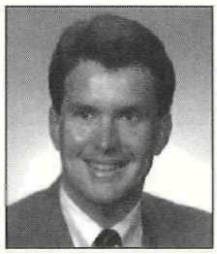
Culturally Diverse Management Teams

Mercy International Sponsors Project on Guam

BY KENNETH R. WHITE



Mr. White, a former senior administrative adviser and project leader for Mercy International Health Services, is currently a doctoral candidate at Virginia Commonwealth University.

"Our first task in approaching another people, another culture, another religion, is to take off our shoes, for the place we are approaching is holy. Else we may find ourselves treading on people's dreams. More serious still, we may forget that God was there before our arrival."

—John V. Taylor, The Primal Vision: Christian Presence amid African Religion, *2d ed., SCM Press, London, 1972*

Mercy International Health Services (MIHS) sponsors a broad range of projects in both developed and developing countries. As part of their growing presence in Micronesia and other areas of the Pacific, MIHS in 1989-93 undertook a project aimed at upgrading the skills of the managers of Guam Memorial Hospital. As work forces on the U.S. mainland become more culturally diverse, the lessons learned in the Guamanian experience may be valuable.

Guam Memorial Hospital, the only nonmilitary healthcare facility on the island, has 159 acute care beds and 33 skilled nursing facility beds. The hospital's service area includes Guam, with a population of approximately 133,152, and Micronesian island referrals, which comprise approximately 6 percent of the hospital's patient days. The hospital historically had experienced high management turnover, problems with financial resources, and political interference from the island's government. Also, the hospital building did not meet codes.

MIHS set out to improve the management skills of the hospital's managers, governing body, and medical staff; to prepare the hospital for a

Summary In 1989 Mercy International Health Services (MIHS) sent a team of advisers to help upgrade the skills of the managers of Guam Memorial Hospital. Their experience offers lessons for U.S. healthcare organizations as they become culturally diverse. The hospital had a number of problems, including high management turnover, troubles with financial resources, political interference, and a building that did not meet codes. The advisers also planned to prepare the hospital for an accreditation survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

MIHS, which has a growing presence in the Pacific, does not take charge of healthcare organizations. Instead, it trains local persons to assume leadership roles. At Guam Memorial Hospital, the MIHS advisers spent their first year assessing the organization and the various cultures represented on its staff. Then the advisers devoted three years to coaching and mentoring their Guamanian counterparts.

The advisers learned that the hospital had basically been run by one person. It had no management team, either formal or informal. The advisers began their coaching by forming a management team in the dietary department. When the rest of the hospital staff saw that team perform successfully, they became willing to join similar teams themselves.

Guam Memorial Hospital had changed by the time the MIHS advisers left the island in 1993. It has not yet been accredited, but it does have management teams working to meet JCAHO standards. The hospital also has in place a continuous quality improvement system, with more than three years of documentation. And the hospital building now conforms to codes.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation survey; and to fulfill a mission of community outreach, a value of the Sisters of Mercy, MIHS's sponsor.

MIHS uses an approach that works. It does not take charge of foreign healthcare organizations, but, rather, trains local persons to assume leadership roles in improving the status of healthcare delivery in their communities. MIHS team members always work closely with local counterparts. The philosophy of MIHS is to begin a project by showing a local counterpart how the job should be done. As time goes on, however, the local person is given increasing autonomy and the MIHS adviser becomes a coach and mentor.

MIHS trains local persons to improve healthcare in their communities.

The experience of the MIHS team assigned to the Guam hospital project suggests several lessons critical to cross-cultural management development success:

- Teams must consider cultural values.
- Management teams must be carefully selected from among local persons.
- External advisers and the local managers must periodically negotiate modified goals.

Facts about Guam

The MIHS team, of which I was a member, had to learn certain facts about Guam before going there:

Location and History Guam is an island in the Pacific, 1,400 miles east of the Philippines and 8,000 miles west of the U.S. mainland. It was a Spanish colony until 1898, when the United States acquired it in the Spanish-American War. Today a U.S. territory, it continues to have problems getting mail and supplies because of its distance from the mainland. The nearest U.S. civilian hospital is in Honolulu, an eight-hour flight away.

Government Guam has a territorial government which closely oversees Guam Memorial Hospital. To make changes at the hospital, it is necessary to get the approval of governmental representatives.

Politics Political affiliation is taken very seriously on Guam. Party membership must be taken into consideration, for example, in forming management teams. It can be a source of conflict.

Natural Disasters Because of its location, Guam is struck often by typhoons, tidal waves, and earthquakes. We found the hospital staff adroit at forming itself into ad hoc teams to deal with such disasters. However, this teamwork tended to dwindle once the danger was past.

Divisive Factors The staff had a tradition of banding together for celebrations and sports events, as well as disasters. At other times, however, there was little communication among physicians, administrators, and other hospital personnel.

Religion Over 90 percent of Guam's population is Catholic, and more than 50 Sisters of Mercy live on the island. MIHS is respected as a representative of the congregation and the Church.

Assessing the Hospital

The first phase of the Guam assignment involved getting to know the local hospital staff. The staff was made up of native Guamanians (Chamorro people), Filipinos, mainlanders from the United States, and Micronesian island natives of the mid-Pacific and Southeast Asia. Our first step was to recognize the unique characteristics of each of the cultures represented. This took time. Our strategy was to ask questions, to observe routine operations, and to develop an understanding of the reasons things were done in a particular manner. We tried to be sensitive to cross-cultural issues and to avoid controversy. We did not, for example, discuss the "three Ps": people, positions, and politics. Hospital staff members would ask, "How are we doing?" and, "Who do you think should be in a particular position?" But we knew "outsiders" should not make recommendations concerning people and positions. It was important that we not become embroiled in interpersonal issues, that we remain objective in our evaluation of the hospital. Listening to the concerns and issues of the hospital staff proved valuable to us in establishing trust and cooperation, however.

The hospital's management structure was clearly not effective. One person basically ran the facility. There was no management team—either formal or informal—and most middle managers were resigned to receiving no direction from the

top managers. A good way to learn about the hospital was to review previous consultants' reports. Although most of the consultants had not performed in-depth assessments, they had made useful comments. We reviewed regulatory agency reports, governing body documents, and laws and regulations pertaining to the hospital. We interviewed key leaders to ascertain their areas of concern and particular goals. Our early investment in forming relationships with key stakeholders proved a valuable foundation for the work that came later. We conducted mock surveys to give ourselves some idea of the hospital's compliance with the standards of the Health Care Financing Administration (HCFA) and JCAHO—and to give the hospital's managers an idea of the comprehensive standards we hoped to eventually meet.

> Learning proceeded smoothly when we used examples from the local culture.

Management Development Plan

When our assessment of hospital operations was completed and the team members had developed rapport with the hospital staff, we wrote a management development plan. The plan included an assessment of the management team's skills and educational needs. Although many of the managers of the professional departments possessed college degrees, most of them did not have managerial skills comparable to middle and upper level managers of U.S. acute care hospitals. We thought there were several possible causes for this situation:

- Though managers had been given off-island training, the training was not integrated with Guamanian realities.
- There was little in-house continuing education. Most training was provided by community or off-island "experts" who had not made a systematic assessment and had no plan for filling educational needs.
- Few systems were developed in which managers might be held accountable for applying training and improving hospital operations. The MIHS team—whose stay was to be a long one—would address many of these shortcomings.

In the early phase of the project, we planned to have our local counterparts assume more and more of the leadership responsibility once they possessed the necessary skills. This is consistent with the Mercy philosophy of not having a permanent presence in any international location. Training and developing local managers is the best way to provide long-term benefits to the community being served.

The MIHS team was committed from the outset to employing teaching methodologies that would have the greatest long-term benefit for the hospital. We were determined to do more than merely provide the training and leave, as other off-island experts had done. Based on the premise that training and development programs work best when they are a combination of didactic, clinical, and practical instruction with proficiency testing, MIHS's management development plan had six components:

- Classroom instruction using course objectives, syllabi, examples, group participation, and posttests
- One-on-one mentoring of managers and supervisors
- Weekly meetings with managers to review corrective actions, policy drafts, system improvements, and other management functions
- Sending Guamanian managers to other Mercy system hospitals, where they could be cross-trained by Mercy managers
- Sending Guamanian managers to off-island training seminars when specific technological or professional information was not available on Guam
- Using sample policies, procedures, job descriptions, forms, reports, reference material, and other management tools to serve as guides for developing hospital-specific documents

The team developed this plan during its first year on the island. After hospital and government officials approved it, the hospital implemented it over the subsequent three years. Early successes were the establishment of a hospital education department, weekly mentoring sessions with potential leaders, and classroom instruction involving the participants. We found that reading was not an important part of education on the island. The people of Guam rely heavily on oral tradition and learn by watching others apply their

knowledge. As in other cultures, the more of the six senses used to acquire knowledge, the better the rate of retention. Learning proceeded most smoothly when we used role playing and examples from the local culture. We also found it helped to ask the local managers to assist the teaching.

> After open discussions, team members no longer feared seeming different.

Building Management Teams

The concept of "management teams" was unknown at the hospital. To introduce it, we formed such a team in the dietary department and gave it intensive training. Other teams watched it in action and began to see how a team approach could enhance decision making, staff motivation, and the quality of outcomes. In some situations, incidentally, it is best to form these teams out of top managers and let lower-level personnel learn by watching the managerial team in action. On Guam, it worked the other way around. Our first team was composed of lower-level persons. Top management—trustees and government officials—needed to observe it working successfully to understand the team concept. Only then would they commit to restructuring the organization. In fact, an executive management team of seven persons was finally formed after other personnel were reorganized in teams.

We found four steps were vital in forming these teams.

Establishing Goals After discussing the hospital's mission, team members decided for themselves what their work would be, how they should organize themselves, and what goals they should set as a team and as individuals. These goals were modified periodically over the years.

Building Trust At first, team members were reluctant to share problems, for fear of appearing inept. Saving face is a big concern in Guamanian culture. But weekly meetings and periodic retreats led to a gradual increase in mutual trust.

Improving Communication At first, team members thought the fact that there were differences among them was not a good thing. But the MIHS team leader facilitated open discussions in which it was shown that diversity was beneficial, and team members lost their fear of seeming different.

Establishing Routine Information Sharing This was especially difficult for the seven members of the executive management team. But the group established a weekly meeting at which they would discuss operations issues and problem-solving opportunities.

Mentoring and Modeling

Our coaching worked best when we worked one-on-one with our Guamanian counterparts. We found it difficult, however, to select local counterparts who were acceptable to the hospital's board of trustees and the elected government officials. A thorough knowledge of the hospital staff helped us select several ambitious and motivated people to groom for management positions. Even so, it took us over a year to obtain decisions on these management positions. Meanwhile, our team worked with a small number of managers, mentoring them for future challenges and modeling behavior appropriate for managing hospital operations. Our biggest problem was their lack of a frame of reference, for they had had little opportunity to compare their local experience to that gained in other hospitals. Guamanian hospital managers had been told many times the "why" and "how" of management, but they did not know how to relate textbook understanding of management principles to practical experience.

We held weekly mentoring sessions to give them the basics of hospital administration and to review the requirements of regulatory agencies. These meetings were successful because they provided the Guamanians with a forum for discussing problem-solving techniques. One of the tenets of island culture is to postpone decisions. A favorite saying of the Gaumanians was *mañana,* or tomorrow. Using the MIHS approach, we taught them to maintain a consistency of purpose that would help them make continuous improvement.

We evaluated our counterparts, sharing our findings with the board of trustees and government officials. We also showed trustees and officials how to formally evaluate a hospital administrator themselves. We found that neither the managers, the trustees, nor the government offi-

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SAFEGUARDING

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The *ERD*'s norms are directed at the community's common good.

Some have questioned the right of ethics committees in Catholic facilities to follow the *ERD* for all patients in the facility, suggesting that there should be a separate committee for those patients who do not agree with some of the *ERD*'s restrictions.[8] However, as we explained in our commentary on the first part of the directives[9], the norms of the *ERD* are directed toward the common good of the community and are not applicable to members of the Catholic community alone. Though the directive says that particular dioceses will have "appropriate standards for medical ethics consultation," it seems unrealistic to expect every diocese to frame such standards. □

NOTES

1. "Bishops' Pastoral Letter on Health and Health Care," *Origins*, December 3, 1981, 1,A.
2. *ERD*, Introduction to Part 2.
3. *ERD*, Introduction to Part 2.
4. "Sources of Concern about the Patient Self-Determination Act," *NEJM*, December 5, 1991, p. 1666.
5. Daniel Callahan, "Medical Futility, Medical Necessity," *Hastings Center Report*, July-August, 1991, pp. 30-35; Gina Kolata, "Withholding Care from Patients: Who Decides?" *New York Times*, April 3, 1995.
6. Congregation for the Doctrine of the Faith, *Donum Vitae*, pp. 2, 22, 87; n. 28.
7. USCC Committee on Health Affairs, Clarification on Directives 6 and 20, March 15, 1973.
8. Eric Lowey, "Institutional Morality, Authority, and Ethics Committees," *Cambridge Quarterly on Health Care Ethics*, Vol. 3, 1994, pp. 578-584.
9. Jean deBlois and Kevin D. O'Rourke, "Introduducing the Revised Directives," *Health Progress*, April 1995.

DIVERSE TEAMS

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New decisions will be made on the foundation that was created.

cials had been shown how to conduct a candid evaluation.

EVALUATION

Over several decades Guam Memorial Hospital had developed from a small tuberculosis facility operated by the military into a general, acute care community hospital employing sophisticated technology. Its managerial practice had not kept pace with the technology and the changing healthcare environment. Developing leaders meant evaluating successes and failures and modifying approaches to achieve results.

Past failures occurred when advisers did not consider the local environment: political interference, natural disasters, and the island life-style. Since the hospital was a semiautonomous agency of the government of Guam, each turnover in governmental leaders brought new goals for running the hospital as well as a change in top hospital administrators and trustees. The typhoon season interrupts normal hospital operations because its entire staff is used to ready it for major storms. The island—isolated yet autonomous, self-reliant, and resilient—has a particular culture which affects learning, change, and decision making. These factors had to be considered in setting goals and expectations for an effective management development plan.

The team met frequently to assess progress and to informally brainstorm new and creative ways of developing and training managers. One approach that worked was jointly establishing goals with key hospital officials. We introduced the concept of planning, organizing the hospital's first planning retreat for managers, governing body, and medical staff. Since then, planning retreats have begun every annual planning and budgeting cycle. The hospital managers now prepare semiannual reports of their progress for the board of trustees and the governor of Guam.

OUTCOMES

Today Guam Memorial Hospital is a different place from what it was nearly five years ago. The building itself has undergone major reconstruction to conform to the current codes. Continuing political changes have helped delay accreditation by the JCAHO. But the managers are now familiar with the standards of JCAHO and HCFA and what must be done to achieve accreditation. A hospital-wide continuous quality improvement system is in place, with over three years of documentation. Developing motivated local leaders was the key to improvements in the hospital.

Were the goals of the team accomplished? In the long run, we can answer that only by assessing the future operation of the hospital. MIHS's stated goals were to set tasks, develop management, and build systems. Our unstated goals were much broader and more ambitious. Although we saw certain changes during our years at the hospital, change will continue to occur and new decisions will be made on the foundation that was created. The hospital's managers now know how to learn and how to solve their own problems. They may still need assistance, but they should be able to recognize that need and know where to turn to find help in solving future challenges.

In joining hands with this developing hospital, MIHS transcended the interests of the system, and thus acted on one of the values of Catholic healthcare. □

Those interested in Mr. White's experience on Guam may contact him at 804-282-8708.