Management by co-creation

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Introduction

Over the last decade, the debate on the role of managers has been an issue of paramount importance. It has come to be widely acknowledged that management by planning and control is not enough in the information and knowledge era (e.g. Drucker, 1999, Mintzberg, 2004). In this the 21st century, organisations are in need of inspiring leaders - managers who are able to take provocative decisions and lead radical change. This requires managers who can build and create. These competencies cannot be developed by merely "following" a management development (MD) programme as consumers: digesting content and exercises prepared by others, and then translating these into one's own daily practice, with all the transfer problems we are only too familiar with. If managers are to be creators and leaders, they need to be in charge of their own learning, co-creators of their own development. The design of the learning process should be consistent with the objectives of learning and with what is required in day-to-day work.

Although the debate on and ideology of the co-creation approach to MD has grown, little has been written that is based on research in actual practice: can it really work? What does it take to make it work? What are the difficulties and dilemmas? We therefore started an elaborate case study, in which we designed and thoroughly evaluated an MD programme, based on co-creation and in which individual development and organisational development went hand in hand.

The case examined in this chapter describes how a hospital in the Netherlands attempted to implement its new mission statement, in which the requirements and needs of the recipients of care played a central role. This demanded an entirely different working method and organisational structure. The managers and potentials were the key figures in shaping this change. It turned out, however, that they did not possess or did not possess sufficiently the competencies that were necessary to carry this through. This was the reason for drawing up an MD programme. In this chapter, four issues will be examined:

1. Theoretical frame: What views on MD by co-creation and learning in organisations were used during the development and implementation of the MD programme?
2. Research context: What did the MD programme look like? How did we design the evaluation of this programme?
3. Results: What benefits has the MD programme produced for the hospital? What were difficulties and dilemmas?
4. Discussion: What recommendations can be made based on the experience gained from the MD programme? This relates to recommendations for a possible follow-up programme as well as to recommendations that could benefit others working in similar situations.

1 Theoretical framework: Starting points for MD

The development of the MD programme was grounded in principles derived from the literature on management development and learning in organisations. These principles were made explicit and were elaborated together with stakeholders in the hospital, as guidelines for the project (Derksen, Geerdink & Rondeel, 2003). This proved to be very beneficial: the principles served as a means of communication and as a compass and reference point for reflection. During the process we worked with many people from both inside and outside the organisation, and it was these starting points that guided all the activities and decision-making of everyone involved in the process. At the same time, they gave the hospital HRD professionals the

opportunity to put into practice their ideas about learning and to show that they practised what they preached.
The principles were as follows:

The organisational process of change is a learning process

The organisational change in the hospital was not a matter of merely implementing a blueprint, but was a learning process in itself. This calls for combining organisational development, individual learning and collective learning; it is a process of co-development and interactive learning (Boonstra, 2004). Facilitating the process of change as a learning process means that thinking about and shaping the future are designed as learning activities, in which participants together structure the new organisation and, at the same time, develop new competencies and behaviours.

By co-designing, experimenting and reflecting, managers were enabled to:

- together develop a clearer, shared vision of the organisation in the future (Keursten & Sprenger, 2004);
- develop new knowledge, ideas and building blocks for the future by thinking about and working together on such questions as: how will the hospital look in the future? What form will a client's visit take, and what role should professionals and managers play in that new organisation?

Responsibility for and ownership of learning rests with the learner

Managers in the organisation bear a great responsibility in their daily work. They are the initiators of the "new" hospital. In the MD process, the managers need to be encouraged to exercise that responsibility and to assume the role of initiator too: they need to be co-creators (Wierdsma, 2004). By definition, learners own their own learning and choices: you cannot be taught and you always have more than one option (Koestenbaum and Block, 2000). This calls for an approach that actively supports exercising this freedom and at the same time leaves the responsibility with the individual learners.

This point was operationalised as follows. At the start, each participant was given a self-diagnostic instrument, based on which he/she could formulate his or her own development ambitions. These were defined in terms of competencies and work results, and were then discussed with their supervisor. Participants then created their own MD programme, based on the ambitions and needs that were agreed upon. In all the learning activities, it was the manager's own contribution, questions and wishes that formed the starting point. Managers co-created their own MD, and almost every individual created his or her own mix and learning path. The importance of their responsibility was also stressed by organising reviews of the learning process, and especially of the results of this learning, based on work-related evidence that the participants had gathered in their portfolios.

Working is learning

Managers tend to learn most from their work (de Kleer, van Poelje, van den Berg, Singerling & Brave, 2002; van der Sluis, 2000; Streumer, 2005): work is a powerful source of learning. The organisational change in the hospital provided the managers with many opportunities for development. In their day-to-day practice, they are confronted with unexpected problems and complex questions and these challenges formed the starting point for setting learning objectives and for each learning intervention: working instead of talking about work. In the first part of the MD programme, we used current daily challenges as a starting point for learning and developing new practices. In the second part, innovation projects on key elements of the organisational change provided the practical work-learning context.

In MD, managers were given the support to recognise the learning opportunities in their day-to-day practice and to use these effectively. This is important for the future, because organisational change is a permanent feature. The hospital is on its way to becoming a new hospital, but there will never be a status quo.

Reflecting on critical dilemmas and tensions, as opposed to presenting *the* solution

Change and innovation often stem from situations in which existing routines and processes have reached their limits: more of the same will no longer work. These situations reveal themselves through growing tensions: more and more energy is expended with ever diminishing results. In such cases, new directions need to be found, and this often involves dealing with dilemmas: there is no single good solution, trade-offs need to be made or new positions developed (Hoebeke, 2004). One example of this is the tension between customer orientation and efficiency: both are clearly-agreed, valuable principles, but how should one deal with situations where focusing on client needs calls for additional investment, while budgets have to be cut to reach financial targets?

The decisions made in these situations often have a major impact: they can either create or frustrate development and innovation. Here, the integration of competencies and true leadership is crucial and can be developed. We therefore deliberately brought to the fore such tensions and dilemmas from daily work in order to focus on the essentials of individual and organisational development. Reflection on and experimentation with these situations provide powerful learning opportunities. It provides a challenge to rethink basic assumptions and beliefs and therefore supports double-loop learning, which is needed for organisational change (Argyris & Schön, 1996). And the skill to deal with dilemmas and tensions, the ability to find new viewpoints and approaches are core competencies for managers. Learning to deal with dilemmas and tensions is thus a key element of MD.

Individually and together: learning as a social process of shared meaning and purpose

Each individual manager will have his own unique learning needs. On the other hand, the hospital is attempting to change in a specific direction. This leads to some shared learning needs. MD needs to provide scope for individual and shared learning needs, which requires a flexible MD programme. It also calls for insight into individual and organisational MD results. We took the view that learning is essentially a social process of constructing meaning and developing common directions and identity (Weick, 1991; Brown & Duguid, 1991, Lave and Wenger, 1991; Van Woerkom, 2003). The design of MD therefore needed to provide many opportunities for co-operation, exchange and challenge across departments and positions.

2 Research context and intervention design

In this section, a description is given of the practical context of the case and the MD programme that was made to operationalise the principles outlined above. We will finish with a description of the methodology for evaluating the implementation and results of the MD programme.

Practical context: a hospital in transition

The population for this study were managers (partly those already in the job, partly potentials in training) in a Dutch hospital. This was a medium-sized, regional hospital in the east of the Netherlands, serving both the local population and the surrounding district. Given the magnitude of the recent changes in the public health care system in the Netherlands, the hospital aspired to be (from its mission statement): ‘a modern, attractive and financially healthy hospital, providing excellent medical care geared to the needs of the regional population. This will result in as many people as possible in the region continuing to opt for care in our hospital.’

The hospital realised that its mission statement required it to be quite different from the “one-size-fits-all” hospital that it then was. Originally, the hospital was arranged around the specialists, instead of the clients. Clinical and outpatient care were kept strictly separate. In the new organisation, the needs of the clients formed the starting point for the care that was to be provided; the organisational structure and the infrastructure had to be linked to this approach. This demanded a radically new method of working and of organising things. HRD was recognised as being able to contribute to the changes needed, both in the attitudes and

behaviour of employees and in the reform of the organisational structure (Bartlett & Kang, 2004). This process of change cannot simply be characterised as the implementation of a blueprint for the new organisation. The problem is that such a blueprint (including all its product and process specifications) cannot be designed in advance, but rather the exact design of the new organisation will develop gradually during this process of change.

It was widely acknowledged that managers were pivotal in this change. They endorsed the mission statement and their key role in the process of change, but were not always able to put this into practice, especially at the beginning of the process. The year 2000 saw the start of the development of an MD programme, in which managers could learn their new role and, at the same time, shape the organisation in the way desired.

Intervention design: The MD programme

This section presents an overview of the MD programme in the hospital. The MD programme started with a working conference involving the hospital administration and the medical specialists, in which they translated the mission statement of the hospital into the future role of management.

Start-up

In the start-up phase, a number of issues were comprehensively discussed in a working conference by a group acting as a sounding board (Williams & Paauwe, 1999). What exactly is MD? Who owns MD? What should be learned; when; artificial restraint or unchecked chaos; separate or integrated; and what difference does it make anyway? The answers to these questions served to formulate the guiding principles of MD in the hospital concerned; the mission statement and the strategic policy document of the hospital formed its basis.

The first step in designing the MD programme was to develop a joint vision of the hospital's future managers. The competency profiles for the managers concerned (operational and cluster managers) were drawn up using the input from a panel, coming from all layers of the hospital (n = 60). The competency profiles of the management team and the management board were then drawn up in a similar way. The activities that were carried out as part of this process were extremely helpful in clarifying and concretising the rather vague image of the "new hospital" that still existed at the time. The discussions also gave direction to the MD programme and helped the panel members to think along the same lines. MD was regarded by the members of the panel as a necessary process, aimed at:

- building the new hospital together, and
- making managers competent to build the new hospital and preparing them for their future role.

After this, the participants were acquainted with the programme and were regularly helped in making the most effective choices to meet their personal development needs.

Assessment procedure

Participation in the MD programme was determined by an assessment procedure; all the current managers and interested potential candidates underwent an assessment, which was based on self-diagnosis. The instrument that was used for this was created on the basis of a competency profile that had been drawn up for "new" managers. An initial dialogue with the participant's own manager, a fellow manager and an HRD professional followed. The participant only started on MD when all these people were confident of his ability to become the desired "new" manager.

The initial dialogue resulted in a developmental agreement. Each MD participant had different developmental needs, according to his own strengths and weaknesses, and the MD programme gave each participant the ingredients to compile his or her own MD menu, based on these personal needs.

Halfway through the MD programme, each participant had a dialogue with his own manager, a fellow manager and an HRD professional, who checked progress, based on a portfolio, and made a new developmental agreement with each other. For a few managers this moment resulted in their ending their participation in the MD programme and making a career switch. At the end of the MD programme, progress was once again checked in a final assessment, resulting in a statement of either "fit for the job" or "not fit for the job" of "new" manager.

Two phases
The MD programme consisted of two parts: in the first phase, personal development played a central role, and in the second, organisational development was at the forefront. The participants composed their own programme from a menu; in other words, they could make use of four forms of learning for developing their competencies. Each participant was given his or her own "budget" that could be used to purchase parts of the MD programme.

In phase two (organisational development), participants were given the assignment of implementing a project plan aimed at achieving an organisational change in the hospital. The board of the hospital was a constituent part of the projects. One example of a project might be: to realise collaboration between neurologists and cardiac and lung specialists that would lead to a rapid - if possible in one day - diagnosis and treatment advice for patients with vascular disease.

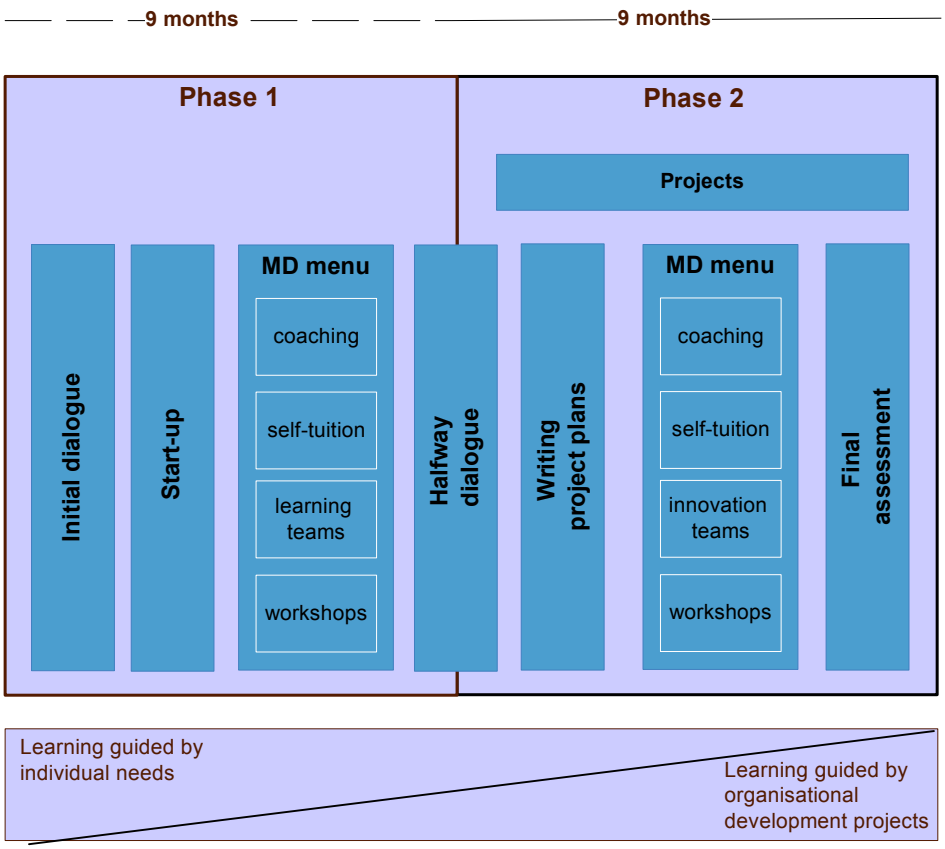

Figure 1: Design of MD Programme

The projects for participants were selected on the following grounds:
They should be valuable to the "new" hospital, challenging for the MD participant and should meet the learning needs of the MD participant.

In both parts, the menu was divided into:
Coaching
Each participant was offered personal coaching and was able to select his own coach from a coach "pool".
Self-tuition
Participants were offered readers and study guides for self-tuition on each of the MD themes.
Learning teams, innovation teams
Each participant joined a learning team of five participants all at the same management level.

Learning teams gave their own interpretation and were supported in their learning process by a facilitator. Personal development was at the forefront in phase one. In phase two, the learning teams became innovation teams. Participants helped each other to carry out an organisational development in phase two.

Workshops

In short workshops, participants learned and experimented with new meanings and behaviour. In each workshop, the participants' day-to-day practice formed the basis of the content. For phase one, a more or less standard programme for each workshop was developed. For phase two, only those themes were suggested that were in accordance with the intended organisational changes. When participants registered, the workshop was tailor-made for them, and very often an innovation team enrolled jointly for a workshop.

3 Analysis and evaluation

This section presents an overview of the main findings of our study. The main questions to be answered by our study were: *What benefits has the MD programme produced for the hospital?* And more particularly*: What have been the effects of MD on the daily work of participants and on the organisation? What were the strong elements (things that worked well) and the weak elements (things that did not work well and had to be improved) of the MD programme? And finally what recommendations can be made based on the experience gained from the MD programme?* The first three questions are dealt with in this section; in section 4 general recommendations (question 4) are made and the results are discussed.

Evaluation treatment

The hospital invested in the MD programme for more than two years. Almost 120 managers and potentials, divided into three groups, participated in MD. After the first group had finished the programme, the hospital board was keen to know the results of their investment in MD. Our evaluation concerns the first group of MD participants (52 managers/potentials).

To be able to evaluate the effects of MD on the working behaviour of the participants and to "measure" its impact on the organisation, it was decided to collect information by means of different instruments and to use different methods of information gathering (Phillips, 1997). The following mix of information sources and instruments was therefore made:

- A questionnaire for all 52 participants. The questionnaire consisted of six two-way questions, 16 ranking scales and six open-ended questions. The questionnaire collected background information of the participants (educational level, years of experience, etc.) and "measured" the entry behaviour and behavioural changes in the managers/potentials as a result of the MD programme implemented. An example of the items is: ' I use at least 75% of what I learned in the MD programme in my work'. The questionnaire was tested and revised before it was applied.
- Five managers who are directly in charge of 29 and indirectly of 19 of the participants of the MD programme were interviewed. A semi-structured interview was used, consisting of two-way questions and open-ended questions. One example of the questions is: ' How many of the participants (percentage) you manage have become more result-oriented since the MD programme started?' Another example is: 'Do you think that the results of MD outweigh the costs?'
- 10 subordinates of MD programme participants were interviewed (semi-structured interview). The questions included: 'What has your manager changed in his working routine in the last two years?' ' In what kind of situations do you recognise this change?'.
- Four "success case" interviews. These were interviews with a few "extremes", meaning two participants who were of the opinion that they had learned a great deal and two who were of the opinion that they had learned nothing or very little from MD programme.

All the answers were processed by means of SPSS, with the exception of the data resulting from the open-ended questions; these were processed by hand.

The overall effects of MD on the participants' day-to-day work

On the whole, it can be concluded that all the MD participants, their managers and subordinates were positive about the effects of the MD programme. The hospital board was also of the opinion that the programme had been successful. The skills that needed to be developed visibly increased in this period of nearly two years Those skills were: exercising initiative and responsibility, being committed to the organisation, being results-oriented, daring to be vulnerable, willing to experiment with new and different ways of working, being entrepreneurial and standing out from the rest.

The operational managers were more successful in achieving the goals of the MD programme than were their supervisors, the cluster managers. The board was positive about this result, because the developmental need of the operational managers was greater than that of the cluster managers. (see also: Derksen, 2004)

During the evaluation nearly everyone mentioned that the MD programme had helped them in building internal networks. Looking beyond the borders of one's own section and working together with other sections in the hospital was an important result of the programme. This really did help the organisation to change.

The strong and weak elements of the MD programme

Greater insight into the effects was gained by explicitly looking at the strong and the weak elements of the starting points and the MD programme

Starting up

Structure

The first phase was very well structured. Participants were allowed to make their own selection from the MD menu. Workshop programmes were fleshed out by the trainers, using the participants' work experience. Learning in the workplace was structured by assignments coupled to the workshops. Participants were very active in phase one; they followed a great number of learning activities and developed rapidly. We mentioned above that the operational managers developed more than the cluster managers. This was partly because the cluster managers were already more experienced and had participated in more training programmes in the past. They had the idea that they already knew most of what they needed to know and were not always able to see what could be additionally learned about things they were already acquainted with.

In the second phase the participants had to develop their own learning interventions and ask for support, guided by the organisational change they had to achieve. This proved to be too difficult: the transition from phase one to phase two was too extreme.

Conclusion: The needs of the participants for a structured programme were underestimated. Next time it might be sensible to make a gradual change from an externally structured programme to a self-structured one.

Composing your own MD programme

All the participants and their managers were very positive about the variety in the MD menu and the fact that they could make their own selection according to their personal needs. This resulted in very different MD programmes. Some participants chose to attend a lot of workshops; others only made use of personal coaching. This was a very strong element of the MD programme.

In making one's own programme we had expected participants to make SMART (specific, measurable, attainable, relevant and time-bound) developmental agreements with their manager. At the start of MD this was difficult for both managers and participants, as they still had to become more results-oriented. However, halfway through the MD programme and at the end, they were better able to make SMART agreements with each other. A measurable developmental agreement also means that there will be a point of measurement. This was new in the hospital. Participants had to make their own portfolio as input for the halfway and final

dialogue. At first, it was received with a great deal of scepticism, but in the end worked very well. It made talking about results much more objective, and provided the participant and his or her manager with greater insight.

Conclusion: Composing one's own MD programme is very successful. Learning to work with SMART developmental agreements and to judge the developmental results takes time. The facilitation of the process is a must; participants need time to grow.

Expecting new behaviour
The MD participants needed new behaviour right from the start, but sometimes they had to learn it first. For example, in the beginning during the initial dialogue, the managers of candidate participants had to give feedback and be clear about their expectations. This did not work well at the start. Some participants had been able to start on the MD programme only because their manager was not yet skilled enough to communicate clearly his - in general poor - opinion of the participant. In the halfway dialogue every manager had learned to communicate his opinion clearly and those participants who did not belong in the MD programme dropped out.

Conclusion: As programme-designers and facilitators, trust your choices and be patient. Communicate clearly what is happening, help in reflecting on the process and patterns and be a role model.

MD Programme

Personal coaching
Most of the cluster managers made use of personal coaching. Participants were able to choose their own coach from a "coach pool". They were almost entirely positive about personal coaching: it gave them a greater insight into themselves, their ambitions, their strengths and their weaknesses. Hardly any of the operational managers made use of a personal coach. One argument we heard was: 'I don't have such a big problem that I need a personal coach'. Choosing one's own coach worked very well. The pool comprised external and internal coaches who were acquainted with the MD goals and agreements.

Conclusion: Personal coaching is a worthwhile intervention in MD programmes. Choosing one's own coach works well. Next time we could do something about improving the image of personal coaching, or give everyone a personal coach without exception.

Self-tuition
For every MD theme, material for self-tuition was available. Many of the participants took note of parts of the material - especially beginners, who wanted to learn a lot, and the experienced managers who thought they already knew it, but wanted to check. Most popular were the practical self-tuition materials. Only a few participants were interested in more theoretical and background materials.

Conclusion: Self-tuition added a useful way of learning to the MD menu. It is difficult to find out exactly what is appreciated by participants.

Learning teams
It was easier for the operational managers to learn from each other in the learning teams than it was for some of the cluster managers. None of the operational managers saw the others as competitors, whereas the cluster managers sometimes did regard each other as rivals. This had a restraining influence in some learning teams on willingness to learn from each other.

In the second phase, the learning teams became innovation teams. This did not work very well all the time. Teams were able to ask for external support, but only a few did so. It proved to be difficult for the teams to make it worthwhile for everyone. The participants chose to expend their energy on daily routine and most of the innovation teams faded out.

Conclusion: Learning teams work well when participants do not see each other as competitors. The best results are made when the team is facilitated by an experienced process facilitator.

Workshops
All participants were very positive about the workshops, especially their practice-orientation. At first participants chose far too many workshops and found that this took up too much time and energy. After a while every participant was able to make excellent choices that were appropriate to their learning needs.

Conclusion: Create workshops that are closely related to daily practice. Help participants to make choices whenever there are choices.

Organisational change (second phase)
In phase two, it was difficult to learn while working on an organisational change project. First of all, it took a very long time for the board to formulate the goals for the project: participants had to wait for a month or two before they could get started. This led to something of a vacuum in the MD programme. When participants were finally able to start on the project, it proved very difficult for them to combine work and learning: their focus was on work and not learning. They tended to pick up the projects in ways they already knew and were used to. Very often these ways had not worked in the past, but they had forgotten to take time for reflection and experimentation and to make use of the learning opportunities they had. This is connected with the self-structure we expected.

Conclusion: To make daily work a useful learning arena takes more than a challenging assignment and facilitating the participants using their initiative.

4 Discussion and learning points

This section will examine the three tensions that appeared during the implementation of the innovation process. These are tensions that occurred as a result of a structure being either provided or not provided to the participants in the MD programme. In fact, this relates to the question of whether the call to be allowed to give direction to your own development always implies that participants have to be fully-fledged co-creators.

In the second place, it concerns the question of which configuration of workplace learning fits best into which phase of the innovation process. It also relates to the question of whether the participants do indeed recognise that they can learn through and during work.

Finally, we devoted attention to the friction caused by the difference between the speed at which the participating managers developed and the slow speed at which their environment reacted to the change in their behaviour.

A lack of structure produces tensions and lack of clarity!
As previously mentioned, the MD programme was a vehicle that supported the process of organisational development in the hospital. The watchword given to the organisational process was “co-creation”. Broadly speaking, everyone knew what the objective of the process was, but the precise outlines still had to be mapped out together. Although the organisation was eager to do this, at the same time this innovation approach produced tensions. The participants in the innovation process were not used to playing an active role in charting the course of change. A frequently heard reaction was: ‘Just tell us first exactly what the innovation process involves and what you’re trying to achieve by it’. There is thus clearly a conflict between the currently generally held “philosophy” that, on the one hand, people themselves have to be able to choose and be able to give direction to their own development process and, on the other hand, people’s apparent need for clarity and direction. It is therefore not surprising that we were regularly bombarded with the following questions:
‘What exactly is expected of me?’ What should the portfolio look like?’ ‘What can I expect from the halfway dialogue?’ We should therefore not be surprised that, if guidelines (for the portfolio, for instance) are provided by the project management, this will again lead to resistance and the participants will immediately feel they have been forced into a straitjacket.

A balance must thus be struck between freedom and using one's own initiative on the one hand and direction and structure on the other.

Working is about work, and learning about learning

Another basic principle of the project was that working and learning had to be integrated as much as possible. This was tackled in a phased approach. In the first phase of the project the participants stepped out of their everyday work with some regularity and were then in a structured way confronted with relatively large amounts of new knowledge by the trainer and facilitator. This knowledge was work-related. Under supervision, they reflected on their own progress in work and were given concrete ideas and tips about making use of what they had learned. They often practised applying this - also under supervision - and then returned to their day-to-day work practice. In phase two, conversely, the participants had to learn more directly in and from their work and had to organise the learning process themselves. It became obvious that the participants' focus was very much on their work and hardly at all on learning in relation to work.

Conclusion: work is about working and not about learning; the connection was hardly seen or made. Participants were barely able or entirely unable to distance themselves from their everyday routine which had proved ineffective. Participants allowed themselves insufficient space for reflection and experimentation. Does it take more than a challenging assignment and being presented with demand-driven learning opportunities for people to detach themselves from their everyday concerns?

Tensions as a result of having to display new behaviour at this early stage

One major problem encountered during the implementation of the project related to the fact that the development of the managers who were participating in the project was not running in parallel with the circumstances in which they had to apply their newly acquired behaviour. Their environment did not keep pace with the development that the managers were undergoing. This "politics of different speeds" led to some friction. What was striking in this was that the managers participating in the project did not feel responsible for implementing changes in their environment: that was a task for others! The following two examples give an impression of these tensions.

Calling each other to account and providing feedback is one of the competencies in the competency profiles for the managers who were participating in the programme. This was an area on which they would have to work very hard in the hospital in the months ahead. It appears that hospital managers tend to be very polite to each other and have difficulty in saying how matters really stand, but it is questionable whether that is really the case. Is there an explanation for this behaviour? One possible explanation can be found in the discrepancy that exists between what is generally proclaimed and the actual situation. On the one hand, the idea is propagated that there must be an open atmosphere, where everyone may express criticism and where providing feedback on each other's performance must be a very normal event. Conversely, however, the hierarchical relations do not as yet allow this desirable behaviour to be displayed. Giving uninvited feedback and assertively responding to this is perhaps not appreciated – or not yet - in broad layers of management. What was striking was for example that during the learning activities that formed part of the MD programme, participants regularly complained about the lack of conditions for change. The participants felt that the MT and the management board were responsible for this, but managers did not directly call them to account on this. We noticed that this was happening increasingly often, yet only once did a learning team have an interview with the MT and the management board to make their dissatisfaction known.

A second example also provides an illustration. The learning activities in the MD programme were set up in such a way that managers learned on the basis of situations and issues from their working practice. It was important that participants both prepared for a learning activity and took part in it, even if they had a heavy workload that would seem to have priority. The success of the learning activity is, after all, largely determined by what people themselves make of it. Not turning up or not preparing sufficiently for the activity has a negative effect both on the participant him or herself and on others. During an interim evaluation that was carried out after

three months, it appeared that the participants felt that the programme management did not demand enough commitment. Managers implicitly assumed that the supervisors of the workshops and learning team meetings would hold them accountable for their responsibilities. Whereas the hospital, on the contrary, wanted to achieve a culture in which managers would call each other to account and act as an example to their employees. The programme management assumes responsibility for the managers, because we believe that changes in the behaviour of managers and in the organisational culture can only be achieved when these changes are expressed in both form and content in the learning programme (see also Schein, 1999). At the initial meeting of the second group of managers (we worked with 3 groups who started approximately 6 months after each other), we invited a number of participants from the first group to relate some of their experiences in the MD programme and to answer any questions. These participants emphasised to the newcomers - without this point having been prepared in advance – how vital it was to be well prepared. And that it was, above all, you yourself who determined how successful the learning activities proved to be. They also pointed out that the MD programme had a great deal to offer, but only if you yourself also put a lot into it. During the learning activities too it was striking that participants, certainly those in the learning teams, were more prepared to hold each other accountable for their responsibilities.

Finally
All in all, this shows that the co-creation of MD is not an easy process; it is complex. Whereas more traditional MD provides good learning opportunities from a clearly defined and thus dependably familiar programme, the co-creation of MD introduces the complexity of everyday life at almost full force. It is extremely important to be aware of this and to explicitly determine whether this approach is feasible and preferable in the given situation. This can only be done by making the basic principles of co-creation explicit and discussing the consequences this may have on the approach to the MD programme with the participants, senior staff and the authority commissioning the programme. We hope that this article will provide a stimulus for others to design an MD programme together!

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