## Network Learning in an Austrian Hospital

(Chapter 25 in Mike Pedler (editor), Action Learning in Practice, 4th edition, Gower Publishing Farnham Surrey England 2011)

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***This Chapter is in two parts: Part 1 is a case study which I wrote in 1997 for the 3rd edition of this book. The second part is written in 2010 and is a reflection based on my practice and learning since then.***

## PART 1

This chapter describes an effort to develop an Austrian hospital as a learning organization based on Revans' principles of action learning. In this case, special attention is given to thinking in terms of networks and in using the possibilities of network learning.

### THE HOSPITAL

In 1994 the corrupt practices of top management, some professionals and staff officers of the local city hospital in Austria became known to the public. The hospital concerned is part of the city administration and city politicians and top officials are responsible for what happens there. They set out to establish a clear direction and mission for the administration and the hospital, a new top management was installed and internal and external control procedures were rigorously applied.

The hospital has 1000 beds and employs about 2000 people, 120 of whom are managers. Schools for nursing and paramedical professions are part of the organizational complex which faces new financial arrangements in the near future, with a heavy impact on its policy and working structure. As the hospital is one of the many departments of the city administration, this greatly reduces the power of the management at a time when competition between hospitals is increasing, and a strengthening of identity is needed in the face of numerous changes in the environment.

### THE NEEDS AND THE OBJECTIVES

A survey conducted among all employees reveals:

- very severe communication blocks between administration, doctors and nurses;
- 'forgotten groups' in the field of therapy and medical technical personnel;
- much anonymity and isolation, little identification with the organization as a whole;
- fighting and blaming as predominant ways of conflict handling;
- overcentralization and lack of transparency; seemingly endless decision processes, and frustration about what is felt as a very high degree of formality;
- dissatisfaction and rudeness among doctors and low discipline of some doctors participating in management;

- complaints about insufficient awareness of the city administration for the peculiarities of the hospital organization with unclarified rights and duties;
- strikingly less possibilities for operational personnel to attend training and seminars;
- not enough support from superiors with too little or no feedback in regard of actions and initiatives;
- ... but also: a lot of vitality and many proposals for improvements;
- a number of remarks were made about the relationship with patients: deficiencies in patient friendliness and also concerns about the increasing demands of patients and the ever growing complexity of patient treatments.

The new top management formulated a series of objectives as a basis for further personnel and organization development:

- awareness of the situation of the patient;
- satisfaction and sustained identification of personnel;
- effectively guided cost management;
- ongoing medical innovations;
- thorough communication.

They stated that a management development programme was to take place and indicated criteria for determining the character and the results of the programme:

- new knowledge must be work-related;
- promotion of interprofessional and interdisciplinary cooperation;
- contributing to the necessary organizational changes now and in the future;
- stimulating towards quality management.

They themselves participated in an intensive higher management course and made international contacts for the exchange of experiences. Their commitment to the necessary learning processes within the organization was great and they promoted the mood of 'We want to develop and perform on a high level with integrity', which already existed among many of the employees, having been shown a good example.

**THE DESIGN OF THE MANAGEMENT DEVELOPMENT PROGRAMME**

The MD (Management Development)programme described was chosen from several tenders. It was attractive to management because learning and working are integrated; projects bringing about concrete and necessary change are 'part of the game', multiprofessional learning in self-directed learning groups and learning partnerships is heavily emphasized; introducing total quality management and management development are intimately linked. (see Figure 15.1):

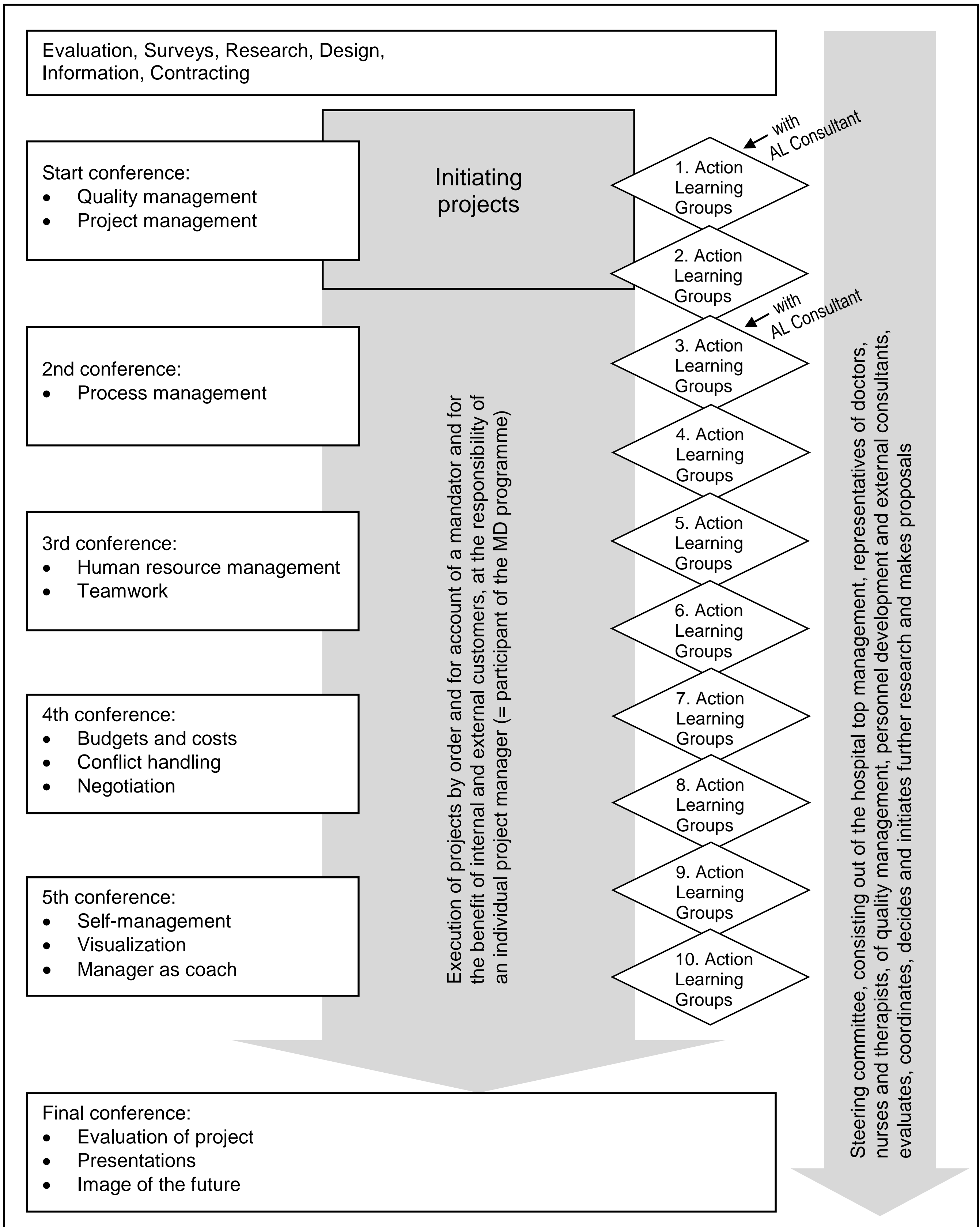


Figure 1 Elements of the 'Learning Care' Hospital Management Development Programme

The elements of the MD-programme are:

1. The project

This is central as it serves as the vehicle and common focus for the learning of the participants, their project clients (mostly heads of departments) and their personal sponsors (mostly high-ranking managers).

Programme participants choose the topic of their project from a list of strategic issues drawn up by management and are personally responsible for the negotiated results. Only projects with a specific client who really needs the project results are accepted (See Figure 15.2)

**Project topics**

- Patient-oriented layout of the department
- Optimalization of patient routing
- Patient transport within the hospital
- Internal Bulletin
- Introduction for doctors in training
- Adaptations of buildings for handicapped persons
- Nursing documentation
- Primary nursing
- Complication conferences
- Mission of the nursing school, of specific departments
- Employee satisfaction survey
- Remobilization of older patients
- Organization of day-care
- Telephone behaviours
- Manual for administrative procedures
- Waste reduction
- Communication between pharmacy and
- departments
- Organizational consequences of the new financial arrangements
- etc.

Figure 2 Project topics in the 'Learning Care' Hospital Management Development Programme

2. The conferences

For each cohort of 22 participants there are six conferences of 2½ days spread over one year. They provide in a very compact form knowledge and skills geared to the needs and explicit wishes of the participants.

3. The Action Learning groups

Thee bring together up to six participants for 10 whole days' meetings between the first and the final conference. The group members coach each other as to the evaluation and planning of their project activities. The groups practise systematically to manage their own learning processes.

4.Bilateral talks between the participants and their project clients and their personal sponsors

The participants and the project-clients negotiate about the assignment and monitor regularly the progress made. Every participant is entitled to choose a personal sponsor, this being a high-ranking manager who takes responsibility for helping the participant with 'helicopter views' and political support. They also meet regularly. Always both parties are expected to learn from the current experiences and to initiate improvements.

5. The steering committee

Top management, delegates from the workers' council, from the professional groups and the city government, as well as the quality manager and the human resource officer are members of the steering committee. They evaluate the course of the 3-year programme, which has now involved almost 70 participants. Decisions are made by top management.

6. Research and future search

During the programme some of the projects deal with surveys concerning specific topics (e.g. patient satisfaction regarding one of the departments). To a limited extent, data concerning certain indicators (e.g. absenteeism) are collected for the purposes of monitoring. Each time a group of 22 participants rounds up its programme activities they meet to look ahead, to describe scenarios and to develop options for the future.

**BASIC ASSUMPTIONS OF THE APPROACH**

There are several reasons why the concept of the learning network appears to be useful for MD activities:

1. Individualistic learning is detrimental to connectivity

Within the fragmented organization of a hospital with its many subcultures there is a great need for integrating the many efforts to the advantage of the patients.

*Programme design*. The participants are evenly distributed from the fields of nursing, medicine, medical technique and administration. In the learning groups members experience very intensively how rewarding it is to be able to gain admittance to the realms of other disciplines and units. From their sponsors they learn 'the great picture' (as they expressed it) which managers need in order to set priorities and make long-term decisions. The regular structured meetings with the client confront both the client and participant with possibilities and limitations of the other party, and awaken the necessity to keep in touch with each other because much is changing along the way, and what was defined at the beginning of the project has to be reconsidered again and again.

2. Attitude of positive interest and social 'safety-net' arrangements are essential conditions for stimulating entrepreneural qualities of learners

Without safety, warmth and recognition it is difficult for the learner to open up for new, unusual behaviours. Project managers by definition are faced with many risks because they operate outside

standard practices and put forward new proposals which can arouse anger and resistance from people who are afraid that their interests are at stake.

*Programme design.* The culture of the learning groups stimulates the participants to leave the zone of comfort to confront feedback and unusual questions. Risk-reduction is provided in a specific way by the personal sponsors and project clients of the participants and the steering committee in a general way.

3. Personal articulation of needs by clients and active creation of social space by sponsors encourage learners to take responsibility

Tension is aroused by the discrepancy between the situation as it is experienced and the improvement as it is envisaged. People with positive energies who perceive the needs of the client in face-to-face contact and realize that there is a social space to engage in are able to embrace this tension as an intensive learning opportunity.

*Programme design*. The programme provides possibilities for participants to take initiatives and they can win substantial rewards for constructive actions: they enjoy learning facilities, have the possibility of making presentations, not only internally but also externally, are able to enlarge their personal network, become known, etc.

4. Organizational structures ensure that the ongoing concern is maintained, network relationships enable actors to undertake unusual and unacquainted initiatives

A social network can be characterized as a system of transactions between persons, which are linked to each other on a voluntary and egalitarian basis with a limited amount of formality, offering each other a great spectrum of possibilities, which actors can make use of in direct contacts. An organization faced with a number of problems, for which there are no ready solutions, can create fewer limitations by tradition and habit, and more space for unusual dealings if a substantial number of the employees have learnt, not only to maintain the going concern in an organized way but also, how to enlarge and enrich networks.

*Programme design.* The programme invites those involved to active role-negotiations in many ways and promotes open solicitation for projects.

5. Often quality management is realized in the style and structure of the differentiation phase (bureaucratic mode); measures of quality management designed according to principles of learning networks are congruent with the style and structure of the integration and association phase (mode of holistic personal interactions)

Those who do not remember the past are condemned to relive it'. This reminder serves change managers well: if they diagnose the developmental stage their organization and take account of the crises it is likely to face in passing from one developmental phase to another, they are likely to be choosing better interventions and more adequate styles of intervening. They are less tempted to 'do more of the same'. Quality management is still very much - sometimes in an absurd way ('ISO-craziness'!) - tuned to the spirit of the differentiation phase of organizations, which is the stage of

development an organization attains if it successfully survives the pioneer stage. The dominant features of the differentiation phase are standardization, automation and specialization. Accordingly, measures of quality assurance are sharply defined by specialists and elaborated in many procedures. Many organizations are confronted with the shortcomings of the bureaucratic way of organizing and have integrated many aspects of client-centredness, multi-professional teams, programme management, etc. and have connected with each other in flexible ways including virtual organization, strategic alliances and lean enterprises. But the 'connecting stage' will be trapped very quickly in super-bureaucratic pitfalls if it is not integrated into the core business processes.

*Programme design*. The MD programme offers a bedding for 'life-oriented' quality assurance.

**RESULTS OF THE MANAGEMENT DEVELOPMENT PROGRAMME**

The objectives of the MD programme were:

1. The development and the realization of solutions which are needed to overcome problems.

2.Increase in personal competence and a wider range of attitudes necessary to cope with future demands.

3. The emergence of new rules of cooperation and of behavioural patterns promoting a more productive learning climate ('culture of a learning organization').

The first results of the projects are seen at the presentations of participants to their clients, mostly with personal sponsors and also with interested colleagues present. A second participant takes part for the purposes of observation: How does the satisfaction of the client with the results of the project manifest itself. How is the result delivered? What comes out of the discussion about the learning results of the participant - and his or her sponsor and clients - which they gathered during the realization of the project? Both participants then report the outcomes of this presentation at the final conference. Finally, the project and learning results are shared with an external audience at a symposium organized by the hospital.

Increases in personal competence and a broadening of attitudes showed up in the first year of the programme:

- Self-organization of learning groups caught on well. After half a year of practice 'veteran' learning sets invited members of sets which had started later to share findings of their own about 'how to craft learning group sessions'.
- Top management returned from meetings with colleagues from other hospitals in Austria and southern Germany reporting that they encountered much interest in the approach. It encouraged them to keep on going in their difficult task to increase morale in the hospital.
- The number of positive recordings in the media about developments in the hospital also contributed to the learning commitments. A project to gain feedback from the patients was deliberately included in order to strengthen patient orientation.
- 'Questioning' is becoming a habit for me' said one of the participating nurses in a review of a learning group session.

- 'I realize that participants in the programme start looking at the broader context and think less fragmentarily' one of the medical department heads told his colleagues in a workshop for clients and sponsors.
- 'We don't get lost so often in our discussions: The clarified objectives keep us on track' remarked a participating head nurses to a programme steering committee member
- 'A great number of issues which remained unresolved for a long time are effectively dealt with now thanks to project routines which we learned in this programme' (members of various sets).

Unwritten rules of the game and tacit convictions behind traditional behaviours are an ongoing concern of the participants. New rules which help bring about open communication and a new 'learning mood' are practised regularly in the learning sets and in the talks with sponsors and clients. Participants express progress in this field as follows:

- 'I now experience a lot of leeway - I had not expected we would gain so much liberty of action out of this programme' (head of purchasing).
- 'The network relations which originate and develop in the sets and between members of sets which consult each other contribute a lot to conflict prevention' (medical head of department).
- 'It is a major task for our group of medical department heads to act as a kind of clearing house and to stimulate constructive discussions and patient orientation. We should do soon the basis of promoting consciousness of mission and goals and team development in our own departments' (medical head of department - not all his colleagues agreed).
- 'The "owner principle" ("owner of the meeting"; "owner of an agenda-item", "owner of an assignment") helps us to overcome diffuse and unclear arrangements which were customary in the field of organizational matters' (young medical doctor).
- 'I am looking forward to our collegial consulting sessions where we coach each other; each time I get glimpses of new worlds - from other departments and the working situations of colleagues from other professions' (an administrator).
- 'I am happy that I can get valid information now so quickly - the network relations I got out of my own set and from other sets are a great help' (hospital technician).

**NETWORK LEARNING**

The various settings for interactive learning which the programme offers bring about organizational learning in a very concrete way. Participants experience that the 'learning organization' is not only an abstract notion and have practised to make it happen deliberately. In a couple of situations they have raised the question how patients and certain external stakeholders could also be included in this network of learning, and which conditions have to be created for doing so.

## PART 2

*In the second part of this account, I revisit the 1990's project from the perspective of some 15 years later. Here I assume that I am undertaking an assignment to design a hospital development project*

*in 2011 and describe the observations and assumptions which guide my negotiations now as an Action Learning Consultant*

**Reflections on the 1990's Project**

**1. The decisive good example – peer coaching right from the start**

An essential success factor in the original project was the authority and learning attitude of the Medical Director, which allowed the Hospital Top Administrator and the Top Nurse to go for a more open and experimental approach in dealing with improvement of communications among professionals and finding more satisfying organizational solutions in dealing with patient care. A medical director admitting in some cases that he did not understand right away what the issue was and how a phenomenon could be explained worked as a liberating surprise to people engaged in discussions with him and brought about an atmosphere which invited joint efforts of investigation.

The medical director and one of his colleagues, also a medical department head, were clear favorites of those participants eager to find a personal sponsor as learning partner, a major item of the network learning design (see point 4 above: "Design of the Management Development Programme") . The two leading personalities mastered the art of listening on a particularly high level, a quality deeply appreciated by many participants. The good example and repeated experience of the benefits of good listening in many interactions had a great impact on developing a new culture of communication.

In any new development project , the personal attitudes, ambitions and learning habits of the top crew have my very first attention. What are the special ambitions and strengths of the top people? To what extent are they able to interact constructively and to help each other "transcend their present capabilities"? For the explorative talks with the top team and their most important contracting parties (like the supervising authorities and the chief delegate from the workers' council) I apply a "flexible coaching"[1] approach. Coaching has been adopted widely nowadays and is very much in tune with the settings of Action Learning. Peer coaching becomes normal from the beginning of the programme, as first, X is coach and Y coachee, in another situation this is reversed.

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[1] Donnenberg O., Halbertsma L., Verhaaren F.: Coaching als inspiratiebron. Streamlinks katern 1 Limited edition, on sale with the authors.

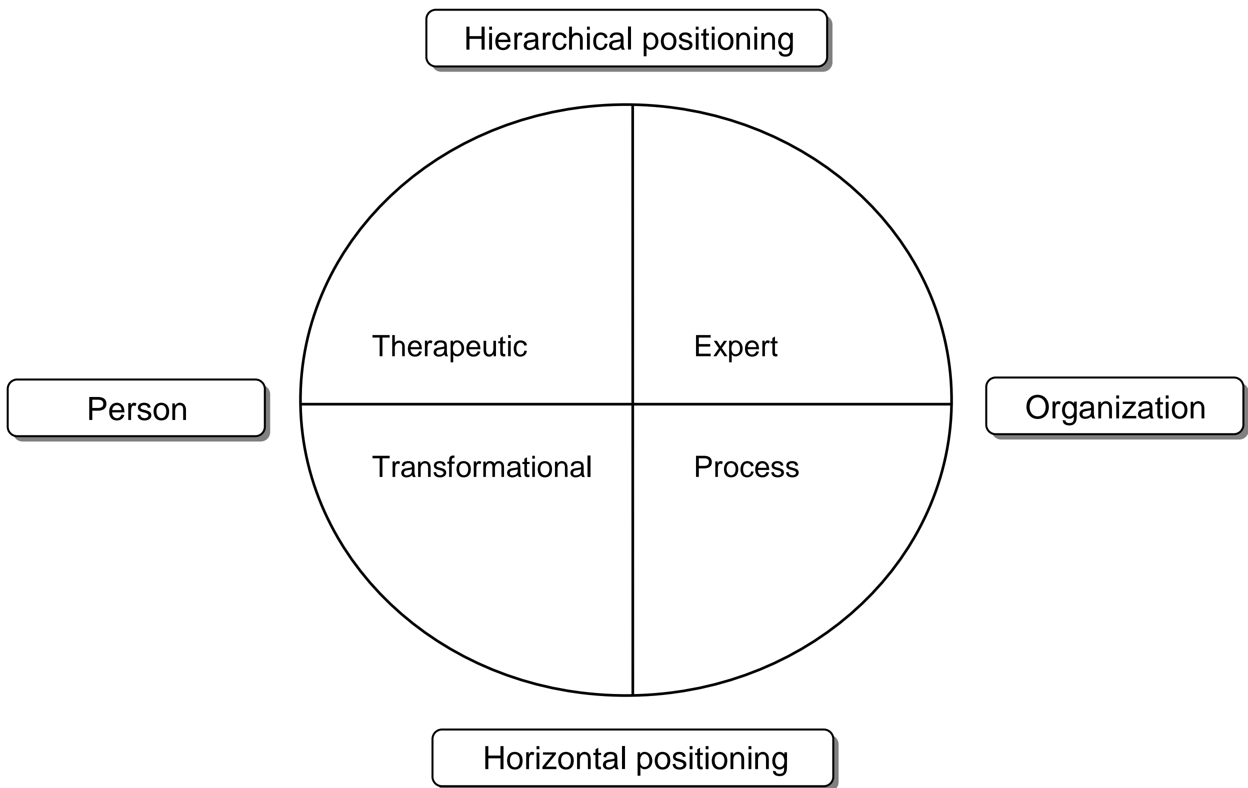


Figure 3 The Four basic approaches of “flexible coaching”

Coaching is here understood as offering a “means of transportation” (“coach”) to get from the unsatisfying situation A to the desired situation B.  In the upper part of the circle the coach fulfills a directive role: therapeutic coaching and expert coaching. These differ according to whether they focus on the individual or on the connection between the individual and the context. In expert coaching the established body of knowledge is dominant in answering questions concerning of the workplace issues;the coach says how it has to be done and the coachee internalizes the knowhow. In therapeutic coaching, intrapsychical phenomena are dealt with: notions and habits which prevent the coachee from doing what is necessary, anxieties and tensions which paralyze him. Contrary to genuine therapy, therapeutic coaching keeps relating to the context of the workplace and performance issues.

In the lower part of the circle, practical issues prevail in Process coaching  and the self determined steering of the process by the client is strongest. In transformational coaching practical problems play a minor role, questions of “where am I here for?” and “what can be my specific personal contribution?” trigger discoveries about tdeeper meaning and the personal tasks of the coachee thereby mobilizing inner forces and new energies.

The four approaches of coaching are used depending upon the demands of the situation, All four are interconnected, used in a flexible way and discussed and made explicit with the client. This helps the client to choose and avoids misunderstandings (for many people rigorous instruction is part of  coaching; for others this is a misunderstanding of the concept); otherwise confusion can spread through the network learning activities, blocking agreements about roles to be played in the joint learning processes.

The coaching approach aims to identify basic strengths and patterns which help to bring about a great eagerness for learning and experimenting. By getting the top fully involved right from the start of the project, peer coaching can serve fully as a flexible instrument for realizing network-learning

## 2. Rethinking to overcome problematic one-dimensionality

Since the 1990's in Germany and Austria, there have been extensive mergers and distribution of tasks between hospitals to reduce costs. Nowadays hospital managers are confronted with:

- battlefields of industrial and professional lobbies, distracting attention from the common good and patient care

- bureaucracy of economic figures, reducing attention to cost reduction and fighting for budgets on formal grounds

- ongoing specialization, blocking sight upon the interrelatedness of people and conditions within the greater whole

- ever-growing pressures to keep up with the increasing morbidity due to demographic developments

- difficulties of financing the seemingly unlimited technological development possibilities

- great strain on the workforce, leading to de-motivation, people leaving organizations and professions, ever more work with less people (eg. unsatisfying work relations in German hospitals cause doctors and nurses to leave for better paid jobs and more agreeable work climates in Switzerland)

- people are less and less ready to accept what is imposed top-down.

All these issues are not new, but new is their acceleration and aggravation, the reason for this being the drastic decline of the financial systems. The devastating effect of their shortcomings is officially hardly acknowledged by economic sciences and experts; a fundamental reflection about the deplorable state is avoided. This leads to very unstable and volatile situations. How can management achieve sustainable solutions and cooperativeness of the involved parties under these circumstances?

*What kind of rethinking is necessary?*

A central proposition here is the necessity for working on a general rethinking! Action Learning offers the opportunity of reflecting critically on basic assumptions and for trying to work on alternatives for re-thinking:

- in the direction of mutual cooperation of the professions and disciplines, institutions and organizations, rather than the competitive patterns of Social Darwinism

- that promotes systemic orientation rather than linear reasoning,

- that fosters trust in the constructive initiatives of individuals rather than depending on abstract and anonymous control mechanisms.

- that includes social and personal aspects instead of limiting itself to mechanistic mind sets;

With their heterogeneous memberships, action learning groups offer excellent conditions for challenging existing thoughts, and for learning conversations using the social capital of the involved network within the hospital and with its environment.

**3. Clarifying the desired future**

Continuous improvement needs a clear picture of a desired future and consciousness about where the hospital stands.

3.1 **Conditions** for such visioning should include:

- Acknowledgement of long-term social and ecological issues, at least equal to matters of short-term business administration orientation

- learning "along the line", in processes of care and curing, on the basis of what really matters to the patient and the people next to them, in a very concrete and vivid way

- refined perception of a) what is going on in the field and b) relating this to a deeper clarification of personal goals and talents of actors in health care.

**3.2 Focus Groups**

Constant monitoring of what matters for the patients could be supported by focus groups, of 6 to 8 persons, gathering over 2 years for periodic review and exploration. Members should have different backgrounds: representatives of patient associations, handicapped persons, persons with experience of parent-child-relationships in hospitals, etc. Connecting these differences will bring forth a lot of stimulus for product development, marketing information, image development and adequate crisis management.

Patient participation in Germany and Austria is low. By contrast the Netherlands have had a national federation for patients and handicapped persons, bringing about a valuable balance of power in relationship to the powerful lobbies of industry and of medical doctors. In Dutch hospitals "client councils" with patient representatives negotiate with management alongside the well established workers council. Focus groups could bring essential improvements in network learning and working in Germany and Austria.

**3.3 Future conferences**

The long-term orientation requires hospital management to connect the Action Learning activities in a series of future conferences[2]. It is an enormous effort especially for doctors and nurses to find replacements and to allow themselves to use time for organizational matters, but a mix of disciplines and professions is essential for the quality of the dialogues. External experts can also play a vital role in the attempts to grasp the total picture..

The first conference could focus on "community building", allowing participants to experience again the richness of their potential for development tasks and to remind them of the value of a common vision. The second conference, one year later, could elaborate the "unique selling proposition" of the hospital: Where can we contribute best? Where can we complement other

[2] The Community Hospital of Havelhöhe in Berlin offers a good example for working with Future Conferences as an ongoing series of events

hospitals in our direct environment? This clarification is increasingly important for the exigencies of working in a system of diagnosis related groups. Costs are reduced and quality increased the more a hospital offers distinct centers of competence which mirror the true strengths of the organization, and joins forces with neighboring medical facilities in local initiatives such as health centers, nursing homes, etc., and with wider ones such as the transition town movement.

The focus of the third conference could be "coping with the course of society" and for aligning the hospital with the ever increasing changes and shifts in society. The repositioning of world powers, peak oil, climate change and demographic trends are creating fundamentally different conditions. What will the accessibility of the hospital, availability of staff, safety issues etc. look like in three to five years? The action learning combination of working and learning helps to identify the gaps in real-time, and keeps the learning associates in touch by involving them in a great spectrum of network capacities.

The communication between the top of the hospital and the various departments is a main avenue for network learning. Based on the conference documentation the top team should meet department representatives for structured dialogues (not just plain talks) about what has been achieved, to deal with difficulties on the way and with what is necessary to correct and supplement agreements and plans. Additionally specific dialogues amongst gatherings of colleagues from the different professions about their impressions of the conferences, together with the results and issues, are important in giving a vivid communicationabout the conference – a special topic of the Action Learning activities.

## 4. Design criteria for the realization of a "strategy to change by learning"

The leading thought behind the envisaged development process is that:

*"We deal with the above mentioned challenges by maintaining a process of intertwined working and learning with a heavy emphasis on network learning; this approach serves as a flexible response to these various and ever changing influences; it builds upon individual initiative and joint reflection; it is structured to achieve a threefoldness of goals"* (see Figure 4 below)

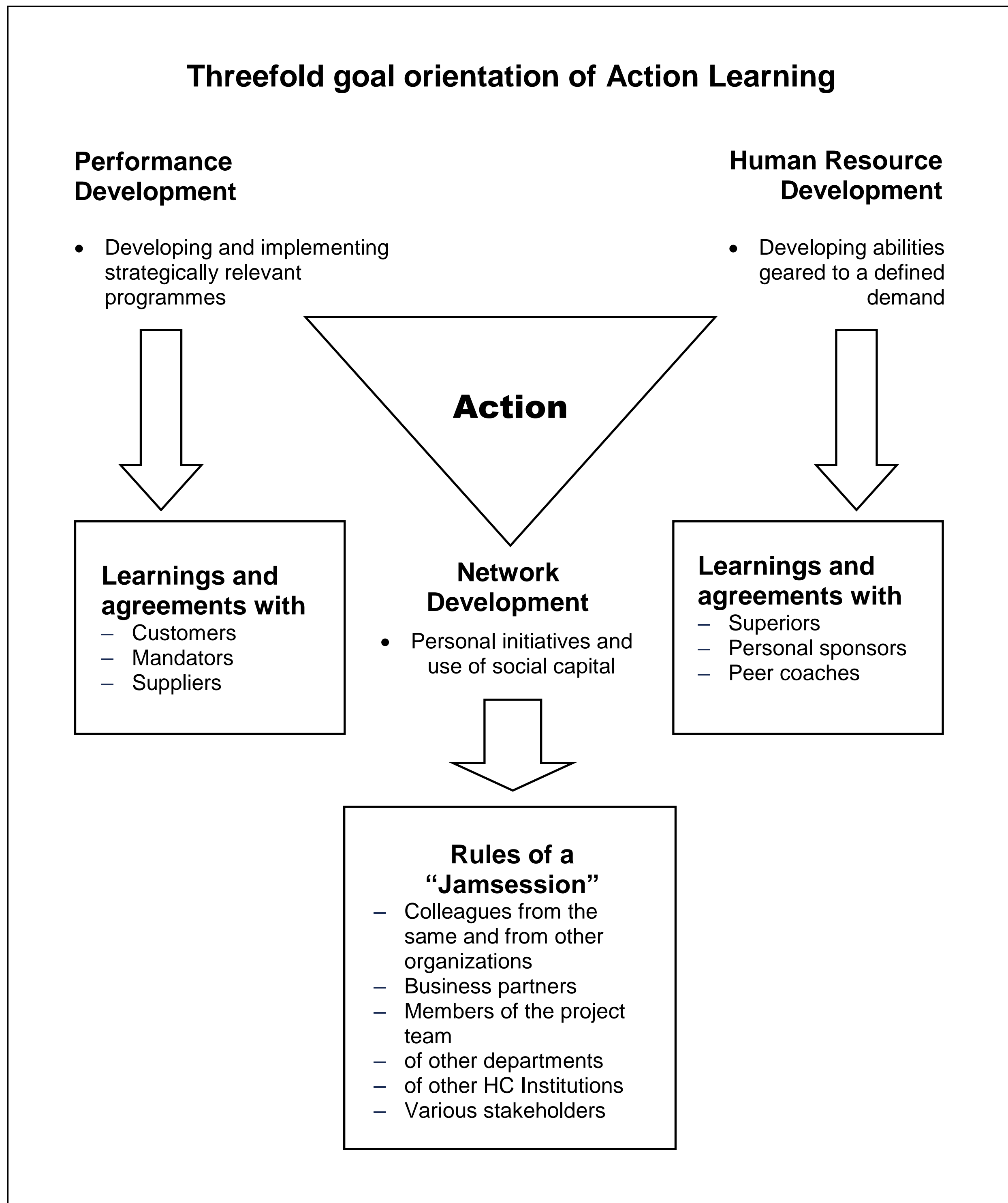


Figure 4 Threefold Goal Orientation of Action Learning

Three features of the proposed network learning approach for AL deserve special attention:

i) Introductory training for hospital employees willing to participate in a programme of network learning. Here they get knowledge of the hospital organization and the fields in which it operates; acquire basic skills for system thinking, practice reflection, conduct dialogues and peer coaching and develop an understanding for essential aspects of learning and reflecting within a network of other people.

ii). AL is an integral part of the operating conditions of the hospital organization; i.e AL activities are regulated just as work procedures, learning is part of the work procedures and working is part of the learning procedures, these procedures are part of one body of regulations. If there is a CLO (Chief Learning Officer in the hospital organization ) this person carries the ultimate responsibility for an adequate design of these settings and for continuous improvement of them.

Employees are granted a right, i.e are entitled to register proposals for improvement and innovation; their proposals have to be discussed locally in their team and generally in the top team which is for this purpose enlarged by representatives from the Works Council and the Focus Group. This body agrees to the suggestions of the employee by appointing a mandator who gives an official assignment to the employee. The employee then proceeds to design and execute the AL project within the network of functionally involved internal and external stakeholders. He also applies for a high-ranking "sponsor", i.e. a manager who has substantial authority, is well established within the Hospital organization and likes to be actively engaged in the promotion of entrepreneurial personalities. The mandator provides resources – financial, personal (moral) support and contacts, so that the employee can implement the self-initiated job.

iii) Give and take

Network learning implies a different pattern of interaction from conventional learning. The clear hierarchy of parent-child and teacher-pupil relationships gives little chances for role-change. In network learning there is a fundamental equality of all those involved. All are in any case in the learner's role, and role changes (from coach to coachee, from leader to follower, from advisor to client and vice versa) are an essential part of the game, manifesting themselves in the form of peer coaching andfunctional leadership (varying with whose talents is most inapposite to a certain situation). Within the framework of network learning it becomes much more evident that leadership is a mutual affair. Leaders "give" direction and those who are led, "take" or ask for direction. Those who are led also bring forward ("give") what they are striving for, and where they are taking responsibility, which becomes part of what the leaders "take" as input to the leadership task of helping to clarify goals, means and what is needed for support.

The flexibility stimulates the actors to see the world again from different angles and brings flow into the mindsets. Everyone who is involved has something to give and feels the necessity to take something, in order to learn and to achieve what is wanted. Unbalance in giving and taking weakens the motivation to learn and promotes fixation of patterns of thought and behavior.

The principle of giving and taking, and maintaining the balance of these, should be a guiding principle in designing the rules for the ongoing "Action Learning game", which includes:

- promoting peer coaching,

- stimulating the interactional concept of leadership and by opening spaces where leaders can fully listen and observe, especially in the questionable situations,

- and by including dialogues (in the technical sense of the term) and systemic structural constellation work (where a subordinate might easily get into the position of a high ranking person for a short amount of time and experience how the world looks like from that place in the order)

## 5. Summary

The original Austrian hospital AL programme lasted for several years, offering one round of Management Development activities after the other. It provoked more open communication, greater acceptance between professional groups and introduced structured ways of learning with each other in and out of work experience. Striking successes were achieved by dozens of participants who experienced that their initiative was well honored and that they could effectively contribute within a structure they codetermined.

On this basis network learning can be driven further by making it part of the operating conditions of the organization. The challenge is to shape the future of the hospital organization still more consciously and more vigorously. Participants whose entrepreneurial attitudes are alerted get well equipped to cope with uncertainties and rapid changes thanks to the rhythms of acting and learning in the sets, bilateral learning conversations and the “backbone” of Future Conferences. These conferences create a vivid and common perspective which is tested and used in many projects for implementation with well structured feedback loops thanks to the structure of network learning.