Using Prosocial Power to Influence Employee Motivation, Identification, and Cooperation in Health Care Organizations

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ABSTRACT

The impact of power differences in health care organizations has often been portrayed in terms of negative consequences. But when power is socially-oriented, those with authority can positively influence individual employee outcomes and behaviors, which in turn positively impact organizational outcomes. In Accountable Care Organizations (ACOs), health care administrators can use their power to create an environment where employees feel their work is meaningful. This is achieved by using influence or resources to notice and reward individual contributions, and actively seeking out opinions and feedback from employees. Power can also be used to encourage organizational identity, such as establishing an environment where employees experience a positive work environment. By establishing an organizational environment centered on supportiveness and psychological safety, employees may perceive they are a valuable member of the ACO and feel internally motivated. In an organization where leaders use power for social goals and employees feel motivated and identify with the organization, positive behaviors such as cooperation among employees are expected to result. This paper contributes to the burgeoning literature on the positive impact that power and status differences can have on employee outcomes and behaviors in health care organizations.

Keywords: Power, health care organizations, employee identification, employee cooperation, employee motivation

INTRODUCTION

Power that emerges from social hierarchies has been studied in the past to explain the negative consequences of power differences, such as suppressed participation and decision-making among low-status members (Berger, Rosenholtz, & Zelditch, 1980; Lichtenstein, Alexander, McCarthy, & Wells, 2004). However, attention has recently turned toward the impact power and status can have when oriented towards social goals. Specifically, research has highlighted the positive outcomes resulting from leader behaviors that are intended to benefit others, such as the correlation between fair treatment by leaders to increased job performance and feeling of trust from employees (Colquitt, Lepine, Piccolo, Zapata, & Rich, 2012), and the impact of team-coaching and leader inclusiveness on feelings of psychological safety among low-status members of surgical teams (Edmondson, 2003; Nembhard & Edmondson, 2006). Furthermore, a recent review of research on organizational learning behaviors by Bunderson and Reagans (2011) found that the potentially negative effects of power on low-status members can be lessened or even reversed if the goals of power-holders are socially-oriented, causing the authors to recommend further research to help explain this phenomenon. This paper addresses the need for an additional examination of the use of socially-oriented power, when influence arising from a dependency relationship is used as a means to achieving social and collective goals. I describe how organizational leaders can use their power in a socially-oriented way to encourage employee motivation, identification, and cooperative behaviors, attributes that are all associated with positive organizational outcomes (Grant, 2008; Dutton, Dukerich, & Harquail, 1994; Dukerich, Golden, & Shortell, 2002). The use of "prosocial power" is then discussed in the context of health care organizations,

specifically Accountable Care Organizations (ACOs), where social hierarchies and subsequent negative consequences from power differences have been well-documented (Valentine, Nembhard, & Edmondson, 2013; Edmondson, Bohmer, & Pisano, 2001).

Power

Power emanates from the ability of one actor to make demands from a weaker actor (Emerson, 1962). Inherent to this definition is the existence of a dependency relationship resulting from a hierarchy, such as the relationship between a parent and child or the relationship between an employee and supervisor, where those with status have power in terms of both influence and control over resources (Bunderson & Reagans, 2011). In situations where a power imbalance exists, low-status workers may not feel their individual effort is important to the organization because those with higher status have more influence over decisions and participate more in the decision-making processes (Lichtenstein et al., 2004). In this way, power and status distances that emerge from organizational hierarchies can impede the behavior of low-status employees, such as their level of effort or participation (Bunderson & Reagans, 2011). However, if the power-holder actively lessens the effect of status differences, such as by seeking out opinions and contributions from employees of lower status, low-status employees are more likely to contribute to the task (Nembhard & Edmondson, 2006). This type of participative and encouraging behavior from those with power describes the central elements of socially-oriented power as defined by Bunderson and Reagans (2011).

The use of socially-oriented power shares concepts from the transformational leadership literature, which is a type of leadership characterized by charisma, intellectual stimulation, and

individualized consideration (Bono & Anderson, 2005). Individualized consideration involves leaders spending time coaching employees, involving them in the decision-making process, and even sharing formalized power (Lo, 2010). Individualized consideration is also used to describe the degree to which low-status employees perceive their supervisor as treating them as individuals and that care about their professional growth (Kanste, Miettunen, & Kyngas, 2007). For low-status employees in particular, the opinion of organizational leaders is important to them (Bunderson & Reagans, 2011), so this leader behavior may be especially impactful for those employees. This type of socially-oriented leadership behavior, showing individual consideration to low-status employees, has been shown to be positively related to employee outcomes, such as increased social capital (Bono & Anderson, 2005).

Motivation

Motivation of employees has been defined in terms of activation and intention (Ryan and Deci, 2000) and also as the willingness to perform and work towards organizational goals (Franco, Bennett, & Kanfer, 2002). Motivation exists in many forms and is related to a variety of antecedents; for example, internalized motivation occurs when employees experience meaningfulness from work and care about the task they are performing (Hackman & Oldham, 1976). Employees assign meaning to work when they value the task outcome and when they perceive their behavior has a direct influence on the outcome (Shepperd, 1993). This is especially true in groups, where individuals have been shown to exert more effort if they believe their contributions are indispensable (Ryan & Deci, 2000). Alternatively, loss of productivity has been linked to a lack of motivation when individuals believe their individual effort has little effect on the collective whole when participating in large groups (Shepperd, 1993). Therefore,

organizations should seek to create an environment that encourages employee internalization of motivation to reap the organizational benefits.

Power can also be used to encourage employee motivation if used to show appreciation or gratitude, a socially-oriented behavior (Grant, 2011). Leaders can show appreciation by directing resources to rewarding employees, such as extra paid time off or cash bonuses. When employees are provided meaningful rewards for their individual efforts, this leads to enhanced employee performance (Locke & Latham, 1990). Additionally, employees are more likely to feel motivated if the importance of their individual contributions is reaffirmed by the organization through the use of recognition or rewards (Sheppard, 1993). This is especially true if a high-status member of the organization is providing the reward or recognition, since the opinions and actions of those in power is important to those of low-status (Bunderson & Reagans, 2011).

Identity

Identity can be defined as the perception of belonging to a group (Ashforth & Mael, 1989). When employees define themselves as having the same characteristics as the organizations, this is defined as organizational identification (Dutton, Dukerich, & Harquail, 1994). Research has shown strong organizational identification is related to positive outcomes such as organizational citizenship behaviors and cooperation (Dutton, Golden, & Shortell, 2002). Individuals must be committed to goals to affect job performance (Locke & Latham, 1990). For these reasons, it is important that employees perceive that their goals and values are shared by the organization in order to foster a strong organizational identification.

Low-status employees are not as likely to participate in decision-making processes as those with high-status (Berger, Rosenholtz, & Zelditch, 1980) and therefore may feel their opinion and membership in the organization is unimportant. However, this negative impact of low status on identification may be lessened if employees believe that all individuals are important in the organization, despite status differences (Gonzalez & Denisi, 2009). To do this, an organization could facilitate increased participation in decision-making processes for those with low-status. For example, the organization may require all employees to undergo teamwork training that focuses on communication and higher-quality relationships among employees throughout the organizational hierarchy. In this way, leaders are using their power over employee time allocation to foster a work environment where employees feel like a valuable member of the organization. In this case power is being used for a social goal, creating an environment that encourages participation, and therefore enhances the likelihood of organizational identification among employees.

Cooperation

Organizational identification and internalized motivation are related to a shared perception of goals and feeling valued as an employee. When employees share the goals of the organization and feel valued, they are more likely to identify with the organization and engage in behaviors to benefit the organization, such as cooperation (Dukerich Golden, & Shortell, 2002). A strong organizational identity can increase effort among employees (Dutton, Dukerich, & Harquil, 1994) and encourage commitment to the organization (Ashforth & Mael, 1989). Furthermore, communication increases cooperation by promoting group identity (Levine & Moreland, 1990), so that when identity and cooperation are combined, a self-reinforcing cycle

may occur. If using power in a socially-oriented manner contributes to employee motivation and identification, and motivation and identification are related to employee behaviors that benefit the organization, it is logical to suggest that when power usage is socially-oriented, this can lead to cooperative behaviors from employees.

DISCUSSION

Research on cross-functional teams in health care has shown that teams often perform ineffectively due to suppression of participation among low-status members and that for teams to work; there must be cooperation, communication, and participation among members of all status (Lichtenstein, et al., 2004). For low-status members in these teams, engaging in learning behaviors (e.g., speaking up, experimentation, and sharing knowledge) is avoided if employees perceive these behaviors to be unsafe or too risky due to the tenuous nature of their status position (Edmondson, 2003; Bunderson & Reagans, 2011). When employees are left out of decision-making processes or otherwise feel un-empowered in their work role, this can lead to feelings of injustice (Colquitt, Greenberg, & Zapata-Phelan, 2005) which is negatively related to organizational commitment and job performance (Colquitt et al., 2012). In health care organizations, a power difference exists between administrators and health care providers. Administrators are responsible for the fiscal viability of the health care organization and have control over resources needed by providers to care for patients, such as hospital beds and diagnostic equipment. However, providers have some power in their relationship with administrators because of their control over patient referrals, which serves to balance the dependency relationship between the two parties (Emerson, 1962). The power of providers over administrators was evident in the sustained and severe backlash from providers over the

managed care model of low cost through restricted access, which eventually led to legislations and loosened restrictions (Shi & Singh, 2012). Given the importance of this power dyad involving health care providers and administrators, studying this relationship in the context of a social-orientation of power appears to be worthwhile.

Recent health reform measures have ushered in new innovations to health care delivery to lower costs, such as ACOs; however, the recent focus on financial goals has resulted in negative reactions from some health care providers (Dukerich, Golden, & Shortell, 2002), potentially due to the conflict between their personal goals related to patient care and the organizational goals of cost-reduction (Franco, Bennett, & Kanfer, 2002). In the ACO model, the organization agrees to meet quality standards in order to keep the "savings" it earned from efficiently managing patient care (RTI International, 2011). For ACOs, the organizational goal of cost reduction is an explicit part of the delivery model. Due to the centrality of the cost-reduction goal of ACOs, the model has been compared to a managed care model. However the difference for ACOs is that the focus on costs savings is combined with explicit consideration of the quality of care being delivered. In this way, organizational leaders have the opportunity to reframe the ACO model as one that is intended to benefit the patient, with any monetary rewards as secondary. Though managed care differs from ACOs, the prominence of the cost-saving objective inherent in the model may still resonate with providers. The scale of the managed care backlash (Shi & Singh, 2012) underscores the level of incongruence that may exist between providers and ACO administrators over the goal of reducing costs.

When employees do not share the goals of the organization, this results in decreased employee motivation and engagement (Locke & Latham, 1990), a key component in

implementing a successful health care innovation (Nembhard & Edmondson, 2006), such as the ACO model. Alternatively, research has shown that employees are more likely to work towards organizational goals if they are congruent with their own personal beliefs (O'Reilly, Chatman, & Caldwell, 1991), such as when employees identify with an organization. Additionally, eliciting cooperative behavior is an important aspect of running an effective performance of a healthcare organization (Dukerich, Golden, & Shortell, 2002). Consequently, studying the antecedents of motivation, identification, and cooperation is especially important in the context of the ACO model.

An organization can foster an environment where employees feel internally motivated if employees believe their individual contributions are important to some overall goal (Locke & Latham, 1990). ACO administrators can signal to employees that their work is an important part of the goal of caring for patients by offering employee rewards or other incentives aimed to show appreciation for individual employee effort, which has been shown to motivate employees (Shepperd, 1993). Grant and Gino (2010) showed that recognition and appreciation shown by a leader, described as a prosocial behavior in their study, was related to enhanced employee feelings of self-efficacy, which has been linked to both employee commitment to goals and work motivation (Locke & Latham, 1990).

Motivating employees who work in groups may become increasingly important for health care organizations as the sector becomes more and more vertically integrated (Shortell & Rundall, 2003). For ACOs, who must provide the whole continuum of care for patients, this means coordinating among multiple providers for some patients, so studying the relationship between motivation and group learning behaviors is important. In a study on group learning

concerning the implementation of an innovative cardiac procedure, nurses who were specifically chosen to be part of the implementation because leaders had confidence in their communication and teamwork abilities were more likely to be motivated and cooperate with other team members compared to nurses who were only chosen for implementation because they were available that day for training (Edmondson, 2003). In a related study on the same procedure, this time focusing on organizational rates of learning, fast-learners of the procedure differed from slow-learners because those members that were picked for the training by high-status members were known to be good communicators and cooperators (Pisano, Bohmer, & Edmondson, 2001). In both these cases, those with authority recognized the value of the individual capabilities and contributions of lower-status employees, which resulted in enhanced motivation for those employees.

Leaders for ACOs can work towards enhancing organizational identification among providers by lessening the potential for goal incongruence. Specifically, they must convince employees that the ACO shares their goal of caring for patients. Research suggests employee motivation may be negatively impacted from the current emphasis on reducing costs (Franco et al., 2002). The conflict exists between the value employees' place on caring for patients and the lack of value they give to the financial goals of the organization (Giacomini, Hurley, Lomas, Bjhatia, & Goldsmith, 1996). For ACOs in particular, where employees are expected to meet specific metrics related to patient outcomes while also being mindful of organizational cost containment goals, the potential for conflict arising from this incongruence is particularly heightened. The way goals are communicated is important to employee perceptions and resultant behaviors (Greenberg, 1990). For ACO administrators, reframing the cost savings goal

away from utilization restrictions, a la managed care in the 1990s, and instead as a social or collective goal that is beneficial to the patient, could potentially reduce any uncertainty providers have about the ACO cost goals. A study on the effects of coordination among health care providers found that shared goals were the most significant predictor of positive patient outcomes (Gittell, Fairfield, Bierbaum, et al., 2000). If providers believe the goal of reducing costs is related to patient wellbeing, they are more likely to exhibit behaviors congruent with that goal (Grant and Hofmann, 2011).

Power can also be used by leaders to require high-status employees to take training that fosters a psychologically safe environment, such as training to increase communication and inclusive leadership behaviors (Nembhard & Edmondson, 2006). When the organization requires those with power to take training that is directly related to creating a more supportive atmosphere and better relationships for low-status employees, they are signaling to those employees that they care about their work environment. Tyler, Degoey, and Smith, (1996) found that "fair treatment and procedures can communicate…identity-relevant information because authorities act as prototypical representatives of groups, and their actions can be seen as highly salient indicators of group opinions" (p.914). Meaning, employees are more likely to identify with an organization if they perceive that leadership endorses and supports a fair and respectful environment.

Cooperative behavior is especially important in achieving the patient outcome goals of ACOs, which emphasizes continuity of care for high-cost patients such as those with chronic conditions (RTI International, 2011), who often require health care services from variety of clinical specialties (Shi & Singh, 2012). Since the majority of health care employees are nurses

and ancillary staff who are low in the medical social hierarchy (Nembhard & Edmondson, 2006), focusing on cooperation among these employees is particularly important. The positive impact of socially-oriented power usage that is hypothesized for both internalized motivation and organizational identification is expected to hold in the case of cooperative behaviors due to the already-established link between those constructs.

The impact of power differences has often been portrayed in terms of negative consequences, but when power is socially-oriented, those with authority may be able to positively influence individual employee outcomes and behaviors. In ACOs, administrators can use their power to create an environment where nurses give meaning to work and feel internally motivated. This can be achieved by using influence or resources to notice and reward individual contributions and actively seeking out opinions and feedback from nurses. Power can also be used to encourage organizational identity, such as establishing an environment where nurses experience a positive work environment. By establishing an organizational environment centered on supportiveness and psychological safety, nurses may perceive they are a valuable member of the organization. Additionally, administrators can show nurses that the ACO shares their goal of caring for patients by making resources available to make patient care the priority. In an environment where leaders use power for social goals and employees feel motivated and identify with the organization, positive behaviors such as cooperation among employees are expected to result.

REFERENCES

Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *The Academy of Management Review, 14*(1), 20-39.

Barsade, S. G. (2002). The ripple effect: Emotional contagion and its influence on group behavior. *Administrative Science Quarterly, 47*(4), 644-675.

Bass, B. M., & Avolio, B. J. (1995). *MLQ multifactor leadership questionnaire* Mind Garden Redwood City, CA.

Berger, J., Rosenholtz, S. J., & Zelditch, M. (1980). Status organizing processes. *Annual Review of Sociology, 6*, 479-508.

Bono, J. E., & Anderson, M. H. (2005). The advice and influence networks of transformational leaders. *Journal of Applied Psychology, 90*(6), 1306-1314. doi:10.1037/0021-9010.90.6.1306

Bunderson, J. S., & Reagans, R. E. (2011). Power, status, and learning in organizations. *Organization Science, 22*(5), 1182-1194.

Colquitt, J. A., Greenberg, J., & Zapata-Phelan, C. P. (2005). What is organizational justice? A historical overview. *Handbook of Organizational Justice,* 3-56.

Colquitt, J. A., Lepine, J. A., Piccolo, R. F., Zapata, C. P., & Rich, B. L. (2012). Explaining the justice-performance relationship: Trust as exchange deepener or trust as uncertainty reducer? *The Journal of Applied Psychology, 97*(1), 1. doi:10.1037/a0025208

Dukerich, J. M., Golden, B. R., & Shortell, S. M. (2002). Beauty is in the eye of the beholder: The impact of organizational identification, identity, and image on the cooperative behaviors of physicians. *Administrative Science Quarterly,47*(3), 507-533.

Dutton, J. E., Dukerich, J. M., & Harquail, C. V. (1994). Organizational images and member identification. *Administrative Science Quarterly,* 239-263.

Dutton, J. E., Worline, M. C., Frost, P. J., & Lilius, J. (2006). Explaining compassion organizing. *Administrative Science Quarterly, 51*(1), 59-96.

Edmondson, A. C. (2003). Speaking up in the operating room: How team leaders promote learning in interdisciplinary action teams. *Journal of Management Studies, 40*(6), 1419-1452.

Emerson, R. M. (1962). Power-dependence relations. *American Sociological Review,* 31-41.

Franco, L. M., Bennett, S., & Kanfer, R. (2002). Health sector reform and public sector health worker motivation: A conceptual framework. *Social Science & Medicine, 54*(8), 1255-1266.

Giacomini, M., Hurley, J., Lomas, J., Bhatia, V., & Goldsmith, L. (1996). *The many meanings of money: A health policy analysis framework for understanding financial incentives* [Hamilton, Ont.]: Centre for Health Economics and Policy Analysis, McMaster University.

Gittell, J. H., Fairfield, K. M., Bierbaum, B., Head, W., Jackson, R., Kelly, M., Thornhill, T. (2000). Impact of relational coordination on quality of care, postoperative pain and

functioning, and length of stay: A nine-hospital study of surgical patients. *Medical Care, 38*(8), 807-819.

Gonzalez, J. A., & Denisi, A. S. (2009). Cross‐level effects of demography and diversity climate on organizational attachment and firm effectiveness. *Journal of Organizational Behavior, 30*(1), 21-40.

Grant, A. M. (2008). Does intrinsic motivation fuel the prosocial fire? Motivational synergy in predicting persistence, performance, and productivity. *Journal of Applied Psychology, 93*(1), 48.

Grant, A. M., & Hofmann, D. A. (2011). It's not all about me motivating hand hygiene among health care professionals by focusing on patients. *Psychological Science, 22*(12), 1494-1499.

Grant, A. M., & Gino, F. (2010). A little thanks goes a long way: Explaining why gratitude expressions motivate prosocial behavior. *Journal of Personality and Social Psychology, 98*(6), 946.

Greenberg, J. (1990). Employee theft as a reaction to underpayment inequity: The hidden cost of pay cuts. *Journal of Applied Psychology, 75*(5), 561.

Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational Behavior and Human Performance, 16*(2), 250-279.

Kanste, O., Miettunen, J., & Kyngäs, H. (2007). Psychometric properties of the multifactor leadership questionnaire among nurses. *Journal of Advanced Nursing, 57*(2), 201.

Levine, J. M., & Moreland, R. L. (1990). Progress in small group research. *Annual Review of Psychology, 41*(1), 585-634.

Lewis, V. A., Colla, C. H., Carluzzo, K. L., Kler, S. E., & Fisher, E. S. (2013). Accountable care organizations in the united states: Market and demographic factors associated with formation. *Health Services Research,* doi:10.1111/1475-6773.12102

Lichtenstein, R., Alexander, J. A., McCarthy, J. F., & Wells, R. (2004). Status differences in cross-functional teams: Effects on individual member participation, job satisfaction, and intent to quit. *Journal of Health and Social Behavior, 45*(3), 322-335.

Lo, M., Ramayah, T., & Run, E. C. d. (2010). Does transformational leadership style foster commitment to change? The case of higher education in Malaysia. *Procedia - Social and Behavioral Sciences, 2*(2), 5384-5388. doi:http://dx.doi.org.proxy.library.vcu.edu/10.1016/j.sbspro.2010.03.877

Locke, E. A., & Latham, G. P. (1990). Work motivation and satisfaction: Light at the end of the tunnel. *Psychological Science, 1*(4), 240-246.

Nembhard, I. M., & Edmondson, A. C. (2006). Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior, 27*(7), 941-966.

O'Reilly, C. A., Chatman, J., & Caldwell, D. F. (1991). People and organizational culture: A profile comparison approach to assessing person-organization fit. *Academy of Management Journal, 34*(3), 487-516.

Pisano, G. P., Bohmer, R. M., & Edmondson, A. C. (2001). Organizational differences in rates of learning: Evidence from the adoption of minimally invasive cardiac surgery. *Management Science, 47*(6), 752-768.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68.

Shepperd, J. A. (1993). Productivity loss in performance groups: A motivation analysis. *Psychological Bulletin, 113*(1), 67.

Shi, L., & Singh, D. (2012). *Delivering health care in America: A systems approach*. Sudbury, Mass.: Sudbury, Mass. : Jones & Bartlett Learning.

Shortell, S. M., & Rundall, T. G. (2003). Physician-organization relationships: Social networks and strategic intent. *Advances in Health Care Organization Theory,* , 141-173.

Simons, T., & Roberson, Q. (2003). Why managers should care about fairness: The effects of aggregate justice perceptions on organizational outcomes. *Journal of Applied Psychology, 88*(3), 432.

Tyler, T., Degoey, P., & Smith, H. (1996). Understanding why the justice of group procedures matters: A test of the psychological dynamics of the group-value model. *Journal of Personality and Social Psychology, 70*(5), 913.

Valentine, M. A., Nembhard, I. M., & Edmondson, A. C. (2013). Measuring teamwork in health care settings: A review of survey instruments. Boston, MA: Harvard Business School.