

# Committees and Boards in Healthcare Organizations: Barriers to Organizational Learning?

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## Are Healthcare Organizations Learning-Disabled?

In our work, my colleagues and I have found that the organizational dynamics in hospitals, medical groups, and other healthcare organizations tend to include an overemphasis

on advocacy, power and control, personal agendas, blame, and other fear-based dynamics. Although it is true that these elements are seen in all industries, these dynamics seem to be the norm in healthcare organizations.<sup>1</sup> Additionally, fear-based dynamics seem to manifest themselves more in healthcare teams, and especially at the board and committee levels, where managers and physicians interface.<sup>2</sup> This severely limits an organization's capacity to create, adapt, and innovate effectively – skills needed to meet current and future industry challenges related to cost, consumerism, patient safety, and outcomes based in quality<sup>3</sup>. Health care organizations will need to evolve into true learning organizations if they are to survive these industry trends.<sup>4</sup>

Our review examines the challenges of creating a culture conducive to team learning at the level of hospital boards and committees, the nature of the team learning skills lacking in healthcare organizations, and the approach we took with one organization to replace its “governing board” with that of a structured dialogue group, in an effort to advance its efforts in becoming a learning organization while fostering closer relationships with physicians.

## One Source of Dysfunction: Hospital Boards and Committees

Although a full discussion of the factors that contribute to barriers to organizational learning is beyond the scope of this article, many can be attributed to the training environments of physicians, nurses, and other skilled healthcare professionals. These tend to be hierarchical “command-and-control” environments that discourage true creative inquiry and the exploration of new concepts or approaches through generative dialogue.<sup>5, 6</sup> The decision-making styles that evolve in the fast-paced clinical settings are grounded in a need to assess large amounts of data in a rigorous manner, while also doing so in a fashion that allows a team to take action quickly. When transferred to settings that do not involve potentially life-threatening clinical outcomes, however, this particular approach to conversation and decision making can be problematic.

Barriers to organizational and team learning in healthcare organizations are present on fairly high levels, in boards and committees particularly. Well-meaning managers assume that, like themselves, healthcare professionals are reasonably comfortable with learning in teams and that, via their involvement, they seek to fulfill the mission of the team, board, or committee. The mental models that arise from two substantially different types of training – healthcare and business – can lead to suboptimal performance and failure to meet mutual expectations if not addressed. Leaders in healthcare grossly underestimate the degree to which healthcare professionals expect that their roles in meetings of teams,

boards or committees will be directive in nature, involving decision making, advocating for their constituencies, and mandating solutions to problems. Although the “right” people may have been selected for these teams, leaders must understand that gaps exist in terms of the skills required to achieve effective team learning. While more directive approaches do play an important role in team dynamics (a decision must be made or an action taken at some point), generative dialogue must become the primary work of these groups.<sup>7</sup> Failure to do so will inhibit the organization’s ability to rapidly adapt to changing market trends, and to truly explore the real questions that are essential in reducing medical errors and improving outcomes.

### **Defining the Disability and the Nature of Its Impact**

In order to better understand the nature of the “learning disability” that is common among health-care organizations today, it is helpful to review the concepts of a learning organization and of dialogue.

#### **Learning Organizations**

Learning organizations are organizations whose members are continually focused on expanding their collective awareness, capabilities, and intelligence. These organizations are open to challenging their commonly accepted assumptions, structures, and norms, to gaining actionable knowledge, and to sharing knowledge among all their members. As a result, learning organizations are not only able to adapt effectively to current challenges, they also embrace the challenges of the future.<sup>8</sup> As the shared pool of knowledge within the organization grows, so does the collective organizational intelligence, making the organization more adept at quickly identifying opportunities, meeting challenges, and innovating. As many health-care organizations strive to become learning organizations, they struggle with perhaps the most critical skills needed to foster a culture of organizational learning and trust: the skills of *dialogue*.

#### **Dialogue**

Dialogue, then, is a form of conversation through which people think together to arrive at a much larger shared understanding. Whereas discussion, or the fragmentation of thought through debate and argument, seems to be the norm for many health-care teams, dialogue seeks to heighten the collective intelligence of the group.<sup>9</sup> As defined by the physicist David Bohm, dialogue implies a “flow of meaning.” Effective dialogue achieves this “flow of meaning” through the use of two important skills: the ability to understand and make apparent mental models, and the ability to balance advocacy and inquiry.

Mental models are the “filters” through which we perceive and interpret the events of our worlds, and it is upon these often incomplete perceptions that we base actions and decisions. Developing awareness for our internal mental models, with all of their flaws, and continually seeking to clarify and to complete these models requires that individuals make their thinking visible to one another.<sup>10</sup>

The second of these dialogue skills, balancing inquiry and advocacy, places emphasis on generating conversation directed towards understanding the thinking of others. In general, our culture tends to favor advocacy more than inquiry, and the same holds true for teams in healthcare, perhaps to an even greater degree (consider the formats of grand rounds, or “morbidity and mortality” rounds in many hospitals).<sup>11</sup> Inquiry adds a great deal to the collective knowledge by eliciting important perspectives or facets from others that could alter the mental models within the group. Refining the shared understanding of a concept is essential before taking action, making decisions, or reacting with strong emotion.

When performed effectively, dialogue leads to higher levels of trust, true and honest exploration of important concepts and challenges, shared understanding, and innovative thinking that raises the collective knowledge of the group. In healthcare, dialogue most certainly is a critical competency<sup>12</sup> for effective process improvement, as it relates to cus-

Figure 1: The Compass Group: Service Excellence and Patient Satisfaction

**Learning Objectives:**

*By the end of this session, participants should be able to:*

- Describe the strategic importance of customer service and patient satisfaction.
- Describe the process by which the most recent patient satisfaction surveys were developed, implemented, and analyzed.
- Use inquiry skills to engage in more revealing dialogue with providers, staff, and patients regarding service.

**Action Oriented Goals:**

*As a result of this session the following action can be expected:*

- Participants will share their views on patient satisfaction, as well as their “best practices” in the context of their service-related plans at their sites.
- The “best practices” flip chart maintained during the session will be communicated to all providers and staff.

- The management team will assimilate observations in this forum with those of other stakeholders to potentially modify the survey content, questions, and process in the future.
- The frequency and method of monitoring satisfaction on an ongoing basis will be refined.
- The “action items list” maintained during the session will be delegated and acted upon.
- Interested provider-participants will be invited to work on this project with administrative project leaders in the future.

**Pre-Work:**

Participants will be expected to be familiar with the patient satisfaction survey results for their own sites, and should have already had discussed with their managers and directors regarding their action plans based on these results.

tomer service, quality outcomes, financial outcomes, and strategic dilemmas. The skills of dialogue in this setting have impact at a number of interfaces: physician-physician, physician-nurse, physician-administrator, and physician-patient, among others. Organizations that master these skills will be able to achieve high levels of success at each interface as a result. The specific dialogue skills that we have found elusive in healthcare organizations are those related to understanding mental models, and those related to inquiry. Failure to achieve successful dialogue with these skills in an organization leads to cultures based on blame, organizational rituals that are never questioned, processes that cannot be managed effectively, and short-sighted strategic thinking. In today’s marketplace, the lack of this competency will place organizations at a competitive disadvantage.

**Case Study: The Challenges of One Organization**

The governing board of a healthcare organization with which we worked was typical of many seen in this industry. Physicians attended meetings with the expectation of advocating for their constituen-

cies based on location or specialty, while personal agendas promoted a need for control while defending one’s position. Many physicians questioned the value of the board, wondering if they really had any formal control, and these same physicians had indicated to the chairman that they were advocating and lobbying to dissolve the group. Managers learned to fear these meetings, as interactions tended to focus on criticism of the existing situation, solution, or dilemma. Reports on the progress of key departments devolved into “feeding frenzies” for the critical healthcare professionals who were accustomed to such thinking and interaction in the purely clinical setting. Not only were expectations not met, true exploration of challenges through healthy dialogue were rarely observed.

As the chairman and the management team contemplated the future of this board, we were invited to facilitate a retreat to help assess the true beliefs of the current attendees and other stakeholders. Our preliminary work with this organization revealed the following perceptions:

- Physicians and managers believed that there was, indeed, value in meeting together regularly.

- Both groups felt that the “new” strategic themes within the organization (satisfaction of customers/patients; satisfaction of employees; strengthened physician relationships, and financial stewardship) were very important to address, for the benefit of all stakeholders, including patients, and the themes resonated with many on a personal level. We were able to elicit specifics from the group that described how they would envision that their collaborative work might bring value to the following stakeholder groups:

**Patients/Customers** – Provide guidance for administration in monitoring and developing culture and processes that seek to improve service standards across clinics, and to leverage these service successes for contracting/market share

**Employees** – Provide direction for administration in monitoring and developing processes that improve employee morale, retention, and communication

**Physicians** – Provide administration with guidance related to reimbursement issues, contracting, and set a direction for ongoing provider education efforts related to practice management and professional development needs

**The Organization** – Develop physician leaders by working collaboratively to integrate provider ideas and input and by sharing information and best practices.

- Managers understood that they could not develop tactics that address these themes, and that they truly needed to have a collaborative relationship with physicians to realize the full potential of possible approaches.
- Physicians expressed a wish to help create approaches these strategic themes, but wondered if they would have the power and control to make policies and decisions.
- Both groups had difficulty seeing beyond the current formal board structure, envisioning

that the same struggles and limitations would arise.

- Other physicians, nurse practitioners, and physician assistants in the organization were passionate about participating, although they had not had the opportunity to do so historically.

### The Compass Group

Based on observations from the retreat and the strategic themes of the organization, it became clear that a mere evolution or transformation of the existing board structure would be inadequate, resulting in frustration and failure due to the persistence of deep-rooted norms. Nothing short of a complete destruction of the existing paradigms would provide this organization with the freedom to explore new paths to achieving its stated goals. With this understanding in mind, we recommended complete dissolution of the existing structure, in favor of a dialogue-based forum structured around the stated organizational imperatives of customer service, employee satisfaction, strong physician relationships, and financial stewardship. This forum came to be called the “Compass Group,” for the following reasons:

- The group felt that these strategic themes or imperatives were analogous to the directions on a compass.
- The name seemed to convey a sense of purpose, in that the forum could be leveraged to keep the organization on track with strategic goals, just as a compass provides direction for travelers.
- The name also removed the implications and contextual associations with the terms “board,” “council,” or “committee.” It was important for every detail to dissociate the new dialogue sessions from the mental models the group had developed from prior board experiences in healthcare, in which emphasis was placed on debate, advocacy for one’s constituency, power, and “governance.”

The Compass Group was seen as a risky endeavor by many within the organization, both physicians and managers. Much of this fear, as expected, was based on the uncertainty of where dialogue around these concepts could lead the group. The organization, however, was able to understand that some degree of risk is involved in any learning.

### **“Uncoupling” Old Norms**

Old norms that prevailed in this group were important to consider. These cultural and conversational norms had been a major barrier to true learning within the organization. A great fear among many physicians and administrators was that the “old ways” of dealing with each other would carry forward into the new efforts. We recognized that a number of important steps were needed to “uncouple” the organization from old ways of interacting, thus allowing for new ways to emerge and thrive.

### **Associating Pain with the Status Quo**

A critical event during the retreat included dialogue around existing aspects of the meetings that board members disliked, involving not only content, but also emotions, unmet needs, and frustrations. A significant amount of facilitation was required to uncover these real issues, but did result in the shared understanding that all of the participants were concerned about (1) the feeling that they were not being heard by each other or by the administration, and (2) the feeling that they wanted to “make a difference” but were not. By linking these two perceptions, and their associated emotions, we were able to markedly raise the level of discomfort with the “status quo” for this group. This discomfort created a compelling need for change among all board members that was instrumental in effecting necessary change.

### **Incorporating New Perspectives**

The group felt strongly that the constancy of the membership of the board over the past several years had contributed to some degree of stagnation, and had been a major factor in perpetuating norms for interaction among group members that may not

have been acceptable for those outside the group. Understanding that many others in the medical group expressed an interest in and saw value in dialogue meetings, it seemed natural to invite new participants that possessed new and fresh perspectives.

### **Eliciting Desired Norms and Expectations**

Several of the current board members were able to articulate rewarding and fulfilling experiences that they had enjoyed in other meetings and committees. By identifying the specific cultural aspects of these other team experiences from a minority of board members, virtually all of the other participating physicians and administrators were able to articulate their own “best experiences.” Common among these experiences were feelings of “being heard,” of “contributing proactively,” of “understanding one another,” of mutual respect, and of building upon collective contributions to generate new and creative approaches. By explicitly listing these desired norms and expectations, the group was eventually able to develop momentum for change, striving for this “new way.”

### **Generating “Buzz”**

By communicating the themes of dialogue that took place at the retreat, along both formal and informal communications, others in the organization became aware that the Compass Group was “no ordinary board or committee.” The communications were lively, genuine, informal, and carried with them a feeling of realism, openness, and innovation that was not typical of standard emails and memoranda. This “buzz” was instrumental in generating interest and participation from many others who might not have been comfortable in the traditional board setting, and set expectations that helped to “uncouple” the norms of the past.

### **Setting the Stage for Dialogue: Designing the Compass Group**

Because of the risk inherent in any team or organizational learning process, a great deal of thought must be focused on planning for a dialogue session that



allows people to relax, and thus fosters collaborative dialogue, engagement, and exploration of creative possibilities for action. Described here is our approach to the planning of the Compass Group for this particular organization, based on some of the principles used in developing a “World Café.”<sup>13</sup>

### ***Establish a Clear Purpose***

We understood that a significant need for this group, both healthcare providers and managers, was to have a clearly defined purpose and objectives, along with concrete actions. Without these elements, it was unlikely that either group would perceive significant value. Because participants were unfamiliar with the concept that dialogue, by itself, is a valuable endeavor, we felt that it was important to work towards eliciting clear goals that were meaningful from their perspective.

For the first of the Compass Group sessions, the management team had chosen to focus on the strategic theme of customer service. Some smaller projects and work had already begun at a number of facilities along the lines of customer service, and a patient satisfaction survey had recently been completed. The management team wished to gain insight into how to best proceed with this information. With this theme in mind, we structured the dialogue based upon a series of questions that led to greater insight and shared knowledge. Along with a memorandum regarding the outcomes of the recent retreat, the dissolution of the old board, and the creation of the “Compass Group,” a communication regarding the purpose, objectives, and goals of this first Compass Group session was distributed to the medical group’s management team, physicians, nurse practitioners, and physician assistants (see Figure 1).

## Invite Great Guests

With a clearly defined purpose and objectives, we worked with the organization to help them decide who should be invited to attend the retreat for the Compass Group. At one time, the governing board for the organization was comprised of elected positions, which many felt excluded potential contributors within the organizations, while contributing to the dynamic of pushing personal and constituency-based agendas. More recently, the organization had appointed a representative from each of its facilities to serve on the governing body, which balanced contribution somewhat better, but resulted in apathy due to what was perceived as “forced” participation. We supported the management team’s preference to offer invitations to all interested physicians, nurse practitioners, and physician assistants, feeling that true engagement can only be achieved when individuals are free to choose to participate, rather than being forced to do so.

In addition, we felt that the process of inviting participants must convey the sense that the Compass Group was “no ordinary board meeting.” Participants were clear on the purpose and goals of the new dialogue-based forum, and were also aware of the sense of urgency for the change, based on the need to meet organizational and market-driven demands. Enthusiasm was also generated among invitees by actively setting the expectation that this forum, inno-

vative for this organization, would result in dialogue that would truly make a difference.

## Plan for a Safe and Welcoming Environment

In planning an effective dialogue session, paying close attention to details such as ambiance is critical to creating a physical space that is perceived as inviting, hospitable, and intimate. The purposeful creation of a welcoming space brings a tremendous amount of power, and it is surprising how often leaders fail to consider the impact such planning can have. The successful creation of such an environment changes the emotional frame of reference for participants, such that they feel a greater degree of psychological safety, with the openness necessary for true and engaging dialogue.

For this organization, we recommended that the creation of a welcoming environment begin with the invitation process itself. Rather than utilizing the typical emailed appointment scheduling that is used extensively within the organization, stationary and fonts with earth tones were used to convey the message that this experience would be different from the typical hospital board or committee meeting, while also setting the groundwork for creating a sense of hospitality and intimacy during the event.

We continued our work with the organization’s planning team to assist them in designing the physical layout and ambiance for the dialogue session. A number of critical details, described here, were elicited:

- Round, café-style tables with seating for 5–7 people, staggered randomly, rather than in straight rows
- Place cards for seating arrangements to foster dialogue among diverse participants
- Flip charts for recording dialogue themes at each table
- Soft, natural lighting
- Soft jazz as background music
- Catered food around a local theme

Figure 2: Compass Group Dialogue Questions

## Dialogue

### During this dialogue

#### activity, share answers to:

- How did you react to the re-enacted service
- What is your experience with customer service in your facility
- How might these results best be used for improving service across all facilities

### Let one person comment,

#### then use inquiry skills:

- Seek first to understand completely
- “What leads you to...”
- “Tell me more about...”
- “How did you...”

- A table for a host or greeter to welcome guests, to orient them to the environment, and to provide them with materials for the event
- Name tags for each attendee including an interesting fact (in this case, participants were asked to write down the location of their most memorable service experience)

### Form Powerful Questions

Well-structured, open-ended questions are the most important determinant of a successful dialogue session. By framing a dialogue session around a series of questions, we were able to help the organization explore important concepts in a logical progression of discovery. As opposed to traditional board meetings, where agenda items focus on one-way communication of information, or on the presentation of statements to be debated, dialogue sessions framed around questions to be answered set the

groundwork for greater levels of inquiry and mutual discovery.

The formation of these questions is perhaps the single most important factor in determining the success of a dialogue session. The most effective questions are simple, yet thought-provoking, and will both focus dialogue and open the door to exploring new possibilities. Because the theme chosen for the first Compass Group session centered on customer service, questions related to service, and to the recent internal efforts in measuring service perceptions, were developed. See Figure 2 for an example of the questions for one round of dialogue during the Compass Group.

If participants are unfamiliar with dialogue as a process, planners of dialogue sessions sometimes feel pressure to create questions that lead to concrete action planning. Although in some cases this may be a rather natural progression, there is value in having

Figure 3: Compass Group Outline

Topic	Time Allotted	Objectives for Participants
Arrival and Welcome	6:30-6:40 pm	Relax, mingle, and meet your colleagues!
Intro and Overview	6:40-6:50 pm	Develop a framework regarding purpose, roles, and ground rules. Understand inquiry as the basis for dialogue. Provide an overview of the evening.
Video	6:50-7:00 pm	Observe practice site staff feelings regarding patient satisfaction, taking note of your own reactions, through this entertaining reenactment of actual patient experiences.
Project Description	7:00-7:10 pm	Gain an understanding of how the most recent patient satisfaction project took place, from the driving force, to planning, to implementation and data analysis.
Reactions and Dialogue	7:10-8:00 pm	Participants, in groups, will share their reactions to (1) the video; (2) their own experience with the project & its results; and (3) what they would like to see happen with the results. Participants will practice inquiry skills as they dialogue.
Travel Plans	8:00-8:40 pm	Participants will participate in dialogue to answer the following questions: <ul style="list-style-type: none"> <li>• How do you feel about the structure and questions that are part of the patient satisfaction survey process?</li> <li>• How will we continue to monitor progress?</li> <li>• What do you envision happening as a result?</li> </ul> Provide direction for the management team.
Forum Feedback, Door Prizes, and Closing Comments	8:40-9:00 pm	To gather feedback regarding this forum. To provide recognition to selected participants. To provide more questions for reflection.

the process of dialogue by itself as a goal without assuming that any decision or action will take place. Focusing on inquiry and exploration to truly understand is a valuable outcome by itself. With this organization, as with many in healthcare, we understood that many administrators and physicians perceived value by also arriving at some action. For this reason, we chose to provide the management team with a specific flip chart for “Action Items” to record observations that might require further research or planning, or at least further dialogue.

### **Facilitating for Success**

By hosting the initial session, we felt that our role as facilitators was (1) to model the process for internal facilitators in the future, (2) to provide a larger structure for the evening in the context of facilitating between rounds of dialogue, and (3) to provide some training around the skills involved in dialogue, with a heavy emphasis on inquiry. Figure 3 shows an overview of this organization’s first Compass Group session, focused on customer service.

Members of the management team had already received some training from us in hosting a dialogue session and in facilitating smaller conversations, mainly by encouraging a balance of inquiry and advocacy. We decided to leverage these skills by placing one management team member as a facilitator at each table. The other members at each table were carefully distributed to ensure sufficient diversity of conversations.

The Compass Group opened with a designated amount of time for attendees to arrive, get oriented, and to enjoy food and beverages while conversing with colleagues. Participants were asked to write the answer to the question “What is the location of your most memorable service experience?” on their name tags. Prior to starting the session, participants were encouraged to use this as a starting point for conversation with others.

We provided participants with an overview of the evening, as well as a brief didactic session on dialogue. We find that it can be immensely helpful to use “recipes” or “protocols” for dialogue, especially

in situations where some individuals may be new to dialogue skills. The participants were reminded of the basic elements of the “recipes” for effective inquiry prior to each round of dialogue.

Each round of dialogue was structured around a series of questions. In this particular circumstance, a review of the organization’s patient satisfaction data, as well as the video reenactments of actual patient experiences, was used as the starting point for forming dialogue questions. During the rounds of dialogue, facilitators at each table helped to encourage effective inquiry, and to surface hidden or underlying assumptions. In addition, the facilitators were asked to record the predominant themes of each round of dialogue.

Between each round, each table was asked to share their dominant themes, discoveries, and insights with the group and to comment on their success with using dialogue skills.

As one of the goals of the Compass Group was to provide an opportunity to share “best practices,” a separate flip chart was maintained specifically for this purpose. In addition, another chart was maintained to document items that warranted action, follow up, or future dialogue.

### **After the Dialogue Session**

The feedback from post-session surveys indicated an overwhelmingly positive level of enthusiasm, engagement, and perceived value. Participants, both managers and healthcare providers, felt that they had achieved a level of shared understanding that was greater than the sum of their individual knowledge. Most importantly, the attendees felt that they truly had accomplished a great deal in terms of the “real work” of the organization, something that had not been felt by the previous board structure, and that they felt passionate about continuing the conversations.

The themes and best practices that were identified through table dialogues were distributed to all members of the organization, and clear plan was described for future dialogue. In addition, efforts to continue the dialogue around service were implemented by providing powerful weekly questions for each man-

ager, physician, or department to use with their staff.

Ongoing dialogue sessions continue to focus on the strategic directions defined by the “Compass,” and high levels of engagement continue.

## Conclusion

Based on our observations, boards and committees in healthcare organizations tend to operate in a mode that is heavily dependent on one-way communication, debate, and criticism. Indeed, the same dynamics also tend to be present at other levels of these organizations, including clinical teams. Unfortunately, these dynamics present a barrier to developing learning organizations that are able to innovate and adapt effectively to tumultuous market conditions, a necessity for the healthcare organization of today.

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## Endnotes

- 1 *Creative Conflict Management in Healthcare. Final Report.* March 24-26, 2004. Vancouver, BC, Canada. The Morris J. Wosk Centre for Dialogue. Simon Fraser University.
- 2 Baker, G. R., Ph.D., Tregunno, D., Ph.D., and Law, M., M.A. (2004). *Challenges in Linking Team Effectiveness and Health Outcomes Research.* Presentation. Academy Health Conference. June 9, 2004. University of Toronto. Toronto, Ontario, CA.
- 3 Kohn, L. T., Corrigan, J. M., and Donaldson, M.S. (Eds.). (2000). *To Err Is Human: Building a Safer Health System.* Committee on Quality of Health Care in America. Institute of Medicine. 2000.
- 4 Boan, D. and Funderburk, F. (2003). *Healthcare Quality Improvement and Organizational Culture.* The Delmarva Foundation. November 3, 2003.
- 5 *Creative Conflict Management in Healthcare. Final Report.* March 24-26, 2004. Vancouver, BC, Canada. The Morris J. Wosk Centre for Dialogue. Simon Fraser University.

Dialogue – specifically, the skills of understanding mental models and of balancing advocacy with inquiry – is essential for building organizations that learn effectively. Such skills are sorely needed in healthcare at all levels.

By challenging the assumption that committees and boards in healthcare must always be structured in the traditional, formal manner, organizations may be more likely to explore formats that are more conducive to dialogue. Shifting to dialogue-based forums focused on organizational strategic imperatives can be one approach that fosters organizational learning, while engaging and improving relationships with physicians.

- 6 Baker, G. R., Ph.D., Tregunno, D., Ph.D., and Law, M., M.A. (2004). *Challenges in Linking Team Effectiveness and Health Outcomes Research*. Presentation. Academy Health Conference. June 9, 2004. University of Toronto. Toronto, Ontario, CA.
- 7 Taylor, B. E., Chait, R. P., and Holland, T. P. (1996, September-October). *The New Work of the Non-Profit Board*. *Harvard Business Review*.
- 8 Senge, P., Kleiner, A., Roberts, C., Ross, R., and Smith, B. (1994). *The Fifth Discipline Fieldbook: Strategies and Tools for Building a Learning Organization*. New York, NY: Doubleday/Currency.
- 9 Issacs, William. (1994). Dialogue. In Senge, P., Kleiner, A., Roberts, C., Ross, R., and Smith, B. (1994). *The Fifth Discipline Fieldbook: Strategies and Tools for Building a Learning Organization*. New York, NY: Doubleday/Currency.
- 10 Senge, P., Kleiner, A., Roberts, C., Ross, R., and Smith, B. (1994). *The Fifth Discipline Fieldbook: Strategies and Tools for Building a Learning Organization*. New York, NY: Doubleday/Currency.
- 11 Boan, D. and Funderburk, F. (2003). *Healthcare Quality Improvement and Organizational Culture*. The Delmarva Foundation. November 3, 2003.
- 12 Brown, J. and Isaacs, D. (1996, December-1997, January). Conversation as a Core Business Process. *The Systems Thinker*, 7;10.
- 13 Brown, J, Isaacs, D., and The World Café Community. (2001, June-July). The World Café: Living Knowledge Through Conversations that Matter. *The Systems Thinker*, 12; 5.

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