of health care. It is rare that a pure variant of a fundamental style will "do the trick". Nuance and ability regarding leadership are usually required.

In the next essays in this series, I leave the world of leadership styles behind and turn to the matter of leadership competencies. What are the skills and what is the knowledge required to be an effective leader in a health care system – regardless of one's preferred leadership style. Once again, I look to the insights offered by McKenna and Pugno as they spend time asking physicians how they go about being effective as leaders. I focus in particular on results from a survey McKenna and Pugno sent out to practicing leader-physicians.

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References

Arima, Yoshiko (2021) Psychology of Group and Collective Intelligence, New York: Springer.

Bergquist, William (2003) Creating the Appreciative Organization. Harpswell, Maine: Pacific Sounds Press.

Bergquist, William (2014) The Revised Balint Method: A Powerful Tool for Reflecting on Professional Coaching Practices, Library of Professional Coaching. Link: The Revised Balint Method: A Powerful Tool for Reflecting on Professional Coaching Practices | Library of Professional Coaching

Bergquist, William, Suzan Guest and Terrence Rooney (2004) Who is Wounding the Healers. Harpswell, Maine: Pacific Sounding Press.

Bergquist, William and Agnes Mura (2011) coachbook. Harpswell Maine: Pacific Sounding Press.

Bergquist, William, Jeannine Sandstrom and Agnes Mura (2024) The Ark of Leadership. Harpswell, Maine: Atlantic Soundings Press.

Bolton, Robert (1986), People Skills. New York: Simon and Schuster.

Cooperrider, David L. (1990) "Positive Images, Positive Action: The Affirmative Basis of Organizing," in Srviastva, Cooperrider and Associates, Appreciative management and leadership. San Francisco, California: Jossey-Bass.

DISC (2024) Diskprofile. Managers and DiSC management styles - discprofiles.com Retrieved August 27, 2024.

Durkheim, Emile. (1933) The Division of Labor in Society. New York: Free Press (originally published in 1893).

Frost, Peter and Carolyn Egri (1990), "Appreciating Executive Action" in Srivastva, Cooperrider and Associates, Appreciative Management and Leadership: The Power of Positive Thought and Actions in Organizations. San Francisco: Jossey-Bass.

Gergen, Ken and Mary Gergen (2004) Social Construction: Entering the Dialogue. Chagrin Falls, Ohio: Taos Institute Publications.

Harmon, Willis (1990) "Shifting Context for Executive Behavior: Signs of Change and Revolution," in Srivastva, Cooperrider and Associates, Appreciative Management and Leadership: The Power of Positive Thought and Actions in Organizations. San Francisco: Jossey-Bass.

Jung, Carl (1971) Personality Types. Princeton NJ: Princeton University Press.

Kahneman, Daniel (2011) Thinking Fast and Slow. New York: Farrar, Straus and Giroux.

Kolb, David (1984). Experiential Learning: Experience as the Source of Learning and Development. Upper Saddle River, NJ: Prentice Hall.

Lawrence, Paul and Jay Lorsch. (1967) Organization and Environment. Boston: Harvard University Press.

McKenna, Mindi and Perry Pugno (2006) Physicians as Leaders: Who, How, and Why Now? Oxford England: Radcliffe Publishing.

Otten, Heide (2017) The Theory and Practice of Balint Group Work. New York: Routledge.

Rosenblatt, Robert (1997), "The Admiration of Others," Modern Maturity, January/February, pp. 22-23.

Rosinski, Phillip (2003) Coaching Across Cultures. London: Nicholas Brealey.

Simons, Robert (2005) Designing High Performance Jobs, Harvard Business Review, July-August, https://hbr.org/2005/07/designing-high-performance-jobs

Vaill, Peter (1990) Executive development as spiritual development. In Srivastva, Cooperrider and Associates. Appreciative management and leadership. San Francisco: Jossey-Bass.

Watson, Goodwin and David Johnson (1972) Social Psychology (2nd ed.) Philadelphia Pa: Lippincott.