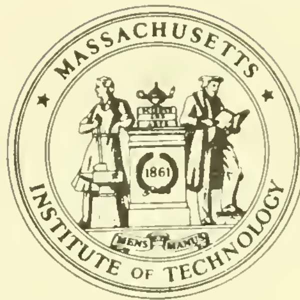

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INITIATING PLANNED CHANGE IN HEALTH CARE SYSTEMS

by

Irwin Rubin, Mark Plovnick, and Ron Fry

August 1973

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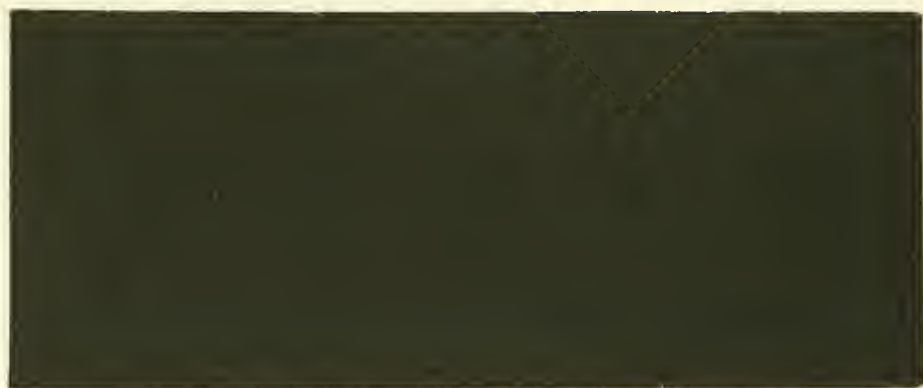

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INTRODUCTION

Over the past few years, an increasing number of behavioral scientists have become involved in trying to improve the quality of health care in this nation. Many, operating in the role of applied behavioral science consultants, have worked directly with a variety of health care organizations such as hospitals, clinics, group practices, and community health centers (Health Maintainance Organizations, neighborhood clinics, etc.). The general thrust of these efforts has been to assist these organizations in the design and implementation of planned changes aimed at enhancing their ability to deliver quality care. Our own efforts have focused on helping these organizations make more effective use of their human resources through programs in management development, team development, organization redesign, etc.[1]

We have sensed a certain regularity about our experiences, particularly in the early stages of what have been called the scouting and entry phases of the process of planned change.[2] Getting into health care organizations and getting started with planned change efforts has been difficult:

- it was hard to set meetings with potential clients; appointments were cancelled frequently for unknown reasons or just forgotten;
- it was even harder to have a group of people within the system meet with each other; usually, no one was capable of setting up such a meeting;

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[1]We are presently involved in a major effort, supported by the Robert Wood Johnson Foundation, to design and test educational programs focusing on the management of health care systems. See "Educational Programs for Health Management: An Overview," MIT/Sloan School Working Paper #617-72, September 1972.

[2]These two phases are part of a seven-phase model developed by D. Kolb and A. Frohman: scouting; entry; diagnosis; planning; action; evaluation; and termination. For a detailed discussion see Kolb, D. and Frohman, A., "An Organization Development Approach to Consulting," Sloan Management Review, 12, 1, (Fall, 1970).

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- the potential client or client group was often unable to make any active decision regarding the initiation of a change project;
- client response to written memos or introductory material was sparse.

We believe that the above experiences result from a set of "causal forces" which exist within a health care organization, within the environment in which it operates, and within ourselves as consultants. These forces influence the process of getting in and getting started, and ultimately influence the success of the relationship between the consultant and the organization. This paper is an attempt to share what we feel we have learned in trying to offer planned change programs to several community health centers and out-patient clinics.[3]

Our intent, in the first part of this paper, is to (1) describe the more salient of these causal forces, pointing out, where relevant, their uniqueness to health systems as compared to other organizations; and (2) discuss their impact on the initiation and implementation of planned change in health care systems.

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[3]See: Rubin, I. and Beckhard, R., "Factors Influencing the Effectiveness of Health Teams," Milbank Memorial Fund Quarterly, July, 1972, Vol. L, No. 3, Part 1.

Beckhard, R., "Organizational Issues in the Team Delivery of Comprehensive Health Care," Milbank Memorial Fund Quarterly, July, 1972, Vol. L, No. 3.

"An Organizational Development Approach to Improving the Effectiveness of Neighborhood Health Care Teams: A Pilot Program," Master's Thesis by Fry, R. and Lech, A. Available from Dr. H. Wise, Martin Luther King, Jr. Health Center, 3674 Third Avenue, Bronx, New York 10456.

In our own efforts to more successfully cope with the impact of these causal forces, we have been forced to re-examine some of our deeply held basic assumptions about planned change and organizational development. The latter part of the paper will deal explicitly with the ways in which, from our own point of view, we as consultants may need to change in order to more effectively initiate change in health care systems.

RESISTANCE: A POINT OF DEPARTURE

In general, the need for change was felt by many individuals in these systems. However, in many instances, the organization was unable to respond to that need -- resistance was high. Resistance to change as Klein[4] points out, ought not be taken only as "something to push through." By resisting, however actively or passively, an organization is communicating a message -- it is providing data. In a real sense, an organization is telling us something about "who it is" -- its major resources and limitations, its attitude towards outsiders and change, its important internal norms and values, the nature of its relationship to other systems in its environment, etc. In trying to understand what the community health centers were trying to "tell us about themselves" when we experienced resistance, several common areas of causal forces were apparent. These forces had to do with (1) things about the particular task that community health centers perform; (2) things about their internal resources--particularly, having to do with physicians; (3) things about the formal structure of these organizations; and (4) things about the larger environment with which these organizations must interface.

THE NATURE OF THE TASK

There is a set of forces within a health care organization directly related to the nature of its primary task which act as potential barriers to the successful initiation of a planned change effort. The task--the delivery of health care--is inherently vague and ambiguous making it very difficult

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[4]Klein, D., "Some Notes on the Dynamics of Resistance to Change: The Role of the Defender," in DYNAMICS OF PLANNED CHANGE, (sec. edition), Holt, Rinehart, & Winston Publishers, N.Y. by W. Bennis et. al.

to set meaningful and measurable goals. Particularly in a ghetto setting where there is a focus on comprehensive health care (medical plus housing, education, nutrition, family planning, etc.), it is difficult to define and measure indicators of change, and even more difficult to see any real signs of success. This is unlike industry wherein production (the task) is often more defined and measurable.[5]

In addition, at a very basic level, a health care organization deals with issues of life and death. This fact adds additional anxiety and stress to the frustration created by not being able to know with any certainty if and when you are succeeding. These conditions have several implications for the initiation and implementation of planned change efforts. First, under such task-created anxiety, it is extremely difficult for a health care organization to develop a climate of experimentation and tentativeness which can facilitate the initiation of a change effort. In any system, any attempt to innovate raises anxiety. This is particularly so in health care where a proposed change is very likely to involve at least some people, methods, or procedures which have direct interface with the patient consumer. The organization message in this case is: "We are in a precarious state of affairs with respect to a very ambiguous, frustrating task. How can we risk upsetting this situation any further?"

In industry, for example, a proposal to do team building may raise less anxiety for two reasons: (1) the intervention is less likely to involve those who actually produce the product (assembly line workers vs. management); (2) even if the intervention does involve "producers," it will have little

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[5]For more details on the impact of certain vs. uncertain tasks, see: Lawrence, P. and Lorsch, J., DEVELOPING ORGANIZATIONS: DIAGNOSIS AND ACTION, Addison-Wesley Publishing Company, Reading, Mass., 1969.

direct effect on the product itself. In a health care situation, particularly where teams are delivering care, the same proposal is met with very high anxiety: the intervention directly involves the "procedures" (health workers) and is very likely to alter the "product" -- the way they function to deliver health care. Given the life/death nature of the task (product), any alteration might appear to have irreparable consequences. This can lead to an attitude of non-experimentation.

In the face of uncertainty and anxiety, the health care organization demands concrete proof that a proposed change will or will not have certain effects. This manifests itself in a predictable set of questions or concerns: "Where have you done it before?" "How much will it improve health care?" "How can you guarantee it will not backfire?" "Have you ever worked in community health centers?" The consultant knows from his perspective that affirmative answers or promises to these queries are often inappropriate and sometimes impossible. What the organization is hearing from the consultant is the message: "Try a new 'something' which might yield better results." An industrial organization regularly conducts research and development and tends to be more experimental and willing to take risks. The health care organization is not. They do not, for example, want to test and develop a drug on their patients. They want a proven solution which is ready to use.

If we replace the word "drug" in the above with "team building," we can see that this attitude has spread beyond its appropriate point of focus. The organization seems frozen in terms of a willingness to experiment with new organizational procedures, structures, etc. as well as being frozen, more appropriately, to experimenting with new drugs and forms of patient treatment. This may be ironic in view of the fact that given their ambiguous and frustrating task, most physicians in health care settings regularly operate from "hunches" and "feelings." The irony becomes clearer if we distinguish between diagnosis and prescriptions. We have found that health workers are more likely to

work from hunches when diagnosing a disorder than when prescribing a solution. Around organizational issues, they may agree with your diagnosis ("The team isn't working well together."), but disagree with your "tentative" solution ("We should try a pilot program in team development."). As we will discuss in detail later, the consultant needs to understand the "scientific" norms influencing physicians in particular to further see why experimental behavior is not legitimate.

What should a consultant do if he chooses not to take these signs of resistance as an indication that nothing can be done and that he should leave? First, he must be very aware of the paradox discussed above. Health care organizations are involved in a very turbulent, uncertain, and ambiguous task. They are, in a sense, in an unfrozen[6] climate with respect to the task. At the same time, they present a relatively frozen and static climate with respect to their attitudes toward change. As a general implication, the consultant needs to be very careful about behaving in ways which increase anxiety and uncertainty, both of which are at a precariously high level already. He may, as we will discuss in detail later, need to be more of an "expert" than is normally required in other settings.

Of particular importance is his willingness and ability to learn to speak with people in health care organizations using their terms. Nowhere has the impact of our unique jargon been more clearly driven home than when we struggled painfully, for example, to communicate to community health workers

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[6]See E. Schein's discussion of the three stages of change: unfreezing, change, and refreezing in "Personal Change Through Interpersonal Relationships," Bennis, W., et. al. (Eds.) INTERPERSONAL DYNAMICS, Dorsey, Illinois, 1973, (third edition).

"the simple concept of team development." We found it crucial to talk about their problems, their concerns, and NOT our methods or values, etc. Change objectives must be very specific. Elusive objectives like "helping you to function together," "smoother interpersonal relationships," etc. which, we find so natural to use, only serve to increase the system's anxiety and uncertainty. The following scenario has been much more productive.

Question : "Do you believe that you could deliver better health care if everyone better understood what everyone else expected them to do."

Answer : "Yes!" (hopefully)

Statement: "We have some ways to help all of you better understand what you expect each other to do."

In other words, what for us as consultants might be most efficiently referred to as role negotiations[7] may require a 5-minute explanation and discussion before any real understanding and commitment can be expected from the client.

[7]Harrison, Roger; "Role Negotiations: A Tough-Minded Approach to O.D." Development Research Associates , Newton, Massachusetts.

THE NATURE OF INTERNAL RESOURCES -- THE PEOPLE

As we discussed above, the nature of the task of a health care organization mitigates initially against their willingness and ability to adopt new solutions without "proof." Related causal forces which result in resistance to change have to do with the attitudes of those who work in these systems. The attitudes and values of the professional physician predominate in these organizations and often pose problems for the change-oriented consultant.[8]

One such attitude has to do with what we call the "preventative vs. curative mode of operation." With respect to the delivery of health care, many community health care delivery systems (community health centers in particular) adopt a curative (crisis-oriented) mode of operation. The problems in their patient populations seem so numerous and insurmountable (and indeed, in some cases they are), that virtually all of the health workers' efforts are invested in fighting immediate fires -- "when a problem comes to our attention, we work to cure it." The alternative, which represents the stated ideal of most community health care organizations, is to strive to eliminate the conditions which caused the problems in the first place (via patient education, legislation, better housing, etc.) -- the preventative mode. That this represents an ideal as yet to be reached is clear. Consequently, a majority of their directly related health care activities remains in the crisis care (curative) mode. Little effort is available for long range planning, and investments in the future are hard to initiate. The paradox

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[8]For a through discussion of the "professional dominance" phenomenon and physician attitudes in care settings, see Friedson, E., PROFESSIONAL DOMINANCE, Atherton, New York, 1970

in this regard is clear: the longer one stays in a crisis management mode, the less time, energy, and resources there are to plan for the future. Consequently, one has to continue dealing with crises (cure vs. prevention).

Many factors contribute to the reinforcement of this attitude, including the nature of the task discussed earlier and certain environmental factors to be discussed later. Another important factor, related to the "people" focus in this section, is an understanding of what we call the "medical model" approach to problem solving.[9] As a function of education and professional socialization, physicians are trained to be experts at both diagnosis and prescription. The popular consultant posture of "we are here to help you work out answers to your own problems," is not one which fits easily with physicians, and hence, with a health care organization's dominant value system. Within the medical model, you involve the patient only indirectly in the diagnosis phase of problem solving, and almost never in the prescription (choice of alternative action steps) phase.

Both the crisis mode and the medical model of change significantly influence the consultant's ability to gain the involvement and participation of the client. Involvement and participation by the client is felt to be essential in the successful initiation and implementation of a change effort. Meetings are scheduled and, with frustrating regularity, cancelled at the last minute or missed by several participants -- "something urgent came up!" One major reason for this, again stemming from the training and education of health workers, is their preference for practice (patient care) over administrative

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[9]Comparative models of styles of consultation, including the medical model, can be found in E. Schein's PROCESS CONSULTATION, Addison-Wesley, Reading, Massachusetts, 1969.

activities. The physician, for instance, is not trained to manage others or to administrate a clinic operation. When faced with choices, practice or research activities will usually come first. When forced to administrate, the crisis-oriented medical mode of problem solving will usually occur. Therefore, pressures will exist to have the consultant accept more of the responsibility to manage the change process than he might otherwise see as appropriate.

We have no simple recommendation on how to cope more successfully with the consequences of the above. Under certain conditions, it is clearly appropriate to confront the organization on issues of responsibility and commitment. Timing is obviously important as in some cases all that will be accomplished is the creation of still another crisis to which the organization must respond.

Finally, with respect to internal resources, it is important to recognize that the community health center is a relatively new entity. As such, knowledge and experience of what is required to effectively manage such an organization are just beginning to develop. Consequently, there is a scarcity of people with the requisite knowledge and skills to manage such organizations. The resulting lower level of managerial sophistication reinforces the crisis orientation and short range perspective discussed earlier.

In addition to the absence of required knowledge or experience, those who assume management positions are confronted with a host of other obstacles. First, the dominance of the physician (and related norms and values described earlier) in these settings often makes it very difficult to influence health workers if one is not an M.D., Second, an administrator

is likely to get little sense of achievement from his work because little useful feedback is forthcoming from health workers.[10] Health workers generally lack appreciation or understanding of the nature of the administrator's work. Third, is the absence of clear paths of promotion. Where does one go after he has been chief administrator in a community health center? Finally, if the administrator is also an M.D., he will experience conflict between loyalty to his physician peer group and activities versus the demands of organization management. Given all these obstacles, it is clear why it is difficult to recruit and retain sophisticated managers in these "anti-administrative" settings.

Several consequences flow from the above. The absence of trained or skilled people to act as buffers between the organization and major systems in its environment leaves the organization in a very vulnerable and continuously reactive posture. Seemingly small changes in the environment can quickly create major ripples throughout the organization. Planned organizational change under these conditions is both more necessary and more difficult to initiate and implement.

In addition, one often finds that members of "management" in health care organizations also serve as "producers." For example, a physician who is medical director is an administrator and is also involved in delivering health care. In discussing with "top management" a possible intervention with health

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[10]This is an extreme but classic case of the situation wherein one only hears from people when they have a complaint about something.

care teams, you are speaking with people who wear two hats. The consultant thus finds himself continually testing the question: "Are you taking that position as a member of management or as a member of the health team?"

The most general point we can make about the issues raised above is that in many health care organizations, getting started (and proceeding) may take much more time, energy, and frustration than perhaps we have become accustomed to experience in other organizations. In terms of the Kolb-Frohman model[11], this may be contrary to some consulting strategies which find more of the consultant's activities focused around diagnosis, planning, and action (middle stages), as compared to scouting and entry (the initial stages). It may also require the acceptance of more initial dependency -- more help, more hand holding, and taking more active responsibility (e.g. different entry contracts). We will return to these points in greater detail in the last section of this paper.

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[11]See Kolb and Frohman, op. cit.

THE ORGANIZATION STRUCTURE - POWER AND CONTROL

Who has what power? Most health care organizations are characterized by the existence of multiple power structures. For example, very often there exists a non-physician administrator whose primary responsibility is the acquisition and allocation of funds. His orientation is politicking with outside systems -- gearing-up for proposal writing, and dealing with a diversity of city, state, and federal funding agencies. His major concern is, "What will look good to a provider of funds?" Given the reality of his world, he has little motivation for anything which will not yield immediate outside visibility.

Operating alongside the administrator is a physician - the Medical Director - who is primarily concerned with issues of health care. If he is one of the socially-minded "new breed," he knows that quality health care is not equal to merely maximizing the number of patient contacts per health worker. To the administrator, however, this may be just the highly visible output measure he needs to keep funding agencies satisfied. In the absence of clearly defined lines of control between these two positions, the relationship between the people is strained and characterized by significant unresolved conflicts over "who really has the power."[12]

This conflict and the resulting strained relationship has consequences

[12] We have found a somewhat opposite case to also result in similar conflicts. This is where the medical director is production oriented -- "let's maximize patient visits" -- and the administrator is more concerned with long range planning and the implications of comprehensive health care. The important point, regardless of the specific individuals involved, is to recognize that the conflict is, at present, an inherent part of the system.

for others in the organization and subsequently for the consultant. A situation can result wherein various parts of the organization "pick and choose allies." Very often, for example, support groups (x-ray, laboratories, records) will align themselves with the administrator and deliverers will align themselves with the medical director. While "we-they" or intergroup problems are certainly not unique to health care organizations, when taken in conjunction with the other causal forces already discussed they result in additional complexities. The "simple" act of getting a team together to discuss a possible intervention (perceived to be an administrative matter) can be easy or difficult depending on who makes the request (administrator or physician) and to whom the request is made (entire team, team physician, team secretary, etc.). At a more general level, the ambiguous and conflicting nature of the power structure causes everyone to be resistant to taking risks, particularly those involving the initiation of change efforts.

Added to this already difficult situation is the role of the community board. A "representative" group of people, somehow drawn from the community, are charged with the responsibility of overseeing - in a "board of directors" sense - the operation of "their" community health center. Little time or resources are available to train these people and to help them learn how to function effectively as a board. Consequently, they either find it difficult to function or they function in ways which may not be supportive of the health center itself. We have found several cases where the board members were predominantly and publicly concerned with expanding their individual power base in the community and not at all with the delivery of health care. This creates more pressure on the administrators and medical directors who usually have little ability to deal with this interface with the board. Thus, the

consultant is confronted with a more complex and uncertain system into which he must enter. This is not usually the case with corporate boards where the interface and division of roles between the board of directors and top management is clear and there is general commitment to common goals.

The need to recognize and deal with these complex power structures can be sharpened by briefly examining the "anatomy of a failure" we recently experienced.

> The medical director of a community health center became the entry point for initiating a discussion of a team building program within the organization. After preliminary discussions with him, it was deemed advisable to involve a small group of influential people including, quite naturally, the administrator of the center.
>
> A lengthy period of prolonged discussions, fraught with cancelled meetings, missed deadlines, etc. ensued. The medical director remained the prime contact, initiator and mover within the system. Although the process seemed to be moving painfully slow, issues were being discussed and positive movement was occurring. Agreement had been reached (so it seemed!) by this group <u>as a group</u> to offer a team building opportunity within the organization.
>
> Then, suddenly, the process came to an abrupt halt. The administrator was asking the community board to request the medical director's resignation. Among the charges was "his irresponsibility in promoting changes which would clearly bring the health care staff into conflict with one another and reduce the quality of patient care."
>
> What followed was a lengthy jury-like process in which the community board listened to witnesses from both sides. The consultant, rightly or wrongly, agreed to appear as an expert witness on health care organizations <u>and</u> less explicitly (but, nonetheless, very clearly) to speak in defense of the medical director. The medical director was cleared of all charges. He waited for the administrator to resign or be asked to resign by the board. When this did not happen, the medical director quit. End of story, and end of a planned change effort at this particular center.[13]

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[13]Since the writing of this brief case description, events have occurred which further reinforce the need to be careful in dealing with the power structure. We have discovered that it was only from the ex-medical director's viewpoint that "team development was dead." Other parts of the organization thought <u>we</u> had abandoned them because the medical director had resigned. Plans are in progress to resume the team development effort.

While one could discuss this case from many points of view, several things are clear in retrospect. The medical director in our story was a deviant in terms of the predominant norms and values of that system. He was clearly not a deviant in terms of our predominant norms and values. Our own needs to succeed may well have blinded us from seeing the consequences of relying too heavily on the medical director. The community board was simply forgotten. No one within the organization mentioned them. We never thought to explore any linkages with them to gain their commitment and enhance their understanding of what was being considered.

Health care organizations, particularly community health centers, are not very structured organizations (in the formal sense, such as IBM, GM). The power structure and human interrelationships are ambiguous, diffuse, and generally highly strained and conflicting. The consultant trying to scout the system and negotiate entry needs to proceed very slowly and cautiously. He should be very careful to diagnose and involve all relevant parts of the diffuse and ambiguous power structure.

Quoting at length from Kolb and Frohman:[14]

> "In choosing the appropriate entry point, the interrelationships among the various units of the system (whether individuals, groups or institutions) are especially important. This is because the acceptance and implementation of change most often requires that the recognized power structure of the system be used to establish the change (revolutionary, coercive change is the exception here). If one's initial contacts with an organization are with the deviant members of that organization, they may be very willing to accept a change for the system (change is what most deviants want), but they are also likely to have little influence with the established authorities in the system.
>
> "The identification of these interrelationships is particularly important in attempts to introduce change in systems where the power

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[14]Kolb and Frohman, op. cit.

> structure and human interrelationships are ambiguous or diffuse. In community development, for example, it is crucial. If a community development worker enters a village and makes initial contacts which offend the power structure (e.g., having a meal at the home of deviant members of the community before formally presenting oneself to the mayor), his chances for introducing change in that community can be closed before he begins. This problem is less acute in structured organizations although it is still important that the consultant understand his entry point, how this person or group is perceived by the organization, the person or group's power within the organization and its receptivity to change."

Being aware of and diagnosing the power structure will not, however, solve the entire problem. Even after the relevant groups or individuals are identified, pulling them together for any substantive decisions is difficult. From the consultant's point of view, it is crucial in many instances that concensus decisions be made around a number of issues. The very act of trying to accomplish such a decision-making process <u>in and of itself</u> represents a major intervention into many health care organizations. It can be usually assumed that in an industrial setting there is some legitimate authority (role position) that can schedule meetings with others. Such is not the case in many health care systems with the medical/administrative power struggle.

Very strong norms exist with respect to the handling of conflict. One can easily see that given the anxiety generated by the difficulty and uncertainty of the task, the potential for the existence of conflict is high. Equally high is the perceived need to ignore or smooth over conflicts. Recall in our "failure" example, one of the key charges against the medical director was the fact that he was, in effect, trying to bring conflict among the staff out into the open. When neither ignoring nor smoothing is feasible, a forcing mode predominates wherein the physician generally has the last word.

The organization has little experience with collaborative problem-solving and joint decision making. Decision making is primarily authoritarian due in part to the crisis orientation, in part to the scarcity of skilled managerial

talent, and in large measure to the dominant force of the physician's medical model in such organizations. As a result of prior training and experience, many MD's are accustomed to and comfortable with being solely responsible for major decisions. Within the context of a hospital operating room, such a posture is clearly essential and functional. Within a community health center, particularly around issues of the initiation and implementation of major changes, a very different mode of operation may be required.

One final area in which issues of power and control impact upon a consultant's ability to get started and work effectively in a health care organization has to do with "who is helping whom." Few people, as we well know, feel particularly comfortable in the "one down" position of a client. They "resist," "fight," and are hesitant to own up to the fact that they may need help. In all likelihood, this issue is more extreme for professional helpers (health care workers and applied behavioral scientists) when they are clients. Nothing has more built-in defensiveness potential than "one helper telling another helper he thinks he can help him!"

Issues of power and control are difficult in any organization. For reasons discussed above, they seem particularly complex and exacerbated in health care organizations. At a minimum, working in health care organizations may require that the consultant be particularly sensitive to and clear about his own motives and behavior. It is exceedingly easy and potentially inappropriate, as we found in the case of the "deviant medical director" discussed earlier, to side with the power which supports our goals and values.

THE WIDER ENVIRONMENT

While there may be little we, as consultants, or health care organizations can do in the short run about environmental forces, several are worth mentioning as they have impact on the feasibility of initiating and implementing planned change. The more salient of these forces are all related to the general issue of funding: "Who is funding? For what purposes (goals and objectives)? Under what conditions or constraints?"

With the possible exception of private group practices, few health care organizations have the luxury of operating as highly autonomous units. In the case of a community health center, there is a community board involved. Most clinics and other health care organizations are tied closely to a hospital organization. Many hospitals are tied to academic organizations. And almost all of these systems are tied in varying degrees to multiple outside sources of funding.

Specifically with respect to community health centers, the present movement is toward more decentralized funding from multiple sources instead of centralized funding from HEW, OEO, etc. As anyone trying to initiate and implement planned change efforts in such organizations during the spring of 1973 can attest, budgetary concerns were of such crisis proportions that little energy was available for anything but survival. This contributes considerably to the short-run, crisis-oriented perspective discussed earlier.

The nature of funding also contributes to the uncertainty of the task. Money (input) is allocated according to criteria which often have little to do with the delivery of health care, particularly comprehensive care (output). Output criteria, if they actually exist, usually appear in terms of patient contacts per physician, referrals per day, number registered, etc. Such short-run, numbers-oriented criteria may not accurately reflect the needs of the patients nor assess the health workers' ability to meet those needs. The

resulting dilemma for the consultant is clear. Unless a change effort can be clearly seen by administrators as helping to assure funding, they may resist it. But since criteria for funding are seldom related to comprehensive health care, the health workers are likely to resist a change effort unless they see it as being concerned with care-oriented criteria as well.

In addition, funding sources seldom provide any legitimacy for the expenditure of funds for organizational development type activities--as we would understand the term. Where a budget does exist, it is primarily for specific skill training activities. What often results is a situation wherein, for example, the health care organization has extensive and costly educational equipment which may or may not be utilized at all. Even where the equipment is being used as opposed to just collecting dust, it is probably being used in an environment which has not designed any coherent or systematic philosophy or plan for the development of human resources. Highly skilled people are then returned to an organization that has not made the changes necessary to utilize these resources more effectively.

Issues such as these have some very specific consequences for an outside consultant. In one center, for example, we were confronted directly by an outspoken physician with the question: "Where is the money coming from to pay you for your services?" The "statement behind the question" was clear: "If we are paying out of our patient budget, the answer is NO!" In that instance, an outside foundation was funding the pilot intervention so "we were acceptable." The dilemma became very clear when the foundation money "dried up." The organization became very hesitant to continue prior activities or to engage in the initiation and implementation of new, previously agreed upon programs. When someone else was making the investment, experimentation was more acceptable. When the organization itself had to make a financial investment, commitment dropped sharply. Getting started may well have been facilitated

several categories or sub-systems within (and outside) organizations. These sub-systems are continuously interacting to produce the phenomenon we observe in organizations.

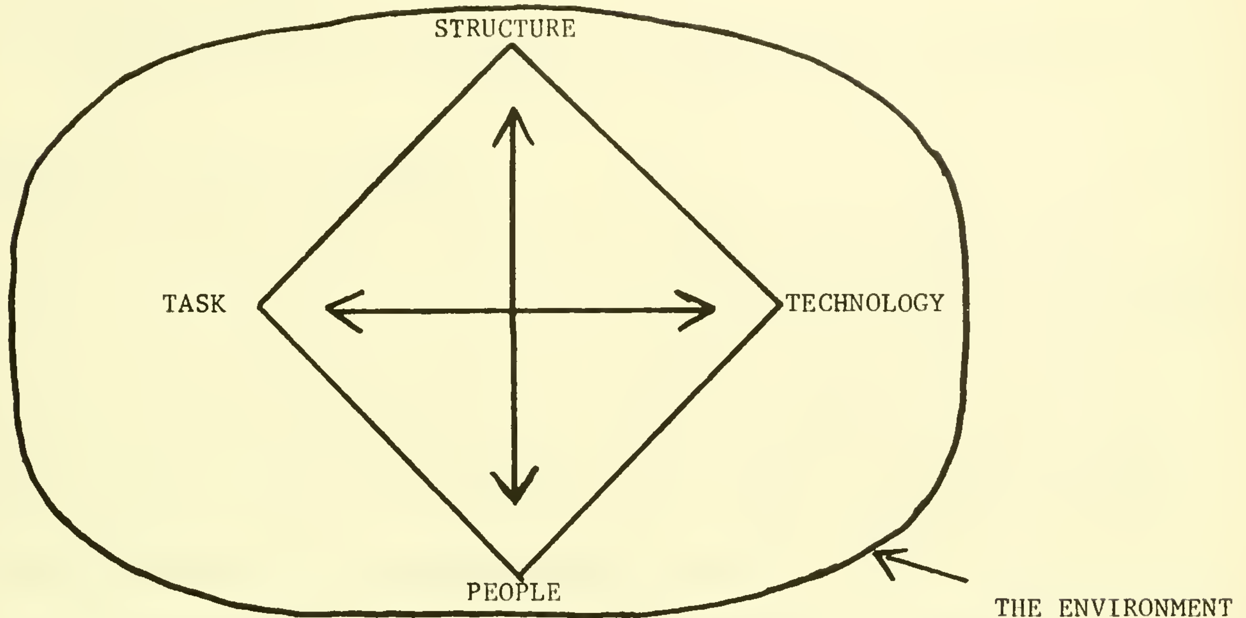

Figure 1

In our description of factors encountered in working with health care delivery systems, we were primarily describing forces associated with the task, structure, people, and the environment as listed below:

Organization Factors in Health Care Delivery

1. Task
   a. long-term vs. short-term care (curative vs. preventative)
   b. specialty vs. comprehensive care
   c. medical vs. health care
   d. no relation between output (care) and input (funding)

2. People
   a. training and socialization of professionals and non-professionals
   b. norms and values: about health care, about management
   c. styles -- personality and cognitive
   d. skills -- health care and andministrative

3. <u>Structure</u>

   a. formal: lines of communication, authority, organization chart
   b. informal: physician dominance of health care

4. <u>Environment</u>

   a. community needs
   b. legislative constraints
   c. financial support: unpredictable and short-term; no investment in development.

THE IMPACT OF THESE CAUSAL FORCES

The interactive nature of these forces presents a challenge to the consultant on two different fronts. On the one hand, the complex interdependent quality of these forces challenges the consultant to "keep a large number of variables in mind" when working in health care organizations. In this sense, planned change in health care organizations may differ from comparable efforts in other systems only in the <u>amount of work</u> required.

On the other hand, to the extent that these forces represent given conditions, unlikely to change in the short run, we also experience a challenge around the ways a consultant can and should function in health care systems. In this sense, planned change in health care systems may not only be more work, it may also require <u>different work</u> than comparable efforts in other systems. Attitudes and assumptions may exist in our field (as we have argued exist among physicians, for example) which, if applied too rigidly and inflexibly, may result in a reduced ability to adapt and function effectively in initiating and implementing planned change in health care systems.

EXAMPLES OF INTERDEPENDENCE OF FORCES IN HEALTH CARE SYSTEMS

With respect to the issue of keeping a large number of variables in mind, it is probably not sufficient to observe only that the life and death

nature of the task in health care delivery influences people's attitudes in health care systems. In fact, the nature of the task varies from location to location (ghetto vs. suburb) and from institution to institution (hospitals vs. neighborhood health centers) -- in other words, the task varies with the environment and the technology.

More subtle is the recognition that the nature of the task is often defined by the nature of the people, rather than vice versa, as when physicians (as a function of their training and socialization) insist on focusing on crisis care as opposed to preventative and/or comprehensive care.

As is the case with many of the large corporate organizations, the interaction between environment and the organization in health care is not strictly one way. Physicians, through their powerful lobbying agencies, have influenced legislation to the extent that they are afforded virtually unchallengeable control of our health care delivery systems. The desire to preserve this control combined with a trained indisposition towards administrative activities make for many of the organizational power and structure issues discussed earlier. Perhaps one of the most difficult phenomenon to deal with is that within health care delivery, the task, formal structure, and the environmental influences are all greatly determined by the nature of the people--their training and the social structure within the health care professions. The major result of this and the other problems discussed is that health care systems do not necessarily respond to strategies based solely on criteria of effectiveness and efficiency in performing their task--the delivery of health care. This type of interdependence demands that the consultant be able to diagnose and deal with health care organizations as very complex, fluid, rapidly-changing open systems.

IMPLICATIONS FOR SCOUTING AND ENTRY STRATEGIES

Arranging the issues we discovered in working in health care delivery settings into a systematic organizational model has suggested several implications for developing strategies for organization interventions. The most general of these is that individual organizations do not have the same type of control over themselves that is characteristic of private profit-making organizations. Powerful governmental control through statutes and funding, and powerful professional norms and controls; (both often incongruent with the task of meeting a community's health care needs) are major constraints in managing health care organizations. Inherent in this situation are several intervention dilemmas:

1. Where in the system does one enter?
2. How much "free choice" does one allow the client with respect to identifying problems and finding solutions? How much does one inject oneself?
3. How much commitment does one have? What is the motivation of the consultant?
4. Whose needs are you meeting with our traditional demands for commitment (or how little commitment from the client is enough)?
5. Can we use power other than participative trust-based power (e.g., expert, positional, etc.)?

WHERE IS THE SYSTEM?

One of the tasks of scouting is to determine the most appropriate entry point in the organization. In health care delivery systems, it frequently appears that the entry point with the most leverage is outside the organization;

that is, with the government, the funding agencies or the medical schools and other training institutions. Indeed many people have chosen to focus their change efforts on these environmental factors.[17] However, if the goal is to provide more immediate assistance, it is necessary to focus on the health care organization with all the frustrations that are likely to result from the dysfunctional impact of the external reward system. In choosing points of entry within the organization, it has been our experience that maximum leverage is gained by working through a physician (not necessarily the medical director). Skeptical physicians listen to other physicians a good deal more than they listen to administrators, other health professionals or unfortunately, consultants.

However, because of the dual authority line present in many health systems, it is important not to overlook the non-medical administrator. While in many cases a physician can go pretty far on his own, as in the example presented earlier, the uncommitted administrator can become an obstacle. Further, many administrators are personally sympathetic to the need for improved management of their organizations. They are, therefore, the best able to understand and appreciate O.D. strategies. Thus, they too need to be brought on board. It is important to remember in health systems that the absence of well-defined lines of authority often makes the old adage start at the top a somewhat ambiguous directive. Our experiences in "neatly organized" industrial organizations can easily lead us into misconceptions about where the "top"

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[17]One very notable example of such an environmental intervention is a program conducted by the MIT Sloan School of Management to provide change and management skills to the participating deans of the American Association of Medical Colleges.

ought to be; what types of decisions the "top" can or cannot influence, and how much weight sanctions from the "top" carry with the producers.

"FREE CHOICE," "INTERNAL COMMITMENT" -- WHOSE NEEDS?

One of the more basic tenets behind much of our intervention strategy are the notions of "valid data" and "free choice."[18] That is, the client should be aware of complete and true information about his organization and that his uncoerced decisions to participate in an intervention reflect his commitment to the need for and the particular strategy of change. In order to minimize client dependency on the consultant, consultants often interpret "free choice" as meaning they must minimize the use of "expert" power as a means of influence on the client.

What do we mean when we say "free choice"? What do we expect when we say "internal commitment"? We are not implying that these are unimportant questions to ask. We are suggesting greater flexibility around what constitutes an "acceptable answer." For example, whose needs are we meeting by our tendency to avoid a high level of client dependency in the beginning of a relationship?

In the medical world, "expert power" is a way of life. When we deal with a physician, they are acting as "patients" and expect us to act as "doctors." If we are really willing to "take the client where he is at" (as opposed to where we wish he were) and if we really believe we can be of help, why not tell him what we think he ought to do (write a prescription)?[19]

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[18]See Argyris, C., INTERVENTION THEORY AND METHODS: A BEHAVIORAL SCIENCE VIEW, Addison-Wesley Publishers, Reading, Mass., 1970, for a clear statement of these criteria.

[19]Friedson, E., "The Impurity of Professional Authority," in Becker, H.S. et. al. (eds), INSTITUTIONS AND THE PERSON, Chicago: Aldine, 1968, 25-35. Complete discussion of the impact of professional socialization on the helping relationships particularly as it relates to physicians and the use of expert power to influence patients.

We may need to provide considerably more concreteness in terms of steps to be taken than is appropriate in other settings.[20]

To re-emphasize, we are not saying that issues of client dependence can be or should be ignored in health care systems. Such issues may, in fact, be more important in these settings. We may well need to view interdependence and independence as ideal states to be achieved as opposed to ideal conditions to expect at the point of getting started.

In addition, we suspect that many of us are reluctant to get involved in the day-to-day nitty-gritty management of change. We are all familiar with the glamorous "war stories" of successful confrontation meetings, etc. It is often necessary in health systems, unused to effective management, for the consultant to get involved in such drab activities as scheduling meetings, insuring their attendance, and in addition, managing their content. The consultant to health systems needs to be aware of <u>his own</u> resources (time, etc) and motivations. To a certain extent, we may well be spoiled by the extent to which we have been able to maintain the position of "elite outsiders"[21] rather than being involved in the "dirty" day-to-day management of change.

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[20]We cannot ignore the potential relevance of an intervention we have all made with "other clients" (other than ourselves) many times. "Perhaps they are resisting our process and not the content of our changes!"

[21]Our colleague, Ric Boyatzis has labeled this phenomenon the "Lone Ranger" approach to consultation.

"FELT NEEDS" -- WHOSE?

Another issue facing the consultant in scouting the health care system refers to the basic principle of "felt needs." At the beginning of nearly every problem solving, consulting, or change model there is a "felt need." That is, the client system, having experienced a "hurt" or feeling a problem is seeking help. In our experience we have found this to be the most effective way of entering an organization -- being asked in.

However, we have also found that many health care organizations, though beset with organizational problems are incapable of summoning a consultant. There are several reasons for this. First, though they are uncomfortable with a situation, they may not be aware that there is anything "wrong" or unusual about it. In many industrial organizations, for example, a crisis situation often unfreezes the organization and stimulates them to search for help to avoid future crises. In health care organizations, the crisis mode is the norm, not the exception --- it's "the way things are in the business." As another example, surprised health team members often comment: "Don't all teams work this way?" Second, health care organizations may suspect there is a better way to organize, but do not know where to find the appropriate resources to help them. Third, though uncomfortable, they may choose to ignore "that administrative stuff." And, finally, being in the helping business themselves, they may find it difficult to ask for help.

For these reasons a consultant who is anxious to work at helping health care systems may have to initiate the contact and essentially market, or create the "felt need." This might require convincing skeptical administrators and physicians that (1) there is a better way to manage, (2) you can help them

to do so, and (3) it is worth their time, effort and resources to try to change the way they are doing things. To many of us this may sound uncomfortable and unprofessional. In fact, to many consultants it represents a deviation from traditional professional roles -- a "role innovation" as Schein describes it.[22] It represents a dramatic shift in the source and amount of influence the consultant brings to bear in a client relationship. Instead of relying comfortably on his professional title and its presumed status as a source of control (often the case when the client calls you), the consultant must rely more heavily on personal competence and the ability to communicate it (more like a salesman). Discomfort with this shift in roles stems primarily from the consultant feeling less control. It is the source of control which has changed, however, and has become more risky in a personal sense. The increased personal risk associated with this role innovation may be disconcerting to the consultant. But a professional's primary concern should be "service to society"[23] and this particular societal need (helping health care systems) may be great enough to require us to rethink some of our own personal reservations.

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[22]Schein, E.H., "Occupational Socialization in the Professions: The Case of Role Innovation," J. Psychiat. Res., Vol. 8, 521-530, (1971).

[23]Moore, W.E., THE PROFESSIONS: ROLES AND RULES, Russell Sage: New York, 1970.

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BASEMENT

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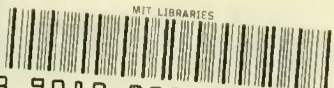

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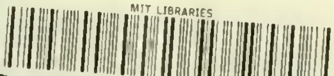

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