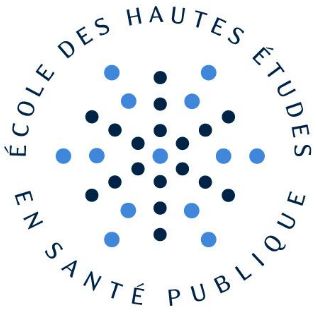

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The Power of Trust in Multidisciplinary Co-Leadership

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Special Thanks

I am deeply grateful to my talented hospital director Yann Bubien who trusts me and gave me the opportunity to integrate the EHMBA. I sincerely hope to give him back as satisfactions as I have received and I am steel receiving.

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List of acronyms

ANAP: Agence Nationale d'Appuie à la Performance
ANCC: American Nurses Credentialing Centre
ARS: Agence Régionale de la Santé
ATIH: Agence Technique de l'Information sur l'Hospitalisation
CHU: Centre Hospitalier Universitaire
CEO: Chief Executive Officer
CME: Commission Médical d'Etablissement
CNG: Centre National de Gestion
CPOM: Contrats Pluriannuels d'Objectifs et de Moyens
DGOS: Direction Générale de l'Offre de Soins
EHESP: Ecole des Hautes Etudes en Santé Publique
HAS: Haute Autorité en Santé
HEC: Haute Ecole de Commerce
IGAS: Inspection Générale des Affaires Sociales
MD: Managing Director
ONDAM: Objectif National de Dépenses d'Assurance Maladie
T2A: Tarification à l'activité
WHO: The World Health Organisation

Introduction

The deficit in state hospitals is a major concern for the authorities[1]. At the same time, hospitals find themselves in very different financial situations. This has led to the General Inspectorate of Social Affairs (*Inspection Générale des Affaires Sociales,* IGAS) including in its work schedule for 2012 a mission aimed at highlighting the internal and external determining factors likely to explain these very different situations (Acker & al, 2012). This report highlights a number of vital points which must be studied in detail, such as the definition of the hospital's strategic project and the improvement of internal organization, performance of clinical and medico-technical departments, and how these are supported by management and coordination resources.

The trust pact of 4 March 2013 (Couty & Scotton, 2013) presented by the Health Minister identifies management and dialogue in human resources as a vital determining factor. This is expressed in particular in the way in which stakeholders communicate: reinforcement of the prerogatives of the hospital medical committee, a technical committee for users and a review of hub-based organization. It is also a matter of facilitating employment relations and identifying indicators for quality of life at work. In addition, the reinforcement of the executive power has its practical outworking in a shift from an executive board in favor of the creation of a management committee in which the "central core" is explicitly stated: the managing director, the chair of the hospital medical committee (*commission médicale d'établissement*, CME), the dean of the medical school for University Teaching Hospitals (*Centres Hospitaliers Universitaires,* CHUs) and the director of nursing.

In addition, financial equilibrium is a major objective required of hospital managers by the governing authorities. **Achieving and maintaining a balanced budget** is the goal set for each hospital management, and the **means** of achieving this is the responsibility of managing directors. In this instance, the means in question is the result of a combination of method and leadership.

Indeed, even in a healthy financial situation, managing directors are subject to sometimes-contradictory pressures at all times, a situation in which their leadership legitimacy is particularly relevant. They are subject to tensions relating to the expectations of patients and staff, the directions of the Regional Health Agency (*Agence Régionale de la Sante*, ARS) and doctors. Future changes to the healthcare system and the number of determining factors involved also have an impact on their positioning.

[1] Commission des affaires sociales 26 mai 2010.

In this context, the 2012 IGAS mission highlighted the determining factors leveraged as a priority by hospitals to improve their financial results. At the same time as identifying these determining factors, the report warns us against seeing things from solely a financial point of view. If we were to do so, we would apply detrimental pressure on the quality and safety of treatment. The same point is made by the National Research Agency (*Agence Nationale pour la Recherche*) (Le Pogam & al, 2009).

Although financial performance is of capital importance for the viability of our healthcare establishments, it is not the only consideration to be taken into account when discussing hospital performance. The answer may be different depending on the person concerned, as well as on local, national or even international issues. In general "performance", even when it is subject to external constraints in a fluid situation, remains the prerogative of hospital managers. They set the course and the goals towards which all treatment and management is directed. It is their **leadership that instills meaning into the actions undertaken**.

The issue of the leadership of French hospital managers has not been the subject of much study, whereas there have been many publications on this issue in the world of business. The particular nature of the hospital world lies in the fact that the managing director coordinates the policy and strategy of their hospital with employees who have differing goals, missions, mandates and visions. Indeed, the managing director of a CHU teaching hospital is appointed by decree by the health minister and the minister in charge of higher education and research. In regional hospitals, they are appointed by decree by the health minister. They co-lead the hospital's managerial dynamic with the chair of the CME, who is elected for a 4-year term of office by their peers, in similar fashion to the dean of the medical school, who is also appointed by their peers[2]. The managing director chooses the director of nursing. Their respective training courses are completely different. Whereas the managing director and care manager are trained in management at the Higher School of Public Health (*École des Hautes Etudes en Santé Publique*, EHESP), the other two are trained at medical school. Their training and professional careers do not naturally lead to convergence between their leadership styles. The challenge for these key players in hospital governance is to bring their visions together within the executive committee, so that vision can be better shared internally with all professionals, and externally with the governing authorities and users. Sharing a common vision is not intuitive – it involves juggling between individual leadership, recognized within each community present, and co-leadership focusing on the common good in the service of

[2] Loi Hôpital, Patient, Santé, Territoire du 21 juillet 2010.

institutional policy and strategy. Within an organisation, “most human activity is not individual, lone activity: it is the product of concerted, coordinated action by a number of players” (Romelaer, 2011); Consultation and coordination on the basis of close collaboration between the players concerned (Friedberg, 1993).
According to Stephen Covey (Covey & Merrill, 2008), “Inspire trust in others and they will follow you: betray their trust, in a company, family or marriage and you will be on the brink of break-up.” Bennis and Nanus (1985) also suggest that one requirement of a leader is to generate trust. Generating trust is finally more than a leadership tool; it is the ingredient that pushes great leaders.

Trust is the vital ingredient for effective co-leadership, which is what has led us to investigate this issue.

Hypotheses

The purpose of this professional dissertation is to consider the place of trust in relationships between hospital managers in order to benefit performance. This relates to the quality of the co-leadership of the managing director, the chair of the CME, the care manager and, for CHU teaching hospitals, the Dean of the medical school. This investigation has led us to formulate the following hypotheses:

The central hypothesis of this paper is that trust is a vital ingredient for the implementation of effective co-leadership of one’s managers to serve hospital performance.

Our second hypothesis is that a trust-based relationship between managers has a positive effect on the decision-making process.

Trust = ➚ efficacy Co-leadership = ➚ decision-making process = ➚ performance

We have made the arbitrary decision to study the issue of trust among the members of the management team by targeting the operational managers of large state hospitals: the managing director, the chair of the hospital medical committee (CME), the care manager and for university teaching hospitals, the dean of the medical school. How coherently a hospital is coordinated is closely linked to the cohesion of this group of people. The configuration of the group varies depending on the terms of office of the various individuals. The common goal is to establish their legitimacy to conduct the hospital’s policy and strategy.

To address this issue, in the first chapter, we will attempt to gain a better understanding of what is meant by hospital performance. This preliminary consideration will then enable us to demonstrate the place of leadership in achieving performance targets before going on to examine the essential role of trust in the relationships between senior managers.

In the second chapter, we will conduct an exploratory survey in the form of interviews with hospital managers, in order to gain an understanding of how they operate as a group. In particular, we will focus our investigations on the place of trust in a situation involving Co-leadership.

In the final chapter we will attempt to establish what lessons can be learned from this exploratory study, in the light of the information in the literature and our own analysis. We will then make recommendations before reaching a conclusion.

CHAPTER 1: Analysis model: Trust as mortar for the leadership of hospital managers serving hospital performance

Before moving on to an in-depth analysis of the concept of trust as mortar for the leadership of managers serving performance, it is important **firstly** to define what is meant by performance in the context of hospitals. Here, performance is examined in terms of the results of policy and strategy implemented by managers.

Secondly, we will make the link between performance and leadership, in particular in co-leadership situations. Although the notion of 'leadership' has been well described in the area of healthcare in English-speaking countries, this has been far less the case in France, where the term 'management' is used more readily.

Lastly, we will present the concept of trust – a vital ingredient for effective, efficient co-leadership. This notion, often expressed in everyday language, is in fact more complex that it appears.

1.1 Performance serving hospital performance

Hospital performance is more difficult to define that it may appear. The recent summer school on performance in healthcare organized by ANAP[3] on 30 and 31 August 2013 strengthened this impression. This is why we believe that in this first part, it is important to detail the multidimensional aspect of the concept of performance. We will then present the challenge of assessing performance, in order to conclude this section by making the link to the key players in hospital performance – leaders.

1.1.1 Notion of performance – a multidimensional concept

The World Health Organization (WHO) has largely contributed to enshrining the word performance as a new paradigm for the care offering in its report entitled: "the performance

[3] ANAP created in 2009 by merge of three entities: the Group for Modernization of Hospital Information System, the National Mission of Support to Investment and the National Expertise and Audit Mission Hospital.

of healthcare systems worldwide", the goal of which was to compare healthcare systems one with another.

It is difficult to pin down performance because it is fundamentally multidimensional and complex. Depending on the lens through which performance is seen, it is defined differently. There is no proper, full-orbed definition that encompasses all the dimensions of performance, although that of the WHO (2003) does come close:

"Performance is the achievement of desired goals. High hospital performance should be based on professional competences in application of present knowledge, available technologies and resources; efficiency in the use of resources; minimal risk to the patient; satisfaction of the patient; health outcomes. Within the health care environment, high hospital performance should further address the responsiveness to community needs and demands, the integration of services in the overall delivery system, and commitment to health promotion. High hospital performance should be assessed in relation to the availability of hospital's services to all patients irrespective of physical, cultural, social, demographic and economic barriers".

In France, politicians and economists have observed the regular increase in healthcare spending alike. Top of the list is hospital expenditure. Consequently, better hospital performance, cost control and optimal use of resources are highly relevant.
There have been successive reforms: expenditure supervision through the National Target for Health Insurance Spending (*Objectif National de Dépenses d'Assurance Maladie,* ONDAM) and procedure-based charging (*Tarification à l'activité,* T2A) have been established in order to control spending.
In order to optimize resources, the National Support Agency for the Performance of healthcare and medico-social establishments (*Agence Nationale d'Appui a la Performance des établissements de santé et médico-sociaux*, ANAP), founded in 2009, has the mission of providing stakeholders with tools for measuring hospital performance. Its goal is to achieve increased productivity through better organization.

In addition, the hospital must meet the needs of the population: these are often varied, poorly defined and exponential in terms of future healthcare needs, in particular with an ageing population and the development of chronic diseases (Broussy Report, 2013). At the same time, it must also incorporate the economic, competitive and technological considerations of its environment. The challenge facing hospitals, at the crossroads of these considerations, is to combine them successfully.

To do so, in addition to successive reforms and irrespective of the size or nature of healthcare establishments, the question of shared vision – shared by the authorities, users and grassroots stakeholders alike – arises. The challenge of hospital performance is probably the challenge of drawing these players' visions together, as each champions their own partial view of performance.

Performance from the point of view of governing authorities

The reforms of procedure-based charges, that of hospital governance and certification procedures have sought to achieve convergence between the healthcare needs of the population, the best quality of care, and maximum efficacy. In addition, the rationale for placing hospitals under contract with Regional Health Agencies (*Agence Regionale de la Santé*, ARS) in the form of multi-year contracts with targets and resources (*Contrats Pluriannuels d'Objectifs et de Moyens,* CPOM) obliges actors to work on their organisational and financial targets. The governing authorities establish a normative framework for the care offering.

Performance from the point of view of hospital professionals

This is more a question of organizational performance. It aims to make the common principles expressed by the governing authorities operational, based on the specific briefs for each category of person involved: management, doctors, and paramedical and administrative staff. Here, performance derives more from a company-like rationale, as described in the Couanau report in 2003. According to Saulquin and Fray (2005), the degree of collaboration between professionals, and therefore organizational performance, are affected by a number of factors: in particular, recognition and trust for individuals who have a 'line manager'. It should be noted that for hospital professionals, the management team and administration are very often assimilated to the governing authorities, whereas the medical and paramedical teams work together on a daily basis even if they have diverging interests. Whether or not professionals get behind the requirements of hospital performance is closely linked to whether or not they share, understand and support the desired performance targets.

Performance from the users point of view.

Users' targets when it comes to performance are focused essentially on improving the quality and safety of cares and treatment.

Performance is conceived according to a number of models that reflect differing visions that are complementary – and sometimes contradictory. Indeed, it is impossible to maximize fulfillment of all these performance criteria at the same time. It follows that performance can

be defined only in terms of the dominant perspective; here, it is more akin to the best balance of criteria chosen on the basis of the leader's vision and their short, medium and long-term strategic targets.

1.1.2 Major challenge of assessing multidimensional performance

Performance is a relative concept because it is valid only with respect to the objective it relates to, its content and the availability of data. Moreover, a performance model will be adopted on the basis of its relevance for the situation.

Measuring performance involves reliance on a robust information system. At the same time, producing information is not in itself enough. Information must also be targeted and prioritized, according to the institution's goals and how the players behave: perspective is needed to make sense of activity. Nowadays there is no lack of information; the vital question is whether the stakeholders can leverage it to make decisions. Hospital managers drive hospital policy and strategy to serve performance.

From the point of view of the care offering, however, a large number of studies show that the criteria for assessing hospital performance do tend to converge (Arah & al., 2003). From the point of view of the demand for performance, there is stillroom for improvement in taking user satisfaction into account alongside that of professionals, in an inclusive performance model. There are some avenues of investigation, such as the Label Recognition Program® developed in the United States by the American Nurses Credentialing Center (ANCC), which awards "magnet hospital" status and regularly quoted as the gold standard in terms of quality of care (Lundmmark, 2008 ; McClure, 2005 ; Tuazon, 2007). This external recognition program focuses on the quality of care practices – and the performance-oriented management schemes implemented to support them.

In terms of an inclusive model for appraising performance, the Donabedian model (1988) is often used. This distinguishes three aspects of quality: structure or input (material, human, organizational and cultural resources), process or output (care, medical and managerial practices) and results or outcomes (the intermediate and final results for the patient and/or staff). The updated model is an Overall Integrated Assessment of the Performance of Healthcare Systems (*Evaluation Globale Intégrée de la Performance des Systèmes de Sante*) (Champagne, Contandriopoulos, Picot-Touche, Beland, & Nguyen, 2005). Its starting principle is that good structure leads to good practice, which in turn produces good

outcomes. This model is based on Parsons' structural functionalist theory of social action systems (1977).

Performance calls for a balance of four vital functions: suitability for the environment, the achievement of strategic goals, efficacy and efficiency of production and upholding values (Sicotte, Contandriopoulos, & Champagne, 1999).

Kaplan from Harvard Business School and Norton (1992) propose a Balanced scorecard which is a strategic planning and management system that is used extensively in business and industry, government, and non-profit organizations worldwide to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals (Cf. Appendix 1).

Closer to French managers, the Hospi Diag system developed by ANAP[4] is another example of a decision support tool that allows the performance of a healthcare establishment to be measured. This was produced with the aid of ANAP, DGOS, HAS, IGAS and ATIH. Its stated aim is to provide hospitals with better self-knowledge, enable them to make comparisons with others more easily, have better dialogue both internally and with ARS[5].

1.1.3 Hospital performance – a goal for all

Measuring overall performance rather than individual types of performance is a challenge faced by governing authorities and hospital managers alike. The starting point is to define the missions of state hospitals and their goals within their own context (Livartowski, 2010).

Finally, whatever the type of hospital performance sought, irrespective of whether it is imposed by legislation, by administrative measures put in place by governing authorities or by measures introduced by hospitals' internal management, it will involve making choices. The expected outcomes are expressed in terms of efficiency[6] and effectiveness[7], along with increased productivity of the administrative and clinical organization.

This clearly indicates the importance and the role of leadership in the coordination of policy and strategy by hospital managers. The study conducted in the UK by Jeremy Hurst and

[4] Conférence de presse du 30 juin 2010. Annie Podeur, DGOS, Dr Gilles Bontemps, ANAP

[5] Dossier de presse, DGOS, ANAP, HAS, IGAS, ATIH. Présentation de l'outil Hospi Diag: Intérêt et enjeux d'un tableau de bord de la performance, conférence de presse, mercredi 30 juin 2010

[6] Efficiency = objective performance, measuring output versus inputs

[7] Effectiveness = from outputs: objective alignment to the consumer value (needs and preferences) in term of results

Sally William (2012) in 2012 confirms that a combination of a high level of leadership and effective clinical management are crucial to increase productivity.
It follows that hospital performance necessarily involves efficient Human Resources management.

In a highly competitive setting, performance is also expressed by the ability of leaders to spot, attract and keep talent. The reason for this investment relates to the proactive desire for on-going change management in the best possible conditions, in order to encourage employees towards excellence. As Stephen M. R. Corvey and R. R. Merill (2008) put it, this engages our credibility and legitimacy for the future.

1.2 Hospital coordination through leadership by hospital managers

In France, although we do not always draw a distinction between management and leadership, this does not really matter because as Henry Mintzberg says (2004), seeking to separate leadership from management is somewhat akin to wanting to play the violin without a violin. Simply put, management consists of finding solutions, while leadership consists of managing paradoxes. Managers focus on operationally and what is reasonable, while leaders use their emotions in their daily life (Rinfret, 2007). These two approaches call on different skills. Table 1 below from John Kotter (1996) demonstrate some of the important differences between leadership and management.

Table 1: Leadership versus Management

Criteria	**Management**	**Leadership**
Creating an agenda	*Plans and budgets*: Establishes detailed steps and timetables for achieving set results and allocates the necessary resources	*Establishes direction*: Develops a vision of the future and strategies for achieving that vision
Developing a network for achieving the agenda	*Organizes and staffs*: Establishes structure for achieving the plans, assigns staff, delegates, develops policies to guide subordinates, and designs control systems	*Aligns people*: Communicates direction and duties to all whose cooperation is needed so as to create teams and coalitions that understand the vision and strategies and accept their validity
Executing the agenda	Controls and solves problems: Monitors results against plans, identifies deviations, and then organizes to close any gap.	Motivates and inspires: By satisfying basic human needs, energizes people to overcome barriers to change.
Outcomes	Produces a degree of predictability and order. Has the potential to produce key results expected by stakeholders.	Produces change, often to a dramatic degree. Has the potential to produce extremely useful change.

Source : J. P. Kotter (1990, 1996)

“Managers are people who do things right and leaders are people who do the right thing” Bennis and Namus (1985)

The first point studied in this part will be the link between performance and leadership. Next, we will present the different leadership theories before reaching a conclusion on the particular nature of co-leadership.

1.2.1 Leadership serving performance

The way in which managers exercise their power leaves fewer and fewer people indifferent – be it governing authorities, users or healthcare professionals. Their decisions have not only economic and social impacts but also a societal impact. Indeed, hospital governance now attracts extensive media coverage and is compared nationally and internationally. The reputation of hospitals is becoming a significant indicator, taken into account by hospital managers. It is illusory to imagine that when governing authorities, peers or our fellow citizens, our performance track record and reputation as well as our actions assesses the policy and strategies of leaders and past results will be overlooked. On the contrary, this is what characterizes us.

Although 86% of French people say they are satisfied with their hospitals[8], the 2012 IGAS report makes a certain number of observations in favor of improvements, in terms of governing authorities, coordinating the quality of care and the efficiency of healthcare expenditure. In a competitive context with a significant human dimension, closely linked to the mission of hospital governance, the enormous challenges and issues surrounding healthcare, place hospital managing directors in a particularly exposed position. They are expected not only to have managerial skills but also and above all the ability to drive hospital professionals towards increasing levels of efficacy, efficiency and effectiveness. What is more, it has been observed that there are few leadership performance indicators, and those that do exist are not combined with other indicators for assessing hospital performance.

In addition, while there is a great deal of literature covering the careers of some great leaders in industry and no shortage of research into their leadership in English-speaking countries, in France there is very little dedicated to the leadership of hospital managers.
There is a dearth of literature both on the initial training of hospital managers at the *Ecole des Hautes Etudes en Sante Publique* (EHESP) and on professionals in management situations. However, a recent study in 2011 of 100 US “Top hospital CEOs” shows that leadership plays a very important role in achieving performance targets (Thomson Reuters, 2011). Rather than adulating a single leadership model, the idea is to highlight

[8] Sondage FHF, TNS-Sofres, février 2012

the combined product of all their teams' actions and the effects of their interactions. Leadership thus becomes a valuable skill and even "a competitive asset that is difficult to reproduce" (Mooney, Thibodeau, 2006).

It is argued that effective leadership has a positive influence on the performance of organizations (Maritz, 1995; Bass, 1997 ; Charlton 2000). Behling and Mc Fillen (1996) confirmed the existence of a link between a high level of performance and leadership in the United States, developing a transactional charismatic leadership model in which the behavior of leaders fosters the emergence of collective performance on the part of subordinates.

There is no absolute definition of leadership, but what the whole host of definitions have in common is that they describe leadership as an influence-based relationship.
Bass' work (1985) is now the most often quoted in research work on the subject of leadership. Bass defines leadership as "a process of influencing other individuals to perform in such a manner so as to achieve a preconceived goal or goals". Leadership is not a quality that can be decreed, but a quality attributed subjectively to an individual by another individual, who thereby accepts their influence (Bass, 1990).
For Stephen M. P. Covey (2008), leadership is also an influence-based relationship that is expressed by "the art of getting results in way that inspires trust". From this point of view, "how" is more important than "what". Formalizing the "how" enables identified factors of success and progress to be capitalized on, in order to serve performance in a transparent manner. This is a dynamic process that propels towards performance of any nature.

1.2.2 Leadership theories

Over time, leadership theory progressed from focusing on the individual to focusing on the situation or context then, on relationship between leaders and subordinates to the impact of effective leaders have on organizational change and alignment on goals. Theories that have emerged over the past century are:

- Great man theory is based on the principle that Great men or leaders were born, not made Carlyle (1847-1993).

- Trait theories focus on personality, intellectual, and physical traits that distinguished leaders from non-leaders. « Traits are precondition for successful leadership. Once the

leader has the requisite traits, they must take certain actions to be successful, such as formulating a vision, role modeling, and setting goals » (Kirkpatrick & Locke, 1991).

- Style and Behavioral approach: three defined leadership styles were identified, autocratic with telling others what to do, democratic with involving others in planning and implementation and laissez faire with giving little or no direction to others (Lewin, Lippert & White, 1939). Blake and McCanse (1991) found two additional leadership styles: consideration as a relationship behaviour and concern for people, and initiating structure as a task behavior and concern for production. Daniel Goleman (2002) proposed six distinct leadership styles based on his theory of emotional intelligence: Coercive « do what I tell you » ; authoritative « this is where we want to go » ; affiliate « we need harmony and bonding » ; democratic « let's see what everyone has to say and most seem to want » ; pacesetting « do what I do, and you'd better follow along » ; and coaching « here's how to get this done », and « here's how to do this better ». Using four or more of these styles seem to foster the best organizational climate and effective business performance (Goleman et al, 2002).

- McGregor's X and Y theory (1960). He believed that leaders could be classified in two groups based on their assumptions about their followers: X when they are « lazy » so the leader tend to develop control methods; Y when followers are proactive, intrinsically motivated, seek responsibility, so the leader tend to give them opportunities for development.

- The leadership grid of Blacke and Mouton (1964). They added to the style theory that different patterns of leadership include concern for task, concern for people, directive leadership, and participative leadership.

- Situational and Contingency approaches of leadership suggested that there are two types of leaders: those who focus on relationship and those who focus on tasks (Field, 1967). The main goal is to reach leadership effectiveness. To go further, House and Michell (1974) suggested the path-goal theory. It focused on the situation and the leader behavior and not on traits or styles. It offers four leadership behaviors: directive where leaders establish ground rules ; supportive or coaching when leadership is sensitive to subordinate's needs ; participative or supportive when decision-making is based on group position ; and achievement-oriented or delegating when leaders trust their teams(Cf. Appendix 2).

- **Transactional leadership** is based on reciprocity when leaders are not only influencing followers but they are also under their influence (Heifetz, 1994). It's a sort of contingent reward and positive reinforcement (Halter & Bass, 1988). The followers are recognized as a willing participant in the exchange with the leader (Avolio & Bass, 1995).

- **Transformal leadership** is focused on alignment to a greater good. Transformational leadership elevate leaders and followers' motivation to reach goals, « engaged in interactions with followers based on common values, beliefs and goals (McGregor Burns, 2003). It's a process that changes and transforms individuals, organizations, and cultures to create clear and compelling visions for the future (Bass, 1985; Kotter, 1996). Transformal leadership align organizational goals and long term goals with personal goals and engage others in reaching the vision with charisma, intellectual stimulation, and individual consideration (Bass, 1990; Bennis 2003; MacGregor Buns 2003).

- Full range leadership development model was developed by Bass and Avolio (2003) which state that the most effective form of leadership is a combination of transactional and transformal leadership factors: Charisma, inspirational motivation, individualized consideration and intellectual stimulation; Contingent reward and management by exception.

1.2.3 From individual leadership to co-leadership

The leadership of hospital managers, which is often confused with power, is as strategic as it is under-studied in France. It poses the question of legitimacy in the exercise of influence. Legitimate power is often considered to be a relationship between social players. Max Weber identifies three distinct types of legitimate authority: traditional, charismatic and rational authority. Each type relates to a different organizational model:
- The first, traditional legitimacy, is based on elders and customary law of a lord-liege type. The organization is paternalistic in nature. Individuals earn their rights only through belonging to a community.
- The second, charismatic legitimacy is based on the belief that an individual can be endowed with exceptional qualities. The organization is charismatic; one such example is Steeve Jobs with "Apple" (Isaacson, 2011).
- The third, legal legitimacy, is based on law and formal, written rules. It is founded on skills and validity of the status rather than on individuals. The organization is said to be modern and rational, relating to the rise of capitalism.

If applied to hospital managers, this classification clearly illustrates the different origins of the legitimacy of the different individuals' power that need to be identified. Although it is entirely possible for the different models of legitimacy to coexist, the management team should be aware of this distribution in order to combine them and serve the institution more effectively. Henry Mintzberg (1984) identifies legitimacy as a major feature of leadership.

In discussing leadership in the public sector, the search is for individuals who will promote institutional change. In a changing environment, the overall question of the leadership of hospital managers should be raised during initial training and fostered throughout professional life, since the degree of transfer is so crucial to the survival of organizations. The healthcare sector is a competitive sector both in terms of its activities and its human resources. Spotting, attracting and holding on to talented professionals is becoming a major strategic goal for hospitals.

Hospital mangers and care managers alike are trained in management and leadership at EHESP[9]. No formal curriculum exists in medical education that cultivates the development of an effective organizational and behavioral leadership skill set. The only way to develop skills is by experience when physicians are involved or by implementing internal leadership programs (McAlearney, 2005). « Medical schools and residency programs must recognize the importance of developing leaders and incorporate leadership skills into the curriculum » (Chaudry, Jain, McKenzie, Schwartz MD, 2008). We noticed that backgrounds are different; it could influence their Co-leadership.

If we focus on large hospitals, governance is entrusted to the Managing Director (MD), assisted by the Chair of the CME, the director of nursing and Dean of the medical school for issues relating to research at CHU teaching hospitals. There is a double-headed, organization – administrative and medical – and this obliges players to get along together.

Shared governance requires continual assessment and re-evaluation in order to be flexible and response to an ever-changing environment (Scott & Caress, 2005). It's an ongoing and fluid process (O'May & Buchan, 1999). Mintzberg (1984) believes that leadership is built up over time, drawing on experience from lessons learned through success and failure.

In the final analysis, co-leadership involves professionals working together to provide services simultaneously to the same clientele (D'Amour & Oandasan, 2004). It also

[9] Rapport d'activité 2012 du Centre National de Gestion (CNG).

involves sharing a professional domain: these calls for trust, tolerance and the desire to share responsibility (Nolan 1995). According to D'Amour, Sicotte and Levy (1999), the members of a multidisciplinary team "open up the borders of their territory" to enable greater flexibility in the sharing of responsibilities. In actual fact, the members of hospital managers' teams do not choose each other. Their ability to work together is not naturally acquired; there are different constellations of roles and relationships in senior positions (Alvarez & Svejenova, 2005).

Even if their legitimacy is recognize in their respective fields, as CEO, they have to face shared positions and shared power in an explicit way. Focus turned from individual achievement to collective achievement. It occurs when all members provides a stronger leadership than when relying on one top leader (Pearce & Manz, 2004). According to Cox, Pearce and Perry (2003), shared leadership has to fulfill three criteria « First, team members must understand that constructive lateral influence is a standing performance expectation. Second, members must accept responsibility for providing and responding appropriately to constructive leadership from their peers. Third, the team members must develop skills as effective leaders and followers ». Consequently, co leadership and distributed leadership leaders challenge is to be involved despite formal position in individual leadership (Jackson & Parry, 2008). The actual leadership tasks and the complex environment put great demands on the leaders, and that improve Co-leadership. It's easier to manage these demands if the task is shared by a group of people (Vine, Holmes, Marra, Pfeifer & Jackson, 2008). Co-leaders are different and complementary each other (O'Tool, Galbraith, Lawer, 2002). The most prevalent coordinating principle for Mintzberg (1983) is probably mutual adjustment.

Co-leadership is not a universal model. Locke (2003) states that some tasks should not be shared, while some could be shared. His ideal leadership model is an integrated one ; a combination of the shared leadership model and the top-down model, but also containing a bottom-up component.

Sharing leadership and its consequences presupposes that the individuals concerned are able to work together with efficacy and efficiency, and want to trust one another for the common good.

1.3 Trust is a core basis of effective leadership

Professionals as being the vital prerequisite for all effective working relationships often intuitively describe trust. This refers to interpersonal trust, which is limited in terms of both

scope and time. It plays an essential role, particularly in the armed forces. The following is found in the army's handbook for future officers: "Trust is the highest form of relationship uniting officers and subordinates". Vadell (2008) has demonstrated that there is a strong relationship between trust and commitment, although commitment can sometimes be irrational. From the work of Louis Quere (2001), it would appear that the rather unclear aspect – the leap of commitment – is counterbalanced by the cognitive and social nature of trust. However, there is nonetheless a link between trust and risk because "trusting means adopting a certain attitude to the future" (Quere 2001).

In the existing literature, there are no specific publications dealing with the subject of trust in the relationships between the members of a hospital management team. However, a large amount of research is emerging in a range of disciplines dealing with the place of trust in interpersonal relationships (Bennis and Nanus, 1985; Zand, 1972).

Trust is now considered to be a key requisite skill for effective leadership. An international study conducted with 1,867 business leaders of 13 nationalities confirms that instilling trust is a reflection of effective leadership (Sullivan & Tucker, 2012). A high level of trust enables the expectations of managers with respect to their subordinates and vice versa to be clarified, transparency to be created in relationships and the players involved in trust-based relationships to be held accountable. Trust is becoming the key component of legitimacy.

In this section, we will establish the principles of trust before presenting its dynamics. We will conclude with the presentation of an integrative model for defining trust that is worth highlighting for co-leadership situations.

1.3.1 Daring to trust – principles

Trust may be considered to be a key skill that is far more powerful than major demonstrations of facts and figures in management meetings. When leadership is shared, trust becomes the driving force for success, lending credibility to speeches and decisions in the eyes of employees.

Trust between individuals is effective at all levels of the organization. It is built up more or less quickly depending on the goodwill of individuals. In particular, the personality of the different players becomes a major determining factor.

Bernard Ramanantsoa, CEO of HEC Paris, characterizes leadership as the ability to turn an organization into an institution[10]. Managers must engage a value system that is shared by employees in order to make the organization meaningful. This system of governance and values is based on the legitimacy of the leader to lead teams to the goal, based on mutual trust.

According to Quere (2001) the main parameters of trust are: favorable expectations with respect to the intentions and actions of a third party, its cognitive dimension and the inherent element of risk-taking. Given its cognitive nature, the phenomenon of trust is different from that of faith. Simmel (1999), however, raises the notion of abandoning oneself to another. This implies that trust involves a little more than simply knowing. He also raises the moral dimension of trust. This flows out of the fact that granting trust is a free choice on the part of the person involved. This in turn implies that genuine trust cannot be obtained through any kind of manipulation (Simmel, 1999).
Luhmann (2006) argues that the person giving their trust cannot be certain of the loyalty of the person they trust. Trusting is an investment in the future. Trusting in someone else for certain aspects of our future therefore involves taking a risk. Risk taking therefore stands as the most proximal behavioral outcome or expression of trust (Mayer & al, 1995; Ross & LaCroix, 1996).
In addition, trust does not systematically involve an act of commitment. Trust-based attitudes are “usually routinely incorporated into on-going day-to-day activities, and are mostly imposed by the intrinsic circumstances of everyday life” (Giddens, 1990).

1.3.2 Dynamic of trust

Colquitt and al (2007) demonstrated that practical benefits of trust were often underscored comparing to power of relationships or other attitudes such as jog satisfaction. The relationship between trust and job performance is stronger than previous attitudes.
Trust predicted risk taking, which is vital in many jobs where formal or legalistic controls do not protect exchange partners (Harding, 1996; Sitkin & Roth, 1993). Trust also predicted counterproductive behaviors, and is strongly correlated with affective commitment, a significant predictor of both absenteeism and turnover (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002).

[10] Dossier decideurs: strategie finance droit, avril 2011, p27.

Damaged trust causes friction, deceit, conspiracies, conflicts between people, and rivalry between departments, all of which ultimately slows down the organization, as described by Stephen M. R. Covey and R. R. Merrill (2008).
The latter go so far as to talk in terms of the “trust economy” inasmuch as trust always affects two factors: speed and cost. When trust wanes, there is a loss of speed and cost increases, and vice versa.

[↘]TRUST = [↘] SPEED [↗] COST
[↗]TRUST = [↗] SPEED [↘] COST

For Covey and Merrill (2008), integrity, good intentions, the abilities of individuals and their results are symbolic of manifestations of trust. Borrowing from the language of economics, they also deal with the issue of organizational taxes, or hidden deficits, adversely affecting results due to an absence or lack of trust – as well as dividends.
‘Tax’ here refers to factors such as redundancy and bureaucracy arising from a complex, burdensome accumulation of rules; tactical, political and strategic manoeuvres for power; loss of motivation; internal and external staff turnover; and delinquent behavior in the form of wasted time and money.
On the other hand, ‘dividends’ are said to include increased value (shareholders and clients); accelerated growth, high-quality collaboration (or progressing from coordination or cooperation to collaboration), stronger partnerships, better implementation (“a second-rate strategy combined with first-rate implementation is better than the contrary”) and increased loyalty are all expressed when trust is the driving force of leadership.

Trust cuts transaction costs and the immobility induced by systematic distrust (Ogien & Quere, 2006) and has the advantage of cutting “transaction costs” relating to the quest for information and the exercise of reciprocal control (Quere, 2001).

In a hospital setting, the notion of trust is often absent from the various conceptual frameworks used to analyze the performance or leadership of managers. However, by observing organizations in different environments, Henry Mintzberg (1989) defines trust as a central; a natural balance between the social and economic goals of an organization. Unlike economic goals, social goals are not easily quantified. The question thus arises as to how performance is measured and the place given to “social” aspects. The strategic decisions of large organizations inevitably involve social consequences as well as economic consequences (Mintzberg 1999). Here, trust is thus considered from the perspective of its contribution to the workings and stability of social life.

Trust is an extremely important characteristic of leadership, described by great business leaders (Garcia, 2011). Certain business leaders themselves have written about trust (Martin, Lenhardt & Jarrosson with "*oser la confiance*" ('Dare to trust'), 1996).

1.3.3: Trust as expressed by Covey and Merrill

Covey and Merrill (2008) describe five waves of trust flowing outwards. They show how the trust effect is propagated from the individual towards relationships with others, then towards relationships with all partners, and finally towards society as a whole, like the ripple effect produced by a stone skimming along the surface of water: Self-trust; Relationship trust; Organizational trust; Market trust; Societal trust.

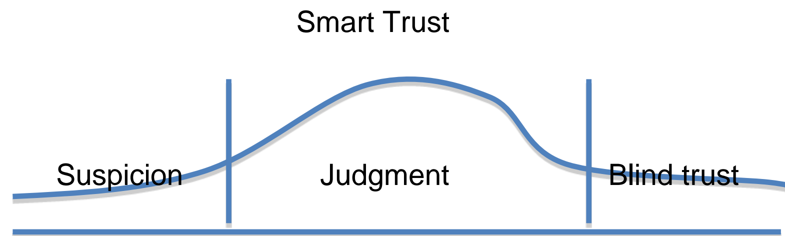
For hospital management, the degree of organizational performance is undeniably linked to that of the cohesion and internal trust between those in senior management. Performance is also expressed through skills, sharing, understanding and stakeholder ownership of the performance goals sought (Saulquin & al, 2004). In addition to this, there is the necessary external trust of each individual in the group they represent. The question is one of establishing their respective legitimacy vis-a-vis the groups they represent.

Trust between an individual and an organization is often considered to be three-dimensional, involving credibility, integrity and goodwill (Le Pogam & al, 2009).
Trust also relies on the principle of creating a shared vision beforehand (Covey & Merrill, 2008), specifying expectations beforehand for oneself and others. Trust means making people aware of the fact that there is room for progress between the existing and potential state of affairs. This space of potentialities opens up a space for empowerment of the actors in the organization.

When seeking to get a message across, there is a major risk of confusion and wasted time. This involves a certain degree of reciprocity and quantifying what is expected in a win-win relationship: What is the result to be achieved; by when; how should this be assessed; at what price; who is responsible for the results; Etc.
In practice, in situations of Co-leadership, it's difficult to achieve both, quality, cost and timeless of the project. Only trust allows each other to make concessions for a win-win relationship to serve the common. Although, when you are dealing with trust, we now that believing or trust everyone is a simplistic view of power of trust, it is blind trust. On the other extreme side, some people don't trust or are suspicious. In the middle, we can

consider "Smart Trust" as a risky position but also create the possibility of reaching the « sweet spot ».

Table 2: Smart Trust representation

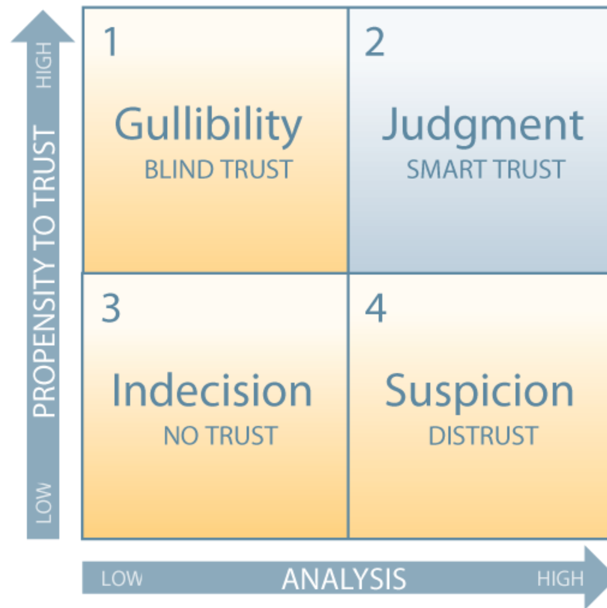


Covey and Merritt (2008), plebiscite the fact that, inspiring trust threw a "Smart Trust", is the key point for leaders. On table 3, we can see the “Smart Trust” matrix

- Zone 1 (High Propensity to Trust: Low Analysis) is the ‘Blind Trust’ zone of *gullibility”*
- Zone 2 (High Propensity to Trust; High Analysis) is the ‘Smart Trust’ zone of *judgment*”
- Zone 3 (Low Propensity to Trust; Low analysis) is the ‘No Trust’ zone of *indecision*”
- Zone 4 (Low Propensity to Trust; High Analysis) is the ‘Distrust’ zone of *suspicion*”

It starts with yourself and your own credibility with the four cores: Integrity, Intent, Capabilities and results. Second, you inspire trust by constantly behaving in trust building ways with other people (Cf. appendix 3: the four cores; appendix 4: 13 behaviors from Covey & Merrill, 2008). For leaders using the four cores and the 13 behaviors in their current activities, « create the alignment in organizations, reputation and contributing to the world » and of course results. Results in term of inspiring talent, creativity, synergy, and highest contribution of others. It's also to effectively leverage yourself (Covey & Merrill, 2008).

Table 3: Covey (2008) "Smart Trust' Matrix



CHAPTER 2: Case study: the opinion of top hospital managers on the place of trust in their Co-leadership

In view of our study topic, our research methodology has been directed towards active research, including the desire to interview hospital CEOs, chairs of CMEs, treatment managers and deans of teaching hospitals directly in order to confirm or overturn our hypotheses:

- Performance can be sought only through shared leadership on the part of managers to serve the decision-making process;
- The mortar for this shared vision is mutual trust between the protagonists for legitimacy to lead teaching hospitals towards full-orbed hospital performance.

It should be noted firstly that trust-based relationships have not been dealt with extensively as regards the population targeted by this study. Secondly, it would be premature to seek to generalize this study to all healthcare establishments. We are simply seeking to cast light on the complexity of the issue, to highlight its various aspects and provide better understanding in order to identify constants in how the individuals interviewed say they apprehend reality. This is therefore is an exploratory study, apprehending complexity.

In the first part we will present the population studied. We will then describe the survey tool itself to get information’s before concluding with the innovative tool to rank collected information’s.

2.1 Presentation study cases

Our objective is not to carry out a scientific demonstration but rather to cause healthcare professionals to think about trust and leadership-related issues. Our over-riding aim is to make a contribution and encourage research in this area, to give talented leaders visibility and initiate further examination of the subject. Consequently, we will attempt to test the hypotheses put forward by interviewing experienced, hands-on professionals, in leadership positions in state healthcare establishments.

The small number of individuals interviewed does not of course reflect the opinion of all hospital managers. Nevertheless, each individual is directly concerned by the questions posed, and this will enable us to examine the detail of the expected data in greater depth.

Our target population is representative of management teams as defined by us: four managing directors, three chairs of CMEs (two from teaching hospitals and one from a large hospital (*Centre Hospitalier*)), as well as three directors of nursing, tow from a teaching hospital and the other from a large hospital, and a medical school dean.

To preserve their anonymity, we will refer to them as follows:
A1, A2, A3, and A4 for the managing directors; B1, B2, and B3 for the chairs of CMEs, C1, C2 and C3 for the directors of nursing and D for the dean.

The aim is not to draw comparisons between the establishments but to focus our survey on the opinions of professionals in leadership and co-leadership situations.

This does not constitute comprehensive research into all relevant scientific data but rather an exploratory study, seeking elements to help understand the role of trust in the group of hospital managers. We remain very cautious that our sample is too little to generalize our findings.

2.2 The exploratory qualitative research interview

We produced our survey tool on the basis of research by Covey and Merrill (2008). It is a four-part individual semi-directive interview plan (DiCicco-Bloom & Crabtree, 2006):

Q 1: General questions about individual leadership
Q 2: Questions about the level of co-leadership in their organizations
Q 3: Questions about the place of trust in their group of three or four within their establishments
Q 4: Open questions on the link between leadership and performance

Advantage of an individual in-depth interview allows the interviewer to delve deeply into social and personal matters. Questions that are not effective at eliciting the necessary information can be dropped and new ones added. The interviewer is also free to ask his questions anytime during the interview because, digressions can be very productive as they follow the interviewee’s interest and knowledge (Johnson, 2002).

In order to validate our survey tool, we sought to check whether the original questions and follow-up questions were realistic and understandable. We therefore initially tested the interview plan with hospital managers who clearly spoke their minds, allowing us to trim down the prepared follow-up questions and make the essential questions clearer.

Due to difficulties in making appointments and the distances involved for certain interviewees, our preparation for the face-to-face interview had to be carried out by means of a preparatory telephone interview (30 to 45 minutes). We tested the methodology for this type of interview with experts who regularly use this tool.

Each interview was recorded and faithfully transcribed, having received the consent of the interviewees and with an undertaking not to make the content of these interviews public. Because of the tape-recorded data can be recognized and be a source of danger for those who are taped, we chose to destroy them just after transcription. Transcriptions have been sent to the owner but won't join this present paper for the same reasons.

Each central question allowed us to gather specific data. For each key question, the information sought was as follows:

Q 1: General questions on individual leadership

- Degree of familiarity with the concept of leadership
- Characteristics of leadership
- Links between individual leadership and hospital performance

Q 2: Questions on the level of co-leadership in their organizations

- Methods for the implementation of co-leadership
- Strengths and weaknesses of co-leadership
- Links between co-leadership and hospital performance

Q 3: Questions on the place of trust in the threesome (or foursome) in their establishments

- Role of trust in their leadership styles
- Role of trust in them as leaders for their counterparts in the management team
- Link between trust and performance

Q 4: Open questions on the link between trust, leadership and performance

- Free expression: advice, suggestions for innovative action to be implemented to encourage trust-based relationships.

We compared the data gathered in order to analyze it and respond, identifying the common points and differences, especially key points, in order to generate an emergent understanding about the research question.

2.3 The exploratory qualitative ranking tool

On one hand, the position of the interviewer in front of an interviewee may influence participants, attitudes and non-verbal attitudes. On the other hand, their environment could disturb the interviewees by phone. Interviews were a pretext to get targeted information's.

We chose to use Covey and Merrill model (Appendix 3 & 4) to rank answers on an innovative scale. This choice revealed further limitations:

- Firstly, we accepted the risk of using non validate tool to rank collected information's.
- Secondly, we noticed a risk of an erroneous transcription by misunderstanding people meanings.
- Then, we created a score scale: Evaluate from 1 to 5 each one of the dimensions on the Credibility cores and 13 behaviors.

CHAPTER 3: Discussion, findings and recommendations

3.1 Discussion

Listening interviewers telling their opinion was very interesting in a way that they all agreed that trust was a key factor to effective leadership. Somehow, their understanding and representations of leadership and trust is rich of diversity. It was easer to find great leaders from outside hospital world than to spontaneously mention a great leader from medical or hospital area.

Leader and Leadership

All the interviewers agreed to say that **leadership is a way to influence people** more in a process way than a personal position: (A1) "*Someone who has a clear vision and who knows how to inspire others to follow the vision*". For A4, he insisted on "*leading a group on a relatively natural way without being in duress*". For B1"*The leader is the one who has been entrusted the rudder*". He also mentioned that leading is "*having professional skills, and doing things with courage* ".

In public hospital, legitimacy to lead is given by law for directors and by votes for medical leaders. A2 and C3, they particularly insisted on (A2)" *It is the one that which by law, and if possible, by his personality, is recognized*"; "*the hospital director is legally a leader by law*". Even if all interviewers agreed with the administrative governance (C3) "*the director is the one who takes the final decision*". (A1) "*Leadership is not hierarchical either authoritarian*", they all agreed with the point that **leadership is a behavior talent**: B1 explained that "the director of nursing is the one which perhaps has less autonomy than the others except by her own personality".

The most frequently cited characteristics of leadership, in order of interest are:

- Collective interest, mutual benefits, clear vision with a strong vision of public service: (A4) "*listen to others*"; (C2) "*Anti leader is someone who will use his authority to his own account*"; (A1) "*research the combination of complementary skills to the public interest regardless of the hierarchical level of leadership*". (D) "*Good leaders are the ones who will be able to ensure that everyone's personal interest are linked on common goal achievement*".
- Exemplarity and transparency (strongly express by D): (A3) "*manage personal (in term of people I represent) and institutional contradictions*";
- Skills, knowledge and style: (C2) "*tell the truth… academic and intellectual rigor*"; "

- Right things done: (C1) "*a leader is training and learning his leadership throughout his private and professional life*".
- Behaviour: (A3) "*Dose action and reaction*"; (B1) "*a leader is someone who has the ability to extract the force fields* (from peers or individual situations) ". Showing loyalty is also specially expected from directors to Co-leaders.

Performance, leadership, and Co-leadership

The link between performance and leadership exists but **leadership its much more than performance attributes**: A1 is the only one who said:" *A good idea may be inapplicable and work at place and not elsewhere*" speaking of strategic and politic idea to focus on financial or other performance. (B1) "A leader is someone who cannot be only a manager. Managing is part of his job but it's too restrictive. His commitment is to deal with leading projects". To reach hospital performance goals, all the interviewers agreed with the idea of (A4) "*learning how to work together*", especially doctors who are not trained to management and leadership questions. In order to understand mechanisms of management and leadership (C1) "*to reach performances (hospital performance included), we all have something to deal with our troupes. We have a duty to explain again and again in a multidisciplinary way how to be more efficient and effective*".

Trust and costs

Unanimously, interviewees recognize the equations:

[↘]TRUST = [↘] SPEED [↗] COST

[↗]TRUST = [↗] SPEED [↘] COST

Some examples were given as from A3 "*It costs time because the paths are longer*". A2 introduce the concept of sustainability "making *ability to work together sustainable*". (C1) "With trust, we can go everywhere, further, and further to excellence". Some of the interviewees said that it was possible to loose money, quality of care or energy. Projects are carried out at slower pace.

Leadership and training

Before being top leaders, doctors and directors declared that their training is not as good as what they were expected. (C2) "*What amazed me is that our school doesn't trained leaders even managers*". (A4) “*My main criticism overlooked the EHESP is that we trained bank account managers more than leaders*". Medical leaders are trained by experience. Their elected mandate legitimates their position. Their main demand is to understand he administrative language to go faster and deeply into Co-leadership. Administrative directors are also looking for shred leadership practices (C1) "*to reach one goal, we need common view, common language and sharing training, like **team building***".

Trust and Co-leadership

"*One of the major Characteristics of leaders is how to enclose himself with people who share the same frame with probably the same charisma and a mutual trust that allows you to work*" (B1).

In fact, with there words, interviewed refer to Covey and Merrill (2008) model: **Trust is a prerequisite for Co-leadership relationship**. We chose to organize answers using the four cores of credibility (table 4) and the fourteen behaviors (table 5) from Covey and Merrill model. We used a simple evaluation model regarding answers, we evaluated from 1 to 5, each dimensions: 5 means is strongly present during the interview (said and explained), to 1 that means it doesn't appear. That doesn't mean that people are not involved in each cores or behaviors as described that only mean they didn't expressly speak about it.

Interviews were rich with a lot of digressions on a limited time. French hospital top leaders are not familiar with the concept of trust. It's an innovative topic unknown in literature review. Presenting results that way is a choice, with limits: A choice to summaries and show the answers of a 30 to 45 minutes interview; a limit being aware that interpretations are always possible but we also accept that we are in an exploratory research.

Table 4: Interviewers answers regarding the 4 cores of credibility (Cf. Appendix 4)

Cores	A1	A2	A3	A4	B1	B2	B3	C1	C2	C3	D	score
1 Integrity	5	3	4	5	5	5	5	5	3	1	5	46
2 Intent	5	4	4	5	5	5	5	5	5	4	5	52
3 Capability	4	2	2	5	2	4	4	5	3	2	2	35
4 Results	3	2	1	3	2	2	1	1	2	1	5	23

Individuals' scores are not relevant regarding the methodology we used.

Global evaluation gives us some understandings regarding Co- leadership trust credibility: Core 4 is the weakest point for everybody 23/55. It's linked with a poor knowledge of trust dimensions. There are no studies and specific trainings around that topic: (C1) "*How recording trust?*" (C3) "*We never evaluate the way how we do as a leader or Co-leaders, I don't ever know how to do it in an academic way*".

Table 5: interviewer answers regarding 13th behaviors

	A1	A2	A3	A4	B1	B2	B3	C1	C2	C3	D	score
Behavior 1 Talk straight	5	4	4	5	3	4	5	5	4	3	5	47
Behavior 2 Demonstrate respect	2	2	3	3	4	3	1	5	4	4	1	32
Behavior 3 Create transparency	3	1	2	3	2	4	1	1	3	2	5	27
Behavior 4 Right Wrongs	5	5	5	5	2	4	5	4	5	5	5	50
Behavior 5 Show loyalty	5	3	5	5	5	5	5	5	5	5	1	49
Behavior 6 Deliver results	2	1	3	2	3	2	2	1	3	1	2	22
Behavior 7 Get better	4	2	2	3	3	4	2	4	3	2	5	34
Behavior 8 Confront reality	5	3	3	4	5	5	5	2	4	5	2	43
Behavior 9 Clarify expectations	5	5	3	4	2	2	2	3	1	1	1	29
Behavior 10 Practice accountability	2	5	2	3	4	5	4	4	5	3	3	40
Behavior 11 Listen first	5	4	5	5	5	5	5	5	5	4	5	53
Behavior 12 Keep commitments	4	4	4	4	4	3	3	5	4	3	2	40
Behavior 13 Extend trust	4	1	1	1	1	1	1	1	1	1	1	14

Individuals' score are not relevant.

Behavior 13: 14/55 on demonstrating a propensity to trust is linked with a low cultural integration of trust in habits, that doesn't mean they don't do, that probably mean they don't talk about it. Explicit feedback is not integrated to leadership practices.
Behavior 3: 27/55 on creating transparency could be linked with individual expressions of possible distrust between Co-leaders.
Behavior 9: 29/55 clarifies expectations in a group is so important (C3) "*is it relevant to have two different groups working separately on the topic subject without knowing that?*".

3.2 Findings

The key findings are:

- Global leadership requires operating with trust Co-leadership relationship.
- Global leadership differs from "domestic" leadership because of the complexities of dealing with people from different professional cultures. (B1) "*Trust level is measured at the time of uncertainty*".
- Trust is the number one glue to effective and efficient Co-leadership.
- Leadership and hospital performance are linked but it's much more.
- Identifying, training and Team building are pillars to promote leadership and trust in Co-leaders relationship. (B2) "*It's better to identify previously those who seek power and those who seek adaptive capacities or skills to new situations*".

The results of this study suggested that hospital leaders have high opinions of the power of Trust as a strong component of Co-leadership characteristic. Additionally, they avoided describing trust characteristics, probably because they practice more than they deeply learn about it. A myriad of definitions of trust have arisen that can explain their ignorance, and surely, none of them studied the power of trust in an academic way.

On the bases of the limits of a qualitative exploratory study, and a small sample of expressions of the hospital leaders, we cannot generalize the expectations.
The first hypothesis investigated the relationship between trust and effective leadership. The findings of our investigations show that there is a real awareness for leaders to integrate trust as a prior condition to their relationship, but relationship between leadership and hospital performance is not completely confirmed. We collected some ideas, as we described in chapter one, telling us that there is a link between leadership and hospital performance. Trust Co-leadership relationship is much more. It's human behaviors serving strategy and politics in a diplomatic way. Diplomatic way means here integrating multidisciplinary visions to serve a common vision.

The second hypothesis investigated trust-based relationship between managers has a positive effect on the decision-making process. The results if this study tells us that lack of trust influence the decision making process as described by Covey and Merril (2008), and impact on performance: longer making process decision = waist of time, waist of money.

Again, we remain very cautious that our sample is too little to generalize our findings.

3.3 Recommendations

"Sending a leader into today's world armed with only the vertical, power-based skills of the past is like sending a Civil War soldier into modern battle. The leadership weapon of the future is trust". (Forbes, Charles Green, 4-03-12).

Bass (1985) defines leadership as "a process of influencing other individuals to perform in such a manner so as to achieve a preconceived goal or goals". The hospital efficiency governance is directly linked to the leader's abilities to cope with governing authorities, subordinates, and patients. Those different stakeholders origins and personality of the different hospital top leaders becomes a major determining factor in favor of a strong **team building.** The Hospital director, the chair of the hospital medical committee (*commission médicale d'établissement*, CME), the dean of the medical school for University Teaching Hospitals (*Centres Hospitaliers Universitaires,* CHUs) and the director of nursing have different mandates. They don't choose each other so, it's important to work on their Co-leadership.

Team building and continuous training is a challenge for top leaders who are used to perform by experience more than by training. Building trust in a group and promote it to subordinates is a challenge to attract and keep talented leaders (medical or non medical).

The leadership challenge is to evaluate the efficiency of Co-leadership. Even if all interviewees explained that it's a day-to-day evaluation, a strong leadership relationship can be evaluated by the members themselves and by the key stakeholders. We propose **Feedbacks** with an innovative tool, easy to use, inspired from Covey and Merrill model (2008) to visualize individual or collective margins progress, and trust level of a group of leaders: **Individual or Team Spider Chart** (table 6: Current performance in believability). Self-trust is all about credibility, about developing the integrity, intent, capabilities, and results that make you believable (Appendix 4).
Behaviors are powerful because they are based on the principles that govern trusting relationships. The Covey and Merrill 13 behaviors require a combination of both character

and competence (Appendix 5). We can also use an Individual or Team Spider Chart (Table 7: 13 behavior Individual or Team Spider Chart).

Table 6: Individual or Team Spider Chart of current performance in believability

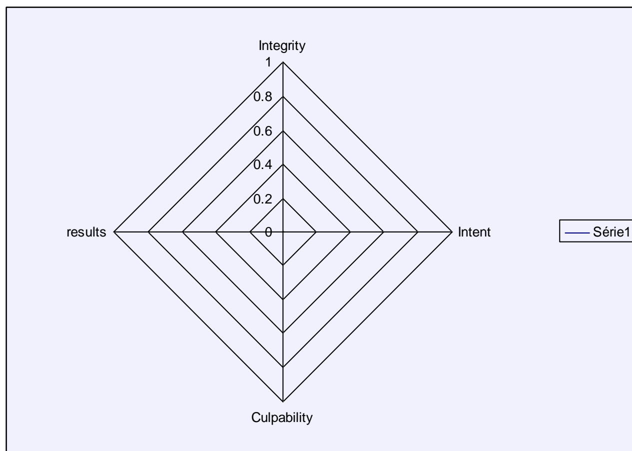
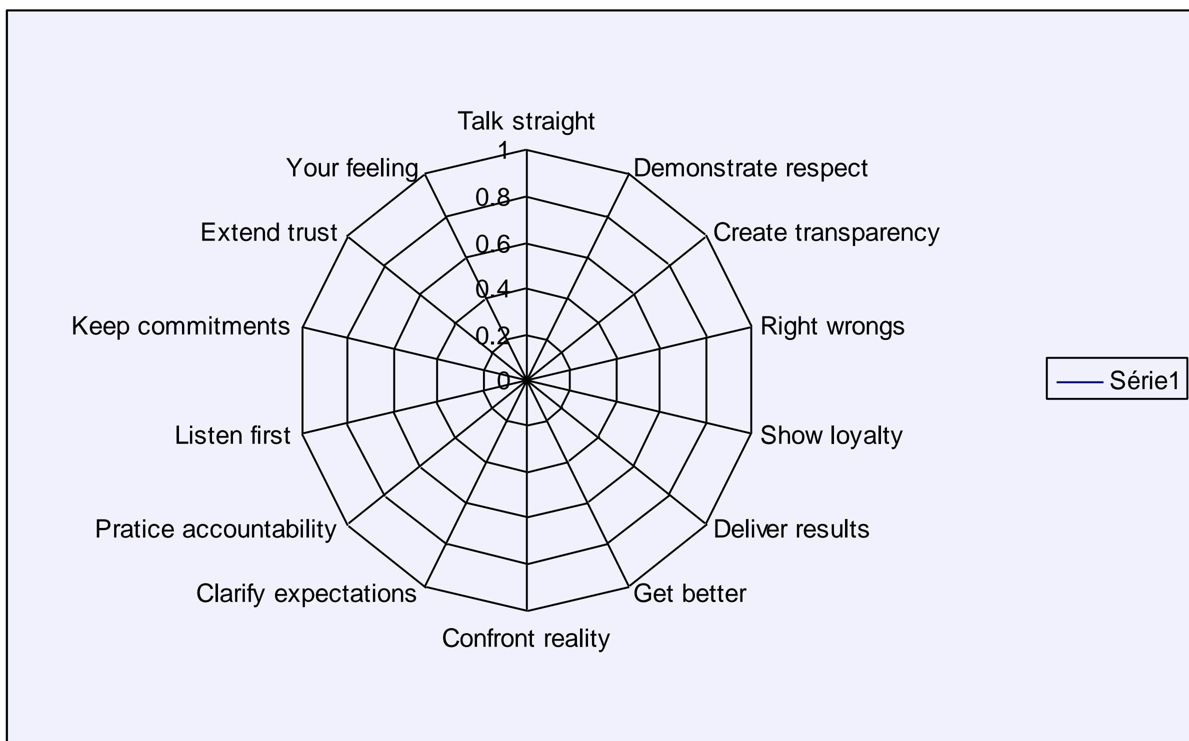


Table 7: 13 behavior Individual or Team Spider Chart



Feeling Spider Charts is a good way to capture a vision of the way high trust leaders interact with others and identify what is your current performance.

We could also use that tool to identify the student's potential competencies.

Trust building and leadership evaluation is a virgin field in French hospital governance. Express, recognize or even mention trust, as the dynamic engine of an efficient leadership is not yet registered in the habits of French top leaders. To promote leadership efficiency,

we could integrate in the accreditation guide (HAS), leadership indicators or principles like:

- Evaluating leadership effectiveness,
- Groups of sharing experiences,
- Simulation trainings programs.

Conclusion

The French Public Hospital director, the chair of the hospital medical committee (*commission médicale d'établissement*, CME), the dean of the medical school for University Teaching Hospitals (*Centres Hospitaliers Universitaires,* CHUs) and the director of nursing are under growing pressure to demonstrate outstanding performance in their corporate governance. Their stakeholders, the governing authorities, the professionals, and the patients, have different, individuals and collective expectations, and needs. The challenge facing hospital, at the crossroads of these considerations, is to combine them successfully. Central to answer those considerations, is the efficiency of the top leaders Co-leadership.

Relationships between Co-leadership and hospital performance, is strongly linked to trust concept. Trust affects two outcomes: speed and cost. A 2002 study by Watson Wyatt[11] shows that total return to shareholders in high-trust organization is almost three times higher than the return in low-trust organizations. In France, literature is poor, we are not aware of the power of trust in Co-leadership teams. In French public hospitals, we often mixed management and leadership, and we are shy to integrate, in our practices, other field's knowledge's. In this study we were expecting, with modesty, to investigate trust power with interviews of small sample of Public hospital leaders.

We found that trust is considered as the foundation of an efficient Co-leadership relationship, but without outputs to demonstrate that. We also noticed that, global leadership requires operating with trust Co-leadership relationship; Global leadership differs from "domestic" leadership because of the complexities of dealing with people from different professional cultures; Trust is the number one glue to effective and efficient Co-leadership; Leadership and hospital performance are linked but it's much more. We finaly Identifying, that continuous training and Team building are the pillars to promote leadership and trust in Co-leaders relationship.

We hope that with this study we will open a new field to investigate trust in Co-leadership teams. We proposed a new innovated tool to evaluate leadership believability and behaviors from the Covey and Merrill (2008) model: a Spider Chart. Feeling Spider Charts is a good way to capture a vision of the way high trust leaders interact with others and identify what is your current performance. We could also use that tool to identify the student's potential competencies. The main goal will be to introduce team building as a standard, and leadership indicators in the HAS accreditation, to boost the leadership of the leaders.

[11] Watson Wyatt Work USA® 2002 Survey.

Bibliography

Acker D., Bensadon A. M., Legrand P., Mounier C. (2012). Rapport de l'Inspection Generale des Affaire Sociales (IGAS) *Management et efficience hospitaliere : une evaluation des determinants*. IGAS, avril 2012.

Alvarez J. L., Svejenova S. (2005). Sharing Executive Power Roles and Relationships at the Top. Cambridge : Cambridge University Press.

D'Amour D., Oandasan I. (2004). Interdisciplinary Education for Collaborative Patient Centred Practice. Ottawa : Sante Canada.

D'Amour D., Sicotte C., Levy R. (1999). L'action collective au sein d'equipes interprofessionnelles dans les services de santee. Sciences Sociales et Sante 17(3) : 67-93.

Arah O. A., Klazinga N. S., Delnoij D. M. J., Asbroek A.H., Custer T. (2003). Conceptual frameworks for health systems performance: a quest for effectiveness, quality, and improvement. *International Journal for Quality in Health* care. October 200, Vol. 15, No. 5, p. 377-398.

Avolio B. J., Bass B. M. (1995). Individual consideration viewed at multiple levels of analysis : A multi-level framework for examining the diffusion of transformational leadership. Leadership Quarterly, 6, p 199-218.

Bass B. M. (1985). Leadership and performance beyond expectations. New York: free Press.

Bass B. M. (1990). Bass and Stogdill's handbook of leadership: Theory, research, and managerial applications. New York: Free Press.

Bass B. M. (1997). Concepts of Leadership. In Vecchio, RP (ed). Leadership : Understanding the Dynamics of Power and Influence in Organizations. Notre Dame : University of Notre Dame Press.

Bass B. M., Avolio B. J. (2003). Predicting unit performance by assessing transformational and transactional leadership. Journal of Applied Psychology, 88, p207-218.

Behling O., McFillen J. (1996). A syncretical model charismatic/transformal leadership. Group and Organization Management. 21 (2) : p120-160.

Benis W., Nanus B. (1985). Leaders: The Strategy for Taking Change. New York: Harper and Row Publishers, New York.

Bennis W. G. (2003). On becoming a leader: A leadership classic, updated and expended (second ed.). Cambridge, MA: Perseus Publishing.

Blacke R., Mouton J. (1964). The managerial grid. Houston, TX: Gulf.

Blake R., McCanse A. (1991). Leadership dilemmas-Grid solutions. Houston, TX: Gulf.

Broussy L. (2013).Mission interministerielle sur l'adaptation de la societe francaise au viellissement de sa population. Rapport Luc BROUSSY. Janvier 2013.
Ordonnance no 96-346 du 24 avril 1996.

Carlyle T. (1847-1993). On heroes, hero workship and heroic in history. Berkley, CA: University of California Press.

Champagne F., Contandriopoulos A.P., Picot-Touche J., Beland F., H. Nguyen (2005). Un cadre d'evaluation global de la performance des systemes de services en sante : Le modele EGIPSS (Rapport de recherche du Conseil de la Sante et du Bien-etre). Groupe de recherche interdisciplinaire en sante, Universite de Montreal. septembre 2005, p176

Charlton G. (2000). Human Habits of Highly Effective Organisationa. Pretoria : Van Schaik, Publishers.

Chaudry J., Jain A., McKenzie S., Schwartz R. W. (2008). Physician Leadership : The Competencies of Change. Journal of surgical Education. Vol 65, No 3, May/June 2008, p213-220.

Couanau R. (2003). Rapport Rene Couanau sur l'organisation interne des hopitaux, pour la commission des affaires culturelles familliales et sociales du 19 mars 2003.

Colquitt J. A., Scott B. A., LePin J. A. (2007). Trust, Trustworthiness, and Trust Propensity : A Meta-Analytic Test of Their Unique Relationship With Taking and Job Performance. Journal of Applied Psychology. Vol 12, no 4, 909-927.

Couty E., Scotton C. (2013). Rapport Ministériel des Affaires Sanitaires Sociales et de la Sante. Le pacte de confiance pour l'hôpital. Synthèse de travaux, Mars 2013.

Covey S. M. R., Merritt R. (2008), The Speed of Trust : The one thing that change everything. Ed February 2008, Free Press.

Cox J. F., Pearce C. L., Perry M. L. (2003). Toward a model of Shared Leadership and Distributed Influencein the Innovation Process. In Pearce, C. L. & Conger, J. A. (eds). Shared leadership : Reforming the hows and whys of leadership. London : Sage publication, p48-76.

DiCicco-Bloom B. & Crabtree B. F. (2006). The qualitative research interview. Blackwell Publishing Ltd 2006. MEDICAL EDUCATION, 2006; 40: p314-321.

Donabedian A. (1988). The Quality of Care, How Can It Be Assessed? JAMA. Septembre 23/30, 1988; 260 (12): 1743-1748.

Fiedler F. E. (1967). A theory of leadership effectiveness. New York: McGraw-Hill.

Friedberg E. (1993). Le pouvoir et la règle : dynamique de l'action organisée. Editions du seuil, Paris

Garcia E. J. (2011). Leadership perspectives sur l'exercice du pouvoir dans les entreprises. 1ere édition, *Edition*s de boeck.

Giddens A. (1990). The Consequences of Modernity. Cambridge, Polity Press.

Goleman D. (2002). Primal Leadership : Realizing the power of emotional Intelligence. Personnel Psychology, 55, p1030-1033.

Goleman D., Boyatzis R., McKee A. (2002). Primal Leadership : Realizing the power of emotional intelligence. Boston : Harvard Business School Press.

Hardin R. (1996). Trustworthiness. Ethics, 107, p26-42.

Heifetz R. A. (1994). Leadership without easy answers. Cambridge, MA : Harvard University Press.

House R., Michell T. (1974). Path-goal theory of leadership. Journal of Contemporary Business, 3, p81-97.

Hurst J., William S. (2012). Can NHS hospitals do more with less. Research repport. Nuffieldtrust. January 2012.

Isaacson W. (2011). STEVE JOB : A Bibliography. Simon & Schuster, Inc.

Jackson B., Parry K. (2008). A very short, fairly interesting and reasonably cheap book about studying leadership. Los Angeles : London : SAGE.

Johnson J. (2002). In-depth interviewing, In: Gubrium J, Holstein J, eds. Handbook of Qualitative Research. Thousand Oaks, California: Sage 2002; p103-119.

Kaplan R. S., Norton D. P. (1992) The Balanced Scorecard : Measures that Drive Performance, Harvard Business Review, January-February, p 71-72.

Kirkpatrick S., Locke E. (1991). Leadership: Do traits matters ? Academy of Management Executive, 5, p48-61.

Kotter J. P. (1990). A Force for Change : How Leadership Differs from Management, New York, Free press.

Kotter J. P. (1996). Leading Change. Boston Harvard Business School Press.

Lewin K., Lippert R., White R. K. (1939). Patterns of aggressive behaviour in experimentally created social climates. Journal of social Psychology, 10, p271-299.

Le Pogam M.A., al. (2009). La performance hospitalière : a la recherché d'un modèle multidimentionnel coherent. Management et Avenir, 2009/5 no 25, p116-134.

Livartowski A. (2010). Efficiece hospitaliere et efficience du systeme de santé. Revue Hospitaliere de France. No 536, p 40- 43. Septembre – Octobre 2010.

Locke E., (2003). Leadership: Starting at the top. In C. L. Pearce & J. A. Conger (Eds.), Shared Leadership (p271-284). Thousand Oaks, CA:Sage.

Lundmark V. (2008). Magnet environments for professional nursing practice (chapter 46). Patient safety and quality: an evidence-based handbook for nurses, 3, Editor R. G Hughes, AHQR.

Luhmann N. (2006). La confiance, un mecanisme de reduction de la complexite sociale. Paris, Economica. Coll. "Etudes sociologiques", 2006, XII.

Maritz D. (1995). Leadership and mobilizing potential. Human Ressource Management. 10 (1) : p8-16.

Martin B., Lenhardt V. Jarrosson B. (1996). Oser la confiance, propos sur l'engagement des dirigeants. *Editions Insep consulting.*

Mayer R. C., Davis J. H., Schoormann F. D. (1995). An integrative model of organizational trust. Academy of Management Review, 20, p709-734.

McAlearney A. S., Fisher D., Heiser K., Robbins D., Kelleher K. (2005). Developing effective physician leaders: changing cultures and transforming organizations. Hosp Top. 2005. 83: p11-18.

McClure M. (2005). Magnet hospitals :insights and issues. Nursing Administration Quarterly, 29(3), 198-201.

McGregor D. M. (1960). The human side of enterprise. New York: McGraw-Hill.

McGregor J., Burns (2003). Transformal leadership. New York : Atlantic Monthly Press, p25.

Meyer J. P., Stanley D. J., Herscovitch L., Topolnytsky L. (2002). Affective, contimuance, and normative commitment to the organization : A mata-analysis of antecedents, correlates, and consequences. Journal of Vocational Behavior, 61, p20-52.

Mintzberg H. (1983). Structure in Fives : Designing Effective Organizations. New Jersey : Prentice Hall.

Mintzberg H. (1984). Le manager au quotidien. Les dix rôles du cadre. Paris, Les Editions d'Organisation.

Mintzberg H. (1989). Mintzberg on management. Inside our strange world of organizations. *New York, 1989.*

Mintzberg, H. (2004). Managers not MBAs. *San Francisco, CA : Berrett-Koehler Publishers.*

Mooney J., Thibodeau C. (2006). Developpement du leadership : peut on créer un impact en milieu de travail ? Université de Sherbrook. Octobre 2006.

Nolan M. (1995). Towards an ethos of interdisciplinary practice. British Journal of Medecine. 311 : pp. 305-307.

Ogien A., Quere L. (2006). Les moments de la confiance. Connaissance, affects et engagements. Economica, Paris. 2006.

O'May F., Buchan J. (1999). Shared governance : a litterature review. International journal of Nursing Studies, 36, p281-300.

O'Tool J., Galbraith J., Lawer E. E. (2002). When two (or more) Heads are Better Than One : The promises and the Pitfalls of Shared Leadership. California Management Review. 44(4) : p65-83.

Parson T. (1977). Social Systems and the evolution of action theory. New York: free Press.

Pearce C., Mans C. (2005). Shared leadership. Executive Excellence, 21(7) : p 6-8.

Quere L. (2001). La structure cognitive et normative de la confiance. La Decouverte , Reseaux , Avril 2001, no 108, p125-152.

Reuters T. (2011). 100 Top Hospital CEO Insight: Keys to Success and Future Challenges. August 2001.

Rinfret N. (2007). L'utilisation d'un leadership transformationnel par un directeur general : ses effets benefiques pour son entourage organisationel et pour lui-meme. Groupe de reflexion Chaire GETOS/INSPQ. Quebec, le 3 mai 2007.

Romelaer P. (2011). Organisation : panorama d'une méthode de diagnostic. Université Paris Dauphine.

Ross W., LaCroix J. (1996). Multiple meanings of trust in negociation theory and research : A literature review and integrative model. International Journal of Conflict Management, 7, p314-360.

Saulquin J. Y., Fray A. M. (2005). Contribution a la mesure de la confiance et de la reconnaissance comme facteurs de succes organisationnel : une application au secteur hospitalier. Gestion 2000 Vol 22 no 4 juillet – aout 2005.

Scott L., Caress A. L. (2005). Shared governance and shared leadership : meeting the challenges of implementation. Journal of Nursing, 2005, 13, p4-12.

Sicotte C., Contandriopoulos A. P., Champagne F. (1999). La performance organisationnelle des organismes publics de santé. Ruptures, revue transdisciplinaire en santé, 6(1), p 34-46.

Simmel G. (1999). Sociologies. Etudes sur les formes de la socialisation. Paris, PUF.

Sitkin S. B., Roth N. L. (1993). Explaining the limited effectiveness of legalistic « remedies » for trust/distrust. Organization Science, 4, p367-392.

Sullivan O. J., Tucker M. (2012). Leading Across Cultures in the Human Age. A groundbreaking study of the intercultural competencies required for global leadership sucess. Right Management, Manpower Group 2012, p7.

Tuazon N. (2007). Is Magnet a money-maker ? Nursing Management, 38(6), 24-31.

Vadell J. (2008). The role of trust in leadership: U.S. Air Force Officer's Commitment and Intention to Leave the Military. Dissertation.com. Boca Raton, Florida. USA 2009.

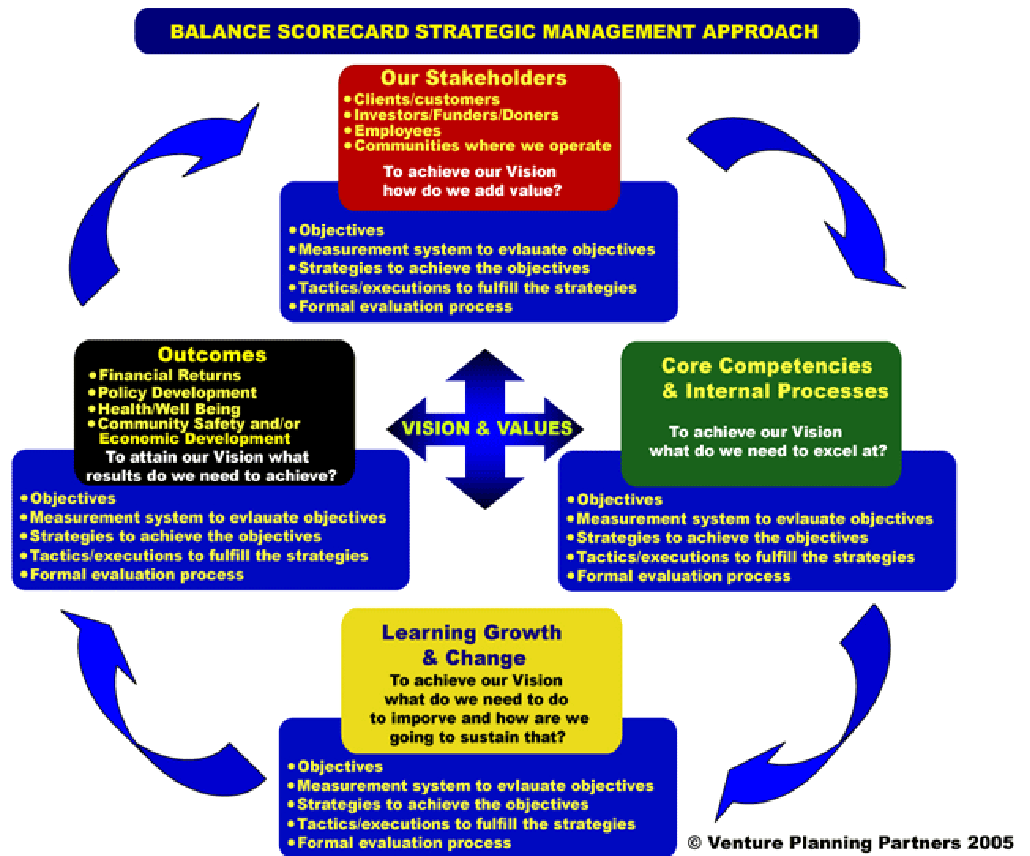
Vine B., Holmes J., Marra M., Pfeifer D. & Jackson B. (2008). Exploring Co-leadership Talk Through Interactional Sociolinguistics. Leadership. 4(3) : p339-360.

Zand D. E. (1972). Trust and managerial problem solving. Administrative ScienceQuarterly, 17, p229-239.

World Health Organization Office for Europe, Measuring hospitals performance to improve the quality of care in Europe: a need for clarifying the concepts and defining the main dimensions, Report on a WHO Workshop Barcelona, 10-11January 2003, 2003, p8.

Appendices

Appendix 1: Balance scorecard strategic management approach (Norton & Kaplan)



Appendix 2: Situational Leadership path-goal theory model (House&Michell, 1974)

Appendix 3: The 4 cores of credibility from Stephen M. R. COVEY (2008, p54)

Cores	Fundamental elements
Core 1: Integrity Deals with character	Integrity includes honesty, and it's much more. It's being congruent, inside and out. It's having the courage to act in accordance with your values and believes.
Core 2: Intent Deals with character	Trust grows when our motives are straightforward are based on mutual benefit. When we genuinely care not only for ourselves, but also for people we are interacting with, lead, or serve.
Core 3: Capability Deals with competence	Abilities we have that inspire confidence – our talents, attitudes, skills, knowledge, and style. They are the means we use to produce results. Also deal with our ability to establish, grow, extend and restore trust.
Core 4: Results Deals with competence	This refers to our track record, our performance, our getting the right things done.

Appendix 4:The 13 behaviors matters from Stephen M. R. COVEY (2008, p54)

Behaviors	Fundamental elements in organization life and at home
Behavior 1 Talk straight	Be honest, tell the truth and leave the right impression to impact on speed and cost. Demonstrate integrity, and leave real impressions.
Behavior 2 Demonstrate respect	Every day, little things have a great impact. Show your care. Respect the dignity of every person and every role. Treat everyone with respect. Show kindness in the little things. Don't fake caring.
Behavior 3 Create transparency	Tell the truth in a way people can verify. Get real and genuine. Be open and authentic, and don't hide information. Operate on the premise of "what you see is what you get".
Behavior 4 Right Wrongs	Make things right when you are wrong. Apologize quickly. Make restitution where possible. Practice "service recoveries". Demonstrate personal humility. Don't cover things up.
Behavior 5 Show loyalty	Give credit to others freely. Acknowledge the contributions of others. Speak about people as if they were present. Represent others who aren't there to speak for themselves.
Behavior 6 Deliver results	Establish a track record of results. Get the right things done. Make things happen. Accomplish what you are hired to do. Be on time and within budget, Don't overpromise and under deliver.
Behavior 7 Get better	Continuously improve. Increase your Capabilities, Be a constant learner. Develop formal and informal feedback system. Act, and thank on the feedback you receive.
Behavior 8 Confront reality	Take issues head on, even the "undiscussables". Acknowledge the unsaid. Lead out courageously in conversation. Remove the "sword from their hands". Don't skirt the real issues.
Behavior 9 Clarify expectations	Disclose and reveal expectations. Discuss them. Validate them. Renegotiate them if needed and possible. Don't violate expectations.
Behavior 10 Practice accountability	Hold yourself and others accountable. Take responsibility for results. Be clear on how you'll communicate, how you are doing.
Behavior 11 Listen first	Listen before you speak. Understand. Diagnose. Listen with your ears, your eyes and heart. Find out what most important behaviors are to the people you are working with.
Behavior 12 Keep commitments	Say what you are going to do, then do what you say you are going to do. Make commitments the symbol of your honor.
Behavior 13 Extend trust	Demonstrate a propensity to trust. Extend trust abundantly to those who have earning your trust. Learn how to appropriately extend trust to others based on the situation, risk, and credibility of the people involved. But have a propensity to trust

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The Power of Trust in Multidisciplinary Co-Leadership

University partnership: ESCP Europe, LSE, Mailman School of Public Health

***Abstract*:**

Regarding to French public hospital performance goals, trust in Co-leadership is the new challenge of French public hospitals governance teams. Relationships between Co-leadership and hospital performance, is strongly linked to trust concept. Trust affects two outcomes: speed and cost that are not studied yet. We expect to introduce a new tool (Spider Charts) to evaluate leaders credibility and behaviors, referring to Covey and Merril model (2008).

***Key words*:**

Trust, leadership, Co-leadership, Performance, Multidisciplinary Co-leadership, public hospital.

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