MULTISPECIALTY GROUP MEDICAL PRACTICE
AND
THE CONSULTATION PROCESS

by

CHARLES PATRICK SLAVIN
A. B., Political Science
Boston College
(1974)

Submitted to the Department of Urban Studies and Planning
in Partial Fulfillment of
the Requirements for the Degree of
Master in City Planning

at the

Massachusetts Institute of Technology

February 1990

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ABSTRACT

This thesis is a case study of an intervention (consultation) within the Downtown Medical Group (DMG)--a large, physician managed, multispecialty group medical practice. The first chapter reviews 1) medical practice settings in the U. S., 2) the organizational mechanics of group practice settings, 3) the Madison-Konrad large group practice typology, 4) general theories and models of the consultation process and 5) the literature on interventions within health care settings. The second chapter provides a history of the DMG prior to the intervention and a detailed chronicle of the intervention itself. The final chapter assesses the impact of the intervention on the organization and reviews theories of intervention in light of the experience with DMG.

The literature on interventions embodies a conflict over the relative appropriateness of process versus structural interventions within health care settings. This thesis articulates the process-structure duality that emerges from the literature and explores two questions in light of the experience with DMG:

1. Is Process Consultation likely to be an appropriate technology for interventions within large, physician managed, multispecialty group medical practices?

2. How applicable to these organizations is Plovnick's hypothesis relative to the primacy of structural interventions within health care organizations?

The thesis argues that Process Consultation is not an appropriate technology for these organizations, at least during the individualistic-autonomous and transitional stages of their development. It also confirms the applicability of Plovnick's hypothesis, arguing however, that Plovnick's rationale for the hypothesis is not entirely consistent with the internal dynamics of these organizations. Another rationale, involving physician perception of organizational reality, is suggested.

Thesis Supervisor: Donald A. Schon, Ph. D.
Title: Ford Professor of Urban Studies & Education
To my mother,

Marie Ida Bisson,

who, in many ways, made this all possible;

to my Aunt,

Mary Kathleen Adamo,

who has provided untold support over the years

and

to the memory of my father,

Thomas John Slavin, Sr.
ABSTRACT

This thesis is a case study of an intervention (consultation) within the Downtown Medical Group (DMG)—a large, physician managed, multispecialty group medical practice. The first chapter reviews 1) medical practice settings in the U. S., 2) the organizational mechanics of group practice settings, 3) the Madison-Konrad large group practice typology, 4) general theories and models of the consultation process and 5) the literature on interventions within health care settings. The second chapter provides a history of the DMG prior to the intervention and a detailed chronicle of the intervention itself. The final chapter assesses the impact of the intervention on the organization and reviews theories of intervention in light of the experience with DMG.

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BIOGRAPHICAL NOTE

Charles Patrick Slavin was born in Lynn, Massachusetts on June 10, 1952. After a relatively uneventful childhood and adolescence, he received his A. B. (cum laude) in Political Science from Boston College in 1974.

From 1975 to 1979, he held several senior staff positions at the Office of State Health Planning, within the Massachusetts Department of Public Health. In those capacities, he was part of the policy team responsible for the Commonwealth's implementation of the National Health Planning and Resources Development Act of 1974 and served as co-editor of the first Massachusetts State Health Plan, published in 1979. From 1980 to 1982, he worked as a Program Manager at Blue Cross of Massachusetts, responsible for facilitating corporate relationships with Blue Cross sponsored Health Maintenance Organizations (HMOs) and for conducting a variety of policy studies.

Since 1982, Mr. Slavin has worked as an independent health care management consultant, providing consulting services to a variety of private and public sector clients. He is also completing his second year as a part-time Instructor in Health Policy and Management at the University of Massachusetts at Boston.

On a personal level, he is interested in Asian philosophy, amateur ichthyology, scenic photography, modern-era U. S. Presidential leadership, Irish folk music and long vacations on tropical islands.
PREFACE

In June of 1987, I was retained as a consultant by the Executive Director of a group model Health Maintenance Organization (HMO) to assist with merger negotiations between his HMO and a large staff model HMO. I worked with the Executive Director and his staff for six months, providing strategic and tactical advice on the negotiation process and drafting proposed contract language for use in the negotiations.

During this time, I became acquainted with the Downtown Medical Group (DMG), a large, physician managed, multispecialty group medical practice. In partnership with a major health insurer, DMG had established my client HMO a number of years earlier. Now, due to a complex combination of mismanagement and misfortune, both the HMO and DMG were in serious financial difficulty. If the merger did not take place as anticipated the HMO would undoubtedly have to file for protection from its creditors; the medical group, while somewhat better off, would be left to face a crippling financial burden. If the merger did take place as anticipated, my client HMO would cease to exist as an organization and its members (i.e. subscribers) would be transferred to the staff model HMO. DMG would become a vendor under the new arrangement, providing medical care to the staff model HMO's members and trading its equity in my client HMO for some measure of financial relief. It was not clear that this was the best choice for the Group. There was the possibility that forfeiture of its equity and acceptance of vendor status was little more than a jump out of the frying pan and into the fire. There were no other realistic choices however; it was not a happy time.

In the final days of that engagement Dr. William A. Blakeley, DMG's President, stopped by my office. Under the circumstances and in the manner discussed later on in this paper, that meeting led to my acceptance of a consulting engagement with DMG. Now, more
than two years later, that engagement has ended and this paper comes as a welcome opportunity to reflect on my experience with the Group.

I was initially retained to assist the Group with an assessment of senior management job descriptions and the development of new job descriptions where necessary, although my contract was open enough to allow me to identify other issues which needed to be addressed. It did not take long to realize that new job descriptions were the least of the organization's problems. In terms of organizational health and effectiveness, DMG seemed to be a seriously problematic entity.

DMG was a physician managed Group: its Board and President were all practicing physicians within the Group; they were all Shareholders in the Group. To the extent that it can be said that a profession has a mindset, over the years the physician mindset towards management has appeared to range from indifference to hostility. In most health care organizations (medical centers, hospitals, HMOs), physicians are only a part of the whole however; the physician mindset is thus balanced against other viewpoints (i.e. management, nursing staff, allied health professionals) and the result is a workable compromise, sometimes uneasy, that allows the organization to be managed.

At DMG, the physicians were the whole and that apparently helped lead to a variety of things generally not seen in $30 million a year modern organizations: weekly Board meetings, held without benefit of agendas or documentation; senior managers, including a President and Finance Director, without job descriptions; a senior management staff with no tradition of team work—a staff that had not formally or informally met as a group in more than a year; an organizational structure requiring 111 physicians in 17 different specialties to report to one part-time individual; an organizational structure which allowed one individual to simultaneously hold the positions of Chairman of the Shareholders, Chairman of the Board, President & CEO, Medical Director and Department
Chair; the absence of a mission statement, five year plan, one year plan, operational plan or, in fact, any kind of business plan and no specific process or identified staff to consider such issues; an absence of criteria, policies and mechanisms to address the issue of physicians who were operating to the direct detriment of the Group as a whole. This was the entity Dr. Blakeley wanted me to consult with.

How does one go about ensuring an effective consultation process with physicians, though? How does one build a working relationship with members of the ultimate profession, most of whom do not understand, have little patience with and do not want to spend time talking about management and organizational structure and process issues? Is there an optimum mix of directive and non-directive consulting behaviors for these organizations? Is a structural focus more relevant to the consultation effort than a process focus, or vice versa?

These are very difficult questions; they will be asked more frequently as the number and power of these unique organizations continues to grow. It is my sense that many consultants will be forced to address them as these organizations increasingly seek assistance to deal with the impact of competitive strategies gone awry. This paper attempts to provide insight into these issues and into the operations of these organizations.

In general, I found working with DMG incredibly difficult. The organization was highly unstable financially, structurally and emotionally; its survival was in jeopardy. There was little management decision making, as much as there was collegial decision making, even though circumstances and events had clearly overtaken the utility of that approach. There was some consensus within the Group that "something" needed to be done, but no real consensus on what that "something" was and, as physicians, the Group's physicians were in no position to be able to think or communicate in management concepts; they actually seemed to have enough difficulty communicating among themselves on
medical matters.

There were other pitfalls as well. Serious management problems that were perfectly obvious to me seemed to be invisible to the President of DMG, so there was often a battle over whether or not there was actually a problem before we could even get into the battle about what to do with the problem. While all of the physicians were more or less cordial, they never left any doubt in my mind that they would rather have been in their examining rooms than sitting with me and their colleagues discussing the management problems of the organization. More than one previously scheduled important meeting was canceled or disrupted because a physician had been on call all night, had been called in to an emergency or still had patients waiting that needed to be seen. I spent a great deal of time admiring the fact that these physicians had cognitive space and psychic energy left to deal with management issues; the rest of the time I spent silently cursing them because they didn't seem to have the cognitive space or psychic energy necessary to deal with management issues. Consultants determined to work with these groups should have a high tolerance for ambivalence.

I also found working with DMG strangely satisfying. There is something to be said for working with an organization whose social usefulness is beyond question; one whose managers were up all night because a life hung in the balance, not because a shipment of styrofoam Big Mac containers was behind schedule. Physicians have to be among the most frustrating people in the world to work with, but there are compensations.

This thesis was a long time in coming; indeed, it has hung over my head for years, always the last item on a to-do list that only seemed capable of expansion. My good friend and co-conspirator, Chuck Winer, finally dragged me to lunch and beat me into agreeing that it was a necessary thing to complete before I could move on with the rest of my life. For that, he should be thanked--or punished; I am still not sure which. Mary Hogan was an
equally insistent and supportive friend who has my thanks. Katy Hogan and Carol Smith were the kindest of friends, distracting me with movies, dinners and laughter when necessary, but always making me go back to work in the end. Ellen Crighton, MBA, DVM, and my oldest living friend, took time from a busy schedule to proof-read my drafts, handle some of my consulting practice and routinely provide telephonic injections of encouragement. I appreciated it guys; I still do.

My advisor, Dr. Donald Schon, also has my thanks. He managed to be a rigorous scholar and a patient, understanding human being at the same time--no mean feat in the world of academia. It is a much better paper because of his gentle nudging.

Cambridge, Massachusetts
January 1990

Charles P. Slavin
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CHAPTER 1
MEDICINE, HEALTH CARE, AND CONSULTING PRACTICE

Introduction

This chapter begins by reviewing the organizational structures within which medicine is practiced in the United States, with a particular emphasis on the characteristics of group medical practice. The Madison-Konrad large group practice typology is then introduced to elucidate the dynamics which appear to govern the organizational evolution of these entities. Several general models of the consultation process are then discussed, followed by a review of the literature on consulting interventions within health care organizations. The chapter closes with an articulation of the process-structure duality that seems to emerge from the literature review and by asking two questions that serve as the analytical focus for the remainder of the paper: (1) Is Process Consultation (PC) likely to be an appropriate technology for interventions within large, physician managed, multispecialty group medical practices and, (2) how applicable is Plovnick’s structural primacy hypothesis to these entities?

The second chapter of this paper sketches a brief history of the Downtown Medical Group (DMG) and provides a detailed narrative of a consultation with the Group that began in November of 1987 and ended in August of 1989.

The third and final chapter reviews the impact of that consultation on the Group, in terms of what was and was not accomplished, discusses changes in the consultant's personal theory of consultation during that engagement and, returning to the theoretical issues outlined in the first chapter, assesses the relative appropriateness of process versus structural interventions within large, physician managed, multispecialty group
medical practices.

This paper argues that Process Consultation, a particular process technology, is not an appropriate initial intervention model with respect to these groups. The experience with DMG suggests that this is true for four reasons: (1) these groups will fail to meet the PC use criteria at the entry and/or contracting phase of the consultation, (2) they will not have the capacity to retain the diagnostic and remedial initiative during the consultation, a key element of successful PC, (3) lacking trained managers, these organizations will have a high level need for consultation services best characterized as educational in nature, a directive stance in conflict with the non-directive stance required by PC, and (4) these groups will be organizations in deadlock, caught in transition between an old culture that no longer serves the manifest needs of the group (although they do serve the needs of a number of powerful individuals within the group) and the emergence of a new culture which will allow the group to take the management steps necessary to protect the organizational and financial integrity of the group. It is the responsibility of the consultant in this situation to attempt to break the deadlock; to intervene on the side of organizational and financial survival.

At the same time, the paper argues that Plovnick's hypothesis relative to the primacy of structural intervention within health care organizations is equally applicable to initial interventions with these group practices, although the reasons for its applicability appear to be different from those advanced by Plovnick for health care organizations in general.

It is argued that the organizational and management needs of a group are perceived of as hygienic needs by its physicians, the fulfillment of which provide no satisfaction, whereas the practice of medicine results in higher-order need fulfillment and the attainment of much satisfaction. Physicians become preoccupied with the practice of
medicine, to the exclusion of almost all else, effectively altering their perceptual threshold. Organizational life thus passes unnoticed and unrecorded and organizational structure and process clues that would serve as danger signals for most professionals are not recognized and addressed as such by the physician managers in these organizations. The results are organizations with serious structural problems, problems which must be addressed immediately as a prerequisite for any further organizational change activity. This dynamic acts to ensure the primacy of structural intervention within these organizations.

**Medical Practice in the United States**

**Medical Practice Settings**

In the United States, medical practice has historically taken place within one of four settings: solo practice, associations, partnerships or group practices.

As defined by Freidson (1970), solo practice involves little more than "a solitary physician working in an office that s/he owns and equips, and seeing patients that have freely chosen her or him as a personal physician". Solo practice has historically been the most common practice pattern in this country; it may even be thought of as the ideal to which generations of physicians have aspired. Even today, after several decades of turbulence within the health care system, approximately 66-75 % of all non-federal physicians in active practice are solo practitioners (Havlicek 1985, 19).

Physicians not willing or able to assume the risks of solo practice have the remaining three organizational forms from which to choose. An association is the most common choice. It allows physicians to share the costs and risks of office facilities, equipment and auxiliary personnel while retaining almost the same level of personal and
professional autonomy found in solo practice.

The distinction between an association and the next choice, partnership, is financial in nature, although there are often more formal arrangements relative to call schedule as well. The physicians in partnership practices share the profits according to a mutually agreed upon formula. While a seemingly small step, it is the first serious introduction of interdependence and is often no small generator of ongoing conflict between the partners.

Finally, there is group medical practice. The first group practices were established around the turn of the century and they have been surveyed extensively over the years yet little is known about them. There has been little work done to determine the point at which a partnership becomes a group practice or to elucidate the variables involved in that transition (Wolinsky 1982). There has been little systematic study of the structural characteristics of these entities (Kralewski, Pitt and Shatin 1985) and the first typology of group practice was just recently published (Madison and Konrad 1988).

There is an established body of literature on management and organizational development consulting within the health care industry yet little of it relates specifically to group practice. Medical centers, hospitals, departments within hospitals, medical school/hospital affiliations, health maintenance organizations, health related public agencies and clinics have been the focus of much of this work. The most recent published text on the subject (Boss 1989) provides case studies involving one operating room, four hospitals, a long term care facility and a state Department of Public Health.

This paper however, is a case study of a large, physician managed, multispecialty group medical practice. The application of earlier research findings to this type of organization could be problematic and perhaps misleading (Kralewski, Pitt and Shatin 1985). Hospitals, for example, are unusual organizations in that they generally employ a dual authority structure. The hospital management hierarchy exists alongside of a
complementary medical staff hierarchy, with the Chief of the Medical Staff often reporting
directly to the Board of Directors, along with the Chief Executive Officer of the hospital.
The operation of the organization itself is clearly left to the management staff while the
physicians are responsible almost solely for the management of patient care. Physician
managers, to the extent that they are present within the organization, are usually located
at the departmental level or within committee structures and generally spend their time
working with and trying to organize their fellow practitioners. "It is almost as if hospitals
have decided that the best way to keep physician managers out of mischief is to keep them
so busy planning and organizing that they will not ask why they do not control any
resources." (Spivey 1986, 178).

HMOs, clinics and other care delivery organizations have similar authority
structures. While a public health department may count as a health care organization,
there is no reason to believe that the organizational issues that would arise in such an
entity would be significantly different from those found within any other bureaucratic
organizational setting.

Large, physician managed, multispecialty group medical practices are unique
organizations. They are invariably closed corporations, with all shares of stock held by the
physicians who practice in the group; the members of the Board of Directors are also
physicians who practice in the group and who are elected to the Board by their fellow
physician shareholders. The President and/or CEO is also a physician, usually chosen by
the Board of Directors, usually a practitioner within the group and often functioning only
as a part time CEO. Many of the physicians in the group will spend their entire
professional careers within the same organization. Unlike medical centers and hospitals,
management initiative resides entirely with the physicians. To the extent that there are
professionally trained managers on site, they report to and follow the direction of the
The Dynamics of Group Practice

Group medical practice is the most organizationally complex and interesting of the medical practice settings and recent data suggest that it is becoming an increasingly important segment of the health care delivery system. Some commentators believe that large, multispecialty group practices will emerge as the "building blocks" of the U.S. health care system within the next decade (Madison and Konrad 1988, 242).

The complexity of a given group practice is determined by the choices the physicians in the practice make with respect to three variables: (1) size, (2) type of practice and (3) participation in managed care programs. A fourth variable, one which need not add to complexity but which is of critical importance, is whether or not the practice will be physician managed or professionally managed.

Size is a critical variable and the meanings of small, medium and large have changed rapidly over the years. As noted by Madison and Konrad (1988, 244) "At the end of World War II, when less than a dozen groups in the U. S. counted more than 25 members, 15 physicians would have been a 'large' group. By 1970, a 'large' group meant at least 20 physicians. At the present time, more than 40 or 50 is 'large'." In 1974, there were 614 group medical practices in the U. S. with more than 15 physicians; by 1984, there were 1,182 such practices--an increase of 93%. In 1974 there were 35 group medical practices in the U. S. with more than 100 physicians; by 1984, there were 158 such practices--an increase of 351% (Madison and Konrad 1988, 245). Between 1980 and 1984, the average number of physicians in a group practice rose from 15 to 27 (Havlicek 1985, 9). In short, large group practices are increasing at a faster rate than group practices as a whole and the average size of a group practice is increasing as well.
The larger a group becomes, the greater the volume of interaction between its members—a factor which increases complexity; increases in size increase the need for the introduction of formal management methods into organizations which have, for the most part, been managed by informal committees of interested physicians.

In terms of type of practice, there are three options available for a group: family or general practice, single specialty practice and multispecialty practice. The latter are more complex organizations than either general practice or single specialty groups. As noted by Kralewski (1985, 35) "multispecialty group practices include physicians with markedly different training and interests and provide a diverse set of services."

In fact, it can be difficult to find an organizational culture, per se, within a large, physician managed, multispecialty group practice. Schein (1985, 6) has described organizational culture as consisting of "basic assumptions and beliefs that are shared by members of an organization, that operate unconsciously and that define, in a basic 'taken-for-granted fashion' an organization's view of itself and its environment." What impresses an observer most is that organizational-wide assumptions and beliefs can be relatively weak in these practices, while each Department (i.e. Internal Medicine, Surgery, Pediatrics, etc.) has a distinct, vibrant and visible culture. The organization may function as a collection of affiliated tribes, each with its own specific culture, linked only by a more general medical culture to which all physicians nominally subscribe.

Finally, there is participation in the managed care movement. Traditionally, medical practice in the U.S. has been fee-for-service practice: a physician would receive a specific fee for each and every patient encounter completed and procedure performed upon a given patient. Government and private sector concern with the costs of medical care has led to the introduction of a number of alternatives to this system, to the extent that many observers predict the death of fee-for-service medicine within the next decade. A group
practice can now choose to own, affiliate with or be owned by one or more Health
Maintenance Organizations (HMOs); it can choose to affiliate with one or more Preferred
Provider Organizations (PPOs), often in addition to whatever HMO relationships it
maintains.

If a group practice affiliates with an HMO, it will probably receive a set sum of
money each month for each member assigned to the practice. For that sum, known as a
capitation, the group will be expected to provide or to arrange for the provision of all the
care that the enrolled patient needs. In effect, the capitation serves as a revenue cap,
requiring the construction of a budget, the use of financial systems to monitor costs and
service utilization and, implicitly, the organizational will to confront those physicians
who are performing in ways that create negative financial outcomes for the group.

If the group is owned by an HMO or if the group owns the HMO, there is usually no
capitation, per se; there is an explicit budget and the physicians in the group are subject
to the limits of that budget. The provision of care must still be managed within this
structure however and that still requires the organizational will to evaluate and address
physician behavior with respect to organizational goals and objectives.

If a group practice affiliates with a Preferred Provider Organization, it will have to
guarantee to provide services to a defined population under some negotiated system of
discounts. This requires, at a minimum, a cost accounting system capable of generating
valid data about the actual cost of a given service or procedure, as well as the political and
technical skill necessary to negotiate and evaluate complicated contracts with insurance
industry representatives.

In either case, what is happening here is somewhat revolutionary: group medical
practices are slowly emerging as strategic business units. They are increasingly involved
in defining business goals for themselves, in relation to their economic environment, and
are moving aggressively to implement strategies designed to achieve those goals. The Geisinger Medical Center, in Pennsylvania, is perhaps an example of how far this trend can be taken: it employs 300 physicians in 20 locations, manages several postgraduate specialty training programs and owns three hospitals, an HMO with 50,000 members, a home health care agency, a research foundation and a health care management consulting firm (Madison and Konrad 1988, 247).

Another decision to be made by the group is whether its organization will be professionally managed or physician managed. This is not to imply that physicians are not professionals, as much as it is to recognize that they are far from being professional managers.

Many group practices have management trained staff in their employ, usually to work on financial or claims processing issues. By physician managed, I mean that management initiative resides with the physicians in the group; the shareholders, members of the Board and, most importantly, the President and/or CEO, are all physicians who practice in the Group. This pattern is not unusual for small groups operating in a minimally complex environment.

There are, unfortunately, no statistics relative to how prevalent this pattern is in large groups. While many such groups have, historically, hired an administrator to manage the business side of the organization, thus replicating the dual authority structure of the hospital, there is an emerging trend of physicians assuming CEO and senior management authority in a wide variety of health care organizations (Spivey 1986).

This trend may be problematic for a number of organizations, adding the difficult variables of physician personality to an already complex mix:

In general, most physicians (i.e. all specialists) are oriented to certain behaviors and values in their clinical practices and these behaviors are successful for them and most likely are needed if they
are to achieve the desired outcomes and acceptance of colleagues and peers. When the physician moves away from the clinical role and into the world of management, administration and leadership, we find that s/he most often will continue to use these learned clinical behaviors, professional norms and values. A negative result is seen when this occurs. While clinical behaviors are critical for success in the practitioner role, they tend to create conflict, resistance and tension in the managerial role (Kurtz 1988, 66).

An ongoing research project sponsored by the American Academy of Medical Directors, has identified a variety of key traits that characterize physician behavior in management situations. One study involved the administration of three batteries of personality assessment tests to a sample of 800 physicians-managers. As part of the same study, the management literature was reviewed in an attempt to identify those personality traits indicative of effective management behavior. The two sets of characteristics were compared and factored to determine those areas where the differences were most critical to performance. The resulting nine traits are presented in Figure 1.1.

The study found that physician managers, in general, "exhibit a number of behaviors that are ineffectual and counterproductive in the management role" (Kurtz 1980, 33). Conflict, for example, which most managers fully expect to have to deal with and which better managers use creatively to develop their organizations, appears to be a problem for physicians. Commenting on the AAMD study, Spivey noted:

(Physician managers)... are uncomfortable with conflict and stress and have strong tendencies to withdraw from it. However, they are not willing to admit to their high level of discomfort. Therefore, in an attempt to control their uneasiness and protect themselves, they switch to an authoritarian style of behavior. This in turn leads to more conflict, and a vicious cycle begins. Display of this behavior pattern in the normal physician-patient relationship is understandable. Authoritarian behavior and masking of uncertainty are effective responses to patient care crises. On the other hand, this type of response to conflict in management relationships is destructive (Spivey 1986, 182).

One problem with physician managers then, is that they often do not have the behavioral and leadership traits necessary to function effectively as managers. One
problem with physician managed organizations, as defined above, is that there are no
senior individuals available in the organization to demonstrate what would be an
especially competing set of managerial behaviors from which the CEO could learn, if, in
fact, s/he recognized the necessity of learning and was willing to do so. Meanwhile s/he is
surrounded by peers who positively reinforce adherence to the behavior of the medical
culture, behavior which is often not consistent with established understandings of
effective management.

Figure 1.1: Major Differences Between Clinicians and Managers

<table>
<thead>
<tr>
<th>CLINICIANS</th>
<th>MANAGERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doers</td>
<td>Planners; Designers</td>
</tr>
<tr>
<td>Prefer 1:1 Interactions</td>
<td>Prefer 1: N Interactions</td>
</tr>
<tr>
<td>Reactive Personalities</td>
<td>Proactive Personalities</td>
</tr>
<tr>
<td>Require Immediate Gratification</td>
<td>Accept Delayed Gratification</td>
</tr>
<tr>
<td>Deciders</td>
<td>Delegators</td>
</tr>
<tr>
<td>Value Autonomy</td>
<td>Value Collaboration</td>
</tr>
<tr>
<td>Independent</td>
<td>Participative</td>
</tr>
<tr>
<td>Patient Advocate</td>
<td>Organization Advocate</td>
</tr>
<tr>
<td>Identify with Profession</td>
<td>Identify with Organization</td>
</tr>
</tbody>
</table>

Source: M. E. Kurtz, "The Dual Role Dilemma", in The Physician Executive, Tampa,
American Academy of Medical Directors, 1988

Madison-Konrad Typology

Madison and Konrad (1988) have developed a useful typology for understanding the
organizational evolution of large medical group practices, as well as the current
organizational status of a given practice. This typology uses two variables, Market
Response Strategy and Organizational Tradition, to create a two dimensional structure
within which most large group practices can be placed.

The authors define the Market Response Strategy variable as a function of (1) a
group’s committed capacity and (2) the number of client agents it chooses to deal with in
order to provide care. Committed capacity refers to the absolute level of medical staff capacity (i.e. physician time) devoted, or "committed" to a given client or clients. For example, a fee for service practice would have no committed capacity whatsoever; physician time would be available for any self-referred or colleague-referred patient. An HMO owned group practice however, would, theoretically, have 100% of its medical staff capacity committed. That is, physicians on staff would be totally devoted to satisfying the medical care needs of a specific enrolled patient population. Assuming that the HMO is the group's sole client, there would be no need to retain physician capacity beyond that necessary to meet the expressed needs of the HMO. Between these two extremes, there is room for considerable variation, with groups free to choose the extent to which they commit their capacity and the manner in which they make that commitment.

Given current market trends towards managed care arrangements, the model views a group decision to not commit capacity as a reactive response to the market; conversely, it views a 100% commitment of capacity as a proactive market response.

Client agents refer "to all of the parties that speak for individual clients or groups of clients in negotiations with the group practice organization" (Madison and Konrad 1988, 252). Fee-for-service patients are generally their own agents; their insurance companies do not interpose themselves between patient and provider to negotiate terms of service. A 50,000 member HMO negotiating for a medical group to provide medical care to its membership is another matter. The negotiator for the HMO is in a very powerful position to arrange the terms of service; there may be substantial financial incentives for the group to agree with whatever appears necessary to obtain the business.

A group may choose to deal with many agents, as in a fee-for-service setting, or it may choose to deal with only one agent. The model characterizes the former approach as market reactive and the latter approach as market proactive.
The value assigned to the Market Response Strategy variable then, is a function of how much of its physician resources a given group has committed to a prearranged relationship plus the extent to which it is involved in business negotiations with patients or agents representing groups of patients. A given group’s strategy towards the market will always be characterizable as either proactive, transitional or reactive.

The authors decompose the Organizational Tradition variable into two sub-concepts as well: (1) the autonomy of the individual physician and (2) the autonomy of the physician collegium. Individual physician autonomy within a group can range from quasi-independence to subordination. Similarly, the independence of the group as a whole can range from sovereignty to subordination to another organization. Taken together, these two variables can generally define the location of a given group within one of three traditions (1) heteronomous, (2) administered autonomous or (3) individualistic autonomous, although, as in the case of the Market Response Strategy variable, it is recognized that these traditions represent more of a continuum than a discreet grouping of options. Figure 1.2 combines both variables to generate the typology structure.

The typology is useful for a number of reasons. First, it correctly identifies autonomy as a critical variable in the lives of large group practices and links it to the tradition within a group. While research (Wolinsky 1982) suggests that physicians who choose to practice in groups have a higher tolerance for peer regulation (i.e. a proxy variable for lower autonomy) that is not to say, on an absolute scale, that such tolerance is very high. Physicians, along with other professionals, guard their personal and professional autonomy regardless of setting; perhaps even more so.

Secondly, it correctly posits the nature of the relationship between the two variables. Market Response Strategy and Organizational Tradition are essentially traded off in the model and that is how it seems to work in reality. The desire for autonomy is
usually an imperative that guides the developmental choices these groups make, if, in fact, there are choices left to be made. When there is no choice left, it will be a grudging tradeoff—physicians accepting an incursion on their autonomy in order to avoid being by-passed completely by a market they probably view as raging out of control—but the tradeoff will often take place if the group needs it to survive.

Figure 1.2: Madison-Konrad Typology of Large Group Practice Organizations

<table>
<thead>
<tr>
<th>Market Response Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive</td>
</tr>
<tr>
<td>Transitional</td>
</tr>
<tr>
<td>Reactive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizational Tradition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heteronomous</td>
</tr>
<tr>
<td>Administered Autonomous</td>
</tr>
<tr>
<td>Individualistic Autonomous</td>
</tr>
</tbody>
</table>

Source: Adapted from D. L. Madison and T. R. Konrad, "Large Medical Group Practice Organizations", The Milbank Quarterly, Volume 66, Number 2, 1988

Finally, the typology is crudely predictive of the kinds of organizational problems these groups may have to address. As Madison and Konrad note, the model assumes symmetry between the two variables; organizations located off of the diagonal in Figure 1.2 are organizations with a lack of fit between their Organizational Tradition and their
Market Response Strategy. Organizations located to the southwest of the diagonal may find that their organizational structure is inadequate to support the market response strategy which the group has chosen. Organizations located to the northeast of the diagonal may find that they are too organizationally bound to respond quickly enough to rapid changes in their market environment. These are obviously different types of problems and as consultants become more involved with these kind of organizations, the typology should be useful in understanding the developmental history of an organization, its current status and the circumstances which define its need for consultation.

The Consultation Process

Definitions and Models

Organizations exhibiting a lack of fit between their operating structures and market strategies, particularly physician managed groups, will often need assistance if they are to make the changes they need to make in order to survive and prosper. Many of these organizations will turn to consultants for this assistance.

There seems to be some disagreement however, over what this kind of assistance should be called and precisely how it should be provided. As Blake and Mouton note: "The field of consultation is in many respects unlimited, ranging as wide as there are knowledge to be used and problems to be solved. The varieties and sub-varieties of consultation are so great that the person wishing to become competent faces a bewildering array of possibilities" (Blake and Mouton 1983, iii).

Steele defines the consultation process as "any form of providing help on the content, process or structure of a task or series of tasks, where the consultant is not actually responsible for doing the task itself but is helping those who are" (Steele 1975, 3).
Lippitt and Lippitt describe consultation as a "two-way interaction--a process of seeking, giving and receiving help (Lippitt and Lippitt 1986, 1). Argyris seems loath to even use the term consultation and prefers the word intervention, although there is clearly a nexus between the prevailing definitions of consultation and his concept of intervention: "To intervene is to enter into an ongoing system of relationships, to come between or among persons, groups or objects for the purpose of helping them" (Argyris 1970, 15).

It seems fair enough to conclude from the above that consultation processes are helping processes: to consult is to help, or at least attempt to help, and this involves intervention. That seems acceptable as far as it goes, but it begs two additional questions: what constitutes an intervention and how does one go about the process of intervening?

A consultant who enters an organization and provides the personnel department with a new salary structure has certainly intervened; a consultant who enters an organization and, after a period of evaluation, recommends that certain departments, plants, sub-divisions or companies be closed or sold, has also clearly intervened. There are a wide variety of similar activities that would clearly constitute interventions within the organization and that would be recognized as such.

The composition of the lower end of this spectrum, involving activities that are much less invasive of the organization, is not as immediately clear. Would a two day seminar provided by a consultant constitute an intervention? Would a lunch meeting at which a consultant provides advice to an anxious manager facing a difficult organizational problem constitute an intervention?

Some would argue that practically any interaction a consultant has with a prospective client or client system is an intervention, one that has the potential to become, as an unintended consequence, quite invasive. Schein notes that the assumption used in traditional consultation models is that intervention is the part of the process that
follows data gathering and diagnosis; he views this as an incorrect and possibly destructive assumption and suggests that:

The correct assumption is that every act on the part of the process consultant—even the initial act of deciding to work with the organization—constitutes an intervention. Asking for help, and having someone accept the responsibility for helping, changes the perceptions and attitudes of some members of the organization. The consultant cannot ignore these changes. He must anticipate them and learn to make them work toward the ultimate goals defined.

The main implication of this latter assumption is that the consultant must think through everything he does in terms of its probable impact on the organization. He must assume that all of his behavior is an intervention of one sort or another (Schein 1988, 142).

While Schein was addressing his comment to a specific model of consultation—process consultation—the dynamic he is concerned with should be thought of as universal across consultation models. The actions taken and statements made, or not made, even during an initial interview with a prospective client, may influence the way in which the client perceives his/her problem, impacting either his/her willingness to act on the problem or changing the nature of the action s/he had intended to take. While the results of this intervention may remain transparent to the consultant, they are nonetheless real and potentially significant, particularly to the client.

This raises the issue of how one should intervene, since there must obviously be different approaches a consultant can take which either maximize or minimize the direct influence s/he has on the client.

There are, in fact, a number of consultant roles available and there are a number of models which purport to clarify these roles. It is beyond the scope of this paper to review all of these models; only two are of concern to this analysis.

Lippitt and Lippitt (1986, 61) provide a role typology, based on the relative directiveness of consultant activity. Their model, provided in Figure 1.3, integrates the
different roles by using the level of consultant activity in problem solving as the integrating variable. At one end of their spectrum, the Advocate role anticipates consultant activity that is either directly invasive or that seeks to direct the client to a specific course of action with respect to a particular problem. The Objective Observer role, at the other end of the spectrum, is a passive, minimally invasive role; one in which the

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Figure 1.3: Lippitt and Lippitt Consultation Role Typology

consultant merely observes events and raises questions to be answered or not answered by the client. Between these two polar extremes, there is a changing symmetry between the initiative for problem diagnosis and resolution held by the consultant versus that held by the client.

In the Lippitt and Lippitt typology, the roles are not thought of as mutually exclusive. Selection of a role by a consultant, both initially and throughout the consultation, depends on a variety of processes and factors including the contract between the parties, unforeseen events, the needs of the client system and consultant predilection; the role selected can change over time.

Up until this point, the discussion has focused on consultation in general. Before describing the last typology however, it is necessary to establish the context within which it occurs.

Organization Development (OD) consulting is a specific field of consulting that has been defined in a variety of ways by a variety of practitioners and theorists. The title is unfortunately ambiguous; many management consultants would say that their work involves organizational development. Beckhard defines OD as "an effort (1) planned, (2) organization wide, and (3) managed from the top, to (4) increase organization effectiveness and health through (5) planned interventions in the organizations 'processes', using behavioral-science knowledge" (Beckhard 1969, 9). This has been described as the "most widely accepted" definition (Boss 1989, 18). Another variant however, somewhat stricter because it actually requires a given change process to result in a change in organizational culture, is provided by Burke: "Organization development is a planned process of change in an organization's culture through the utilization of behavioral science technologies, research and theory" (Burke 1987, 11).

The distinction between management consulting and OD then, is one of both intent and
OD consultants set out to intervene in and change an organization using techniques derived from an established body of behavioral theory; most management consultants are considerably less ambitious.

Schein (1988, 5-12) has developed a typology of consultation that contrasts an organization development model of consultation--Process Consultation--with two traditional consultation models--Purchase of Expertise and Doctor-Patient. The typology is presented below, in definitional form.

<table>
<thead>
<tr>
<th>Consultation Type</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Purchase of Expertise</strong></td>
<td>the client defines a need within the organization, determines that the organization lacks the wherewithal to fulfill the need internally and so retains a consultant to fulfill the need by providing a pre-defined product or service.</td>
</tr>
<tr>
<td><strong>Doctor-Patient</strong></td>
<td>the client either decides that the organization needs a check-up or is exhibiting symptoms of a problem and so retains a consultant to examine and diagnose the organization and to provide an appropriate course of treatment.</td>
</tr>
<tr>
<td><strong>Process Consultation</strong></td>
<td>the client believes that the organization has a problem but is uncertain of its nature and so retains a process consultant to help the client to &quot;perceive, understand and act upon the process events that occur in the client's environment in order to improve the situation as defined by the client&quot; (Schein 1988, 11).</td>
</tr>
</tbody>
</table>
The key to the typology is the realization that in the traditional models, it is the consultant who is responsible for either diagnosing the problem, resolving the problem or both and that the client retains little or no initiative in the process.

Schein appears to argue that the Process Consultation model is an optimum approach to helping an organization. It does not rely on the accuracy of the client's diagnostic, communications or consultant evaluation capabilities or on the client's capacity to foresee the impact of the intervention on his/her organization, as does the Purchase of Expertise model. Neither does it depend on the client's accuracy in identifying the "sick" unit of his/her organization or the willingness of that unit to reveal accurate information about its condition or of the organization to accept the diagnosis and prescription of the consultant, as does the Doctor-Patient model. The Process Consultant focuses on process events, non-directively assisting the client in a joint diagnostic effort, optimizing the chances that the organization will (1) increase its innate ability for self-diagnosis and (2) "own" the resulting diagnosis and the change effort that evolves out of the intervention.

Schein identifies seven specific assumptions that underlie the Process Consultation model:

1. Clients/managers often do not know what is wrong and need help in diagnosing what their problems actually are.
2. Clients/managers often do not know what kinds of help consultants can give to them; they need to be helped to know what kinds of help to seek.
3. Most clients/managers have a constructive intent to improve things, but they need help in identifying what to improve and how to improve it.
4. Most organizations can be more effective than they are if they learn to diagnose and manage their own strengths and weaknesses. No organizational form is perfect; hence every form of organization will have some weaknesses for which
compensatory mechanisms must be found.

5. A consultant probably can not, without exhaustive and time-consuming study or actual participation in the client organization, learn enough about the culture of the organization to suggest reliable new courses of action. Therefore, unless remedies are worked out jointly with members of the organization who do know what will and what will not work in their culture, such remedies are likely either to be wrong or to be resisted because they come from an outsider.

6. Unless the client/manager learns to see the problem for himself and thinks through the remedy, he will not be willing or able to implement the solution and, more important, will not learn how to fix such problems should they recur. The process consultant can provide alternatives, but decision making about such alternatives must remain in the hands of the client.

7. The essential function of Process Consultation is to pass on the skills of how to diagnose and fix organizational problems so that the client is more able to continue on his own to improve the organization (Schein 1988, 10-11).

Although Schein appears to view Process Consultation as perhaps the only legitimate model for organizational intervention, others view it as one role within a range of roles. For example, the Process Counselor role within Lippitt and Lippitt's typology corresponds precisely with Schein's articulation of the Process Consultation model. Other practitioners view Process Consultation as only one technique among many different OD technologies (Plovnick 1982, 236).

Whether used as a model, role or technique, Process Consultation has an element of universality that is appealing. Every organization works through its processes and most of the problems within an organization are created or resolved in these processes. The approach is also non-directive and content neutral; health care settings are often quite volatile and such techniques would be inherently less threatening than specific content approaches that might trigger resistance from client staff--particularly physicians.
Interventions Within Health Care Organizations

The health care industry has been a growth area for consulting activity in general as well as for OD work. There is now a large body of significant literature describing a variety of interventions in academic medical centers, hospitals, health maintenance organizations, clinics, nursing schools, medical schools, health care institutions in general, health related public agencies, dental offices, long term care facilities and nursing departments. Findings from these interventions however, must be scrutinized carefully before they are applied to group practice settings because they arise from organizations that may be qualitatively different.

A review of the literature suggests that there is some controversy over the effectiveness of organizational development intervention within the health care industry. Weisbord (1976), reflecting on a series of interventions within medical center settings, notes that organizational development arose from industry and that science-based professional work differs markedly from product-based work. He describes the existence of three separate social systems within the medical center—Task, Identity and Governance—that "pull and tug at each other."

The Task system (known as management in industry and administration in health care) refers to a specific work organization, which seeks to coordinate three tasks: patient care, education and research. The Identity system refers to the professional development, or career track, in medical science, on which the status and self-esteem of health professionals depends. The Governance system is the network of committees, boards and agencies within and without Task systems, which set standards for the profession.

Each system has its own ground rules and membership requirements. Each is necessary to the others. Health center professionals belong to all three. Yet the Task system is, in many ways, at odds with the Identity and Governance systems, and vice versa (Weisbord 1976, 20).

Weisbord notes that "health administrators operate the least influential of the three, quite
the reverse of the situation of the industrial manager" (Weisbord 1976, 20) and concludes that OD has not worked in these settings--"so far"--because:

First, our knowledge is inadequate. Though we have some ideas about how to coordinate the major tasks, industrial theories shed no light at all on how to link the three systems in ways so that both individuals and organizations are enhanced. They do not, in particular, account for the consequences of a highly competitive Identity system, based entirely on individual achievement.

Second, our structure-reducing, interdependence-enhancing technologies do not work where there is no organizational payoff for interdependent behavior. To practice structure reduction in such an environment is to raise professional anxieties even higher, for these technologies seek to improve a set of conditions physicians do not value to begin with (Weisbord 1976, 26).

Plovnick essentially accepts this assessment of the situation, enumerating, in addition, four "major impediments" to the effectiveness of organizational development activity within health systems: "(1) the conflicting goals, priorities and orientations of groups of organizational members (e.g. care providers vs administrators); (2) lack of formal administrative training among many professionals managing health care systems; (3) the short-term crisis oriented perspective found in health care systems; and (4) the absence of clear structures within health care organizations to facilitate coordinated activity (Plovnick 1982, 236). Reviewing the literature, he suggests that health care systems may benefit more from structurally oriented interventions than from the traditional process oriented interventions utilized by most OD practitioners.

Nadler and Tichy (1982) characterize the results of a decade of experience in attempting to solve health care systems problems with organizational development techniques as "disappointing". They list three specific limitations for OD within health care settings: (1) the environmental pressure which these organizations are under, (2) the inadequacy of their management structures and (3) the relative absence of professional management and modern management techniques. They also suggest that
assessments be made of the managerial competence of relevant individuals within the organization, the capacity of the organization to carry out strategic planning, and the fit between strategy and organizational design, in preparation for any attempted intervention within a health care setting. They conclude that:

The frequent failure of OD in health care settings is not caused by the concepts or tools of OD or by the intractability of health care organizations. Rather, failure is caused by incorrect emphasis and targeting of effort. Tools that are effective in one sector of the economy or in one setting may not be effective in another. In health care organizations, the emphasis of OD efforts must be on environment, strategy, structure and political dynamics, in that order. The more traditional OD techniques should be used later in the organization's development sequence, when they can be employed with great probability of success (Nadler and Tichy 1982, 376).

A different viewpoint is developed by Brill and Pierskalla (1982), although the conclusions they reach go beyond the research they present, seem inadequately qualified and lack references to work in the field other than their own single study. Nonetheless, they feel comfortable concluding that:

Contrary to opinions generally held in the past, the best available information suggests that (1) OD has been used and is now being used in a variety of health care settings, (2) the failure of OD health care projects is more attributable to lack of knowledge and skill on the part of the practitioner than to the uniqueness of the health care setting, and (3) the application of OD concepts and techniques can result in a wide variety of benefits for the organization and its administrators (Brill and Pierskalla 1982, 391).

Curiously, there is no dispute within the literature relative to the volume of OD work occurring within health care settings. There is considerable comment relative to the effectiveness of that work, but it is widely acknowledged to be occurring. Secondly, the authors present neither data nor analysis to support the notion that consultant incompetence is at the root of OD failure within the health care environment--the issue is unmentioned until the concluding statement. Finally, there is no dispute over the theoretical benefits of OD work within health care settings or even over the existence of
successful OD projects within those settings. There is certainly a dispute over the relative frequency of successful interventions, a dispute that the authors provide little data or analysis to address.

The most recent literature on the subject seems somewhat defensive as well. Boss (1989) notes that part of the impetus for his book arose from a (negative) reaction, on his part, to comments from respected OD consultants relative to the impossibility of successfully applying OD within health care settings. The author then goes on to describe five "challenges" to change in the health care setting (i.e. technological pressures, consumer pressures, personnel pressures, financial pressures and management problems); ten "barriers" to change in the health care setting (i.e. autonomy expectations of health professionals, collective benefits of stability, calculated opposition to change, programmed behavior, tunnel vision, resource limitations, sunk costs, an accumulation of official constraints on behavior, unofficial and unplanned constraints on behavior and interorganizational agreements) and thirteen specific ways in which hospitals, alone, are uniquely different and difficult organizations (Boss 1989, 6-16). Boss concludes, primarily on the basis of case studies taken from personal experience, that successful OD interventions are possible, a point that, again, fails to deal with the relative frequency issue. Unfortunately, the author makes no attempt to generalize beyond the presented cases; we are not left with any theoretical insight as to why the interventions conducted by the author were successful.

Assessment of the Literature

There is clearly a debate within the literature relative to the effectiveness of OD consultation within health care settings, yet it is a debate whose terms are unclear. Weisbord's (1976) analysis, for example, is based primarily on his experience
with academic medical centers, one of the most complex organizational forms yet to be conceived by human beings. Large, physician managed, multispecialty group medical practices, while clearly the most complex of the medical practice settings, do not approach the degree of complexity exhibited by these centers. In addition, the Task system within these group practices would be operated by physicians acting as health administrators, not health administrators per se. Finally, one could certainly argue that while there is no organizational payoff for interdependent behavior in a medical center, ownership and management of the group practice by its physicians constitutes an element of common interest likely to foster the development of a higher level of interdependent behavior than that found within the medical center. These differences could conceivably allow for a sufficient reduction in tension between the three systems described by Weisbord--Task, Identity and Governance--to significantly increase the odds ratio for successful intervention within group settings. It would seem that caution should be used before applying Weisbord's conclusions en masse to group practices.

Plovnick (1982) accepts and extends Weisbord's analysis, adding lack of formal management training, crisis orientation and the absence of clearly articulated structures to the list of problems. His conclusion however, is not that OD, per se, is ineffective, but that structurally oriented OD may be more effective. His analysis provides both a statement of how difficult working in a health care setting can be, which is probably beyond challenge, and a working hypothesis for increasing effectiveness within that setting. Nadler and Tichy (1982) are similarly focused, supporting the argument on structure and absence of trained managers, yet concluding that OD can be successful if focused on environment, strategy, structure and political dynamics prior to resorting to the traditional process focus of OD.

Brill and Pierskalla (1982) and Boss (1989) seem preoccupied with rebutting an
argument that no one has actually made. The issue in the literature is not that OD does not work; it is that it has not worked as often as practitioners would have expected. Weisbord et al are looking at the half empty portion of the glass and attempting to explain why it is half empty; Brill, Pierskalla and Boss seem to be looking at the half full portion of the glass and contending that there is no problem because it is half full. In any event, this is not a debate; it is more a case of incomparably focused analyses.

Much of the work on consultation and OD within health care settings has focused on hospitals, certainly the most frequently occurring, complex, public and, until recently, resource rich of the health care organizations. Other organizations have been studied as well, but the volume seems to lie clearly on the side of the hospital world.

The literature search for this paper was unable to find a recorded intervention within a large, physician managed, multispecialty group medical practice. Actually, there has been little published about these practices even within the health services literature. This probably should not come as a surprise. There are relatively few such organizations in the U. S., although their numbers and strength are growing. In addition, they are privately owned organizations and privately owned by physicians at that. As a group, physicians are not noted for introspection nor for inviting close inspection from other professions.

The application of OD consultation approaches to health care organizations is relatively new however, and understanding the parameters of its effectiveness will involve a continuing effort to apply different techniques to different types of health care settings. Only then will a clearer pattern of effectiveness emerge.

Certainly the literature itself, as it now stands, creates an interesting dualism relative to consultation within health care organizations. This dualism involves the choice between process and structural interventions in these settings; there is also a conflict
involving the relative effectiveness of these two approaches within health care settings.

The first side of the dualism consists of process interventions and the technologies used in those interventions. Schein's typology leaves one with a choice of three consulting models, one of which--Process Consultation--is a process intervention technology.

Each of Schein's models impose a different set of burdens on the consultative process, burdens which must be overcome if the process is to be successful.

The Purchase-of-Expertise model assumes that the client possesses a sufficient level of technical ability and insight to correctly define the needs of the organization. There are several collateral assumptions as well, involving the client's ability to choose the "correct" consultant and to clearly communicate the needs of the organization to that consultant, but the primary burden would seem to be derived from the ability of the client to accurately assess both the explicit and implicit needs of his/her organization.

The Doctor-Patient model does not assume that the client possesses the ability to assess the organization. On the contrary, there is an explicit assumption that the client is at least unwilling and perhaps unable to make such a diagnosis. This model does assume that the client may be anxious enough about the organization to want a "check-up" or that s/he is capable of detecting the symptoms of organizational illness, but there is an assumed diagnostic incapacity on the part of the client--thus the need for a "doctor".

More importantly, the model assumes that the consulting "doctor" can obtain sufficiently accurate diagnostic information from the organization to make an accurate diagnosis and that the client will be able to both accept the diagnosis and implement the prescription. The burden here is that even the most well intentioned clients may be incapable of accepting a view of their organization developed outside of their own experience.

Within the context of physician managed group medical practices, the assumptions of
these two models are problematic. Most physicians have neither the propensity nor the training to produce acute assessments of their organizations. In the absence of this capacity, the ability of a physician manager to accurately define the problem and then select the correct consultant for that problem should be highly suspect.

There is a similar issue with the Doctor-Patient model. Physicians are the definitive diagnosticians, heavily invested in their sense of professional judgment and often authoritarian in the exercise of that judgment. Given the absence of propensity and training in management, it is a better than average wager that the professional consultant would reach an organizational diagnosis materially different from that held by the physician manager-client. Given that physicians, as a profession, are not generally noted for their ability to accede to the conclusions of competing analyses, the Doctor-Patient model also seems troublesome with respect to its use with physician managed group practices.

The Process Consultation model provides us with no such problems. The model seems to assume very little, in terms of capacities, on the part of the client: only that s/he believes that there is a problem with the organization and is willing to work with the Process Consultant to identify and address that problem. The assumptions set forth by Schein (N.B. see page 28) are more concerned with the dynamics and presumed benefits of Process Consultation than the specific things which the client must do or be in order for the consultation to succeed. As noted earlier, Process Consultation is content neutral; in addition to requiring little from the client in the way of innate organizational ability or capacity for acceptance, it is the model least likely to directly threaten the client.

On the face of it then, the Process Consultation model should be a reasonably successful approach for intervening in health care organizations or, at least, more successful than the two competing models would appear to be. Yet the literature suggests
that process interventions within these settings have, generally, produced disappointing results. There is a thread, running through the literature, to the effect that process technologies may not be optimally appropriate for health care settings.

The literature does not specifically address physician managed group practice settings however and there is, as already noted, no reason to assume that the factors at work in other health care settings which render process technologies ineffective, are equally present in these groups. The literature is also unclear, at times, as to what it means by process intervention. The use of specific process oriented exercises, such as a team building technique, is a qualitatively different type of process intervention than that anticipated by the use of Process Consultation at the model level.

We are left then, with ambiguity as to the specific usefulness of Process Consultation within large, physician managed, multispecialty group practice settings; we are left with a general theory that suggests it should be an optimally effective technology without regard to setting (Schein 1988), a set of findings which suggest that process interventions within health care organizations have been generally ineffective and several specific theories that seek to explain the apparent lack of fit between process technologies and health care organizations (Weisborg 1982; Plovnick 1982; Nadler and Tichy 1982).

This ambiguity can be approached in a variety of ways. This paper will approach it by attempting to shed light on whether or not Process Consultation is likely to be an appropriate technology for interventions within large, physician managed, multispecialty group medical practices, given the experience at DMG.

The other end of the dualism consists of a variety of structural interventions; the dualism itself embodies a conflict over the extent to which structural interventions are more effective than process interventions and should thus be the technologies of choice for
use within health care organizations.

Plovnick, reviewing the literature on interventions within health care organizations, describes four factors which often create structural problems within these settings. These factors—an absence of management training on the part of senior managers, conflicting goals within the organization, the presence of multiple professional groups within the organization (each with different norms, educational levels, interests and expectations), and a loose reimbursement system that allows providers to work in an environment where efficiency is neither valued nor required—suggest two reasons for assuming the primacy of structural interventions within these settings:

First, managing the inherent conflicts in health care systems requires greater clarification of mission, functional responsibilities, authority structures, reward systems, information systems and control systems—all aspects of organizational structure. Second, these structural issues have thus far typically been avoided by health care systems as a consequence of the intensity of the conflicts, insufficient structural expertise and a relatively benign economic environment (Plovnick 1982, 240).

Plovnick also notes that structural interventions "assume that many of the process problems identified in organizations are symptoms of underlying structural issues" (Plovnick 1982, 237).

Plovnick's analysis seems plausible, at least for pre-Prospective Payment System medical centers and hospitals, but it is not necessarily applicable to large, physician managed, multispecialty group medical practices. The four factors do not appear to pertain to these groups to the same extent that they appear to pertain to other health care settings.

There is no arguing that physician managed group practices, where management initiative resides solely with physicians, are managed by individuals with little or no management training; there is no way to circumvent the reality of the first factor—it is a
common problem across health care setting (although some physicians argue, in all apparent seriousness, that the real problem is the lack of medical training on the part of the managers).

There should be, however, fewer conflicting goals within these groups. For example, most medical centers are constantly trying to balance the competing demands of its patient care, teaching and research roles; group practices are usually involved solely in the provision of patient care. Senior management within hospitals and, in fact, all dual authority entities, is continually involved in attempting to reconcile the demands placed upon the organization by the medical staff with the demands placed upon the organization by the management staff. It should be expected that an organization in which the medical staff and the management staff were essentially one and the same would have to exert less energy to accomplish this integration.

There are also fewer professional groups involved in group medical practices and those that are involved, are clearly subordinate to the medical managers. While medical centers and hospitals have a full range of nursing and allied health professionals on staff, generally reporting to the hospital chain of command, group practices are primarily staffed by physicians and nurses, although there may also be radiology and lab technicians on the premises. The import of this is that there are not nearly as many competing professional power centers within group practices as there are in many other health care settings; most of the competition, in fact, seems to occur among the sub-specialties within the medical staff, all of whom at least share a commitment to the norms of the medical profession.

The financial factor appears even less applicable. Most health care settings are non-profit entities, existing off of a hodgepodge of federal and state government, hospital and medical service plan, private insurer and individual out-of-pocket funding. While the
source of funding is generally the same for group practices, these entities are profit
making entities. As such, they and their shareholders have every incentive to maximize
organizational efficiency as a way of maximizing revenue. Large groups such as DMG, that
have involved themselves in managed care programs, have an even greater incentive to do
so.

What then, does all this mean in relation to Plovnick's two reasons for hypothesizing
the primacy of structural interventions within health care settings?

While there may be "inherent conflicts" within most health care settings, there is
every reason to believe that the nature, scope and intensity of these conflicts within large,
physician managed, multispecialty group practices are of a much smaller order and
magnitude. While some health care systems may have "avoided" dealing with structural
issues because of the intensity of the conflict, the absence of expertise and the benignity of
economic pressure, the only variable among these that seems pertinent to physician
managed group practice is the absence of expertise: conflict intensity should be relatively
less of an issue in these groups, as discussed above, and there is a clear economic incentive
in the other direction--to address and resolve structural issues that are impeding the
maximization of profit.

All of which suggests that there is no reason to presume that these groups should be
in any greater need for structurally oriented interventions than would be any other
normally conflicted organization or that these types of intervention should take precedence
over the more traditional process oriented interventions.

Once again then, we are faced with ambiguity. Plovnick's review of OD interventions
within health care organizations led him to hypothesize that structural interventions
within these settings may be more effective, and thus primary to, process interventions.
Yet his explanation of why that appears to be true is inconsistent with an understanding of
the dynamics which prevail within physician managed, multispecialty group practices. Within the context of the DMG experience then, this paper will also attempt to provide some insight into the applicability of Plovnick's structural primacy hypothesis to large, physician managed, multispecialty group medical practices.
CHAPTER 2

THE DOWNTOWN MEDICAL GROUP CONSULTATION

Introduction to the Case

Description of the Practice and the Operating Environment

With the previous discussion as background, it becomes possible to meaningfully describe the history and operating status of the Downtown Medical Group (DMG) as it existed in 1987 and as I understood it prior to my entry into the Group as a consultant.

The DMG was established in the early 1900's, making it one of the first group practices in the eastern United States. It existed for a number of years as a small, fee-for-service practice in a large urban environment. In terms of the Madison-Konrad typology, its Organizational Tradition was individualistic-autonomous. The Group allowed its physicians maximum personal and professional autonomy and avoided any external entanglement which might have compromised the autonomy of the Group as a whole; its Market Response Strategy was reactive.

All of the Shareholders and all of the Board members were physicians in practice within the Group; there was no CEO, per se, although there was a Finance Director. Until 1978, there was no "Board" per se; management decisions, to the extent that such appeared necessary, were made by an Executive Committee of the Shareholders meeting informally with the Finance Director. There were Departments, defined by specialization, but there were no Department Heads in a formal sense; the most senior physician in each Department was looked to, on an informal basis, for professional guidance or protection in the case of conflict with other members of the Group or within the Department.
In 1978, at the urging of its Finance Director and after a period of being pursued by a major health insurer interested in a joint venture, the Group became a partner in the development of a Group-model HMO. As the insurer enrolled new members and the HMO grew, so did DMG.

By 1987, DMG was a large, physician managed, multispecialty group practice that owned half interest in a 35,000 member HMO. Its 1987 gross revenue was $30.5 million, with $16.5 million of that derived from the operations of the HMO. In 1978, DMG had 20 physicians on staff, practicing in 7 specialties. In 1987, there were 111 physicians on staff, practicing in 16 specialties. Approximately thirty of these physicians were Shareholders; the rest were under contract, although some of these would also eventually be elected eventually to Shareholder status. In 1987, DMG employed approximately 500 individuals, from parking lot attendants to Radiology and Lab technicians and MIS professionals.

The Finance Director had been forced to leave in the early 1980's, as a result of financial irregularities that came to light when the insurer underwrote the construction of a new, state-of-the art clinical building for DMG. The Shareholders, in response, adopted an amendment to their by-laws requiring that the Chief Executive Officer of the Group always be a physician practicing within the Group. Dr. William A. Blakeley, a respected DMG pediatrician, assumed responsibility for functioning as a part-time CEO. Another Finance Director was hired to report to the new part-time CEO. Aside from these changes, the management structure of the Group in 1987 was essentially unchanged from that which existed in 1978.

From the outside, DMG looked quite successful: more patients, more physicians, more revenue, a new state-of-the art health center underwritten by the insurer partner.
The key to a successful HMO however, is the cost-effective management of its health care inputs. The key to a successful group practice involved in an HMO, is the effective management of the care process within the constraints of its capitated budget.

On three separate occasions between 1978 and 1986, DMG had incurred significant losses because of its inability to manage the delivery of care under what was thought to be a liberal capitation agreement. In each case, the insurer turned the losses into a long term debt for the Group, removing them from immediate financial pressure. In 1986 however, the Group lost $2.6 million in inpatient and referral risk sharing revenue; in 1987, another $3.1 million in losses were incurred. There were other incremental losses as well. Altogether, the Group faced a total of approximately $4.8 million in current liabilities at the end of 1987. The HMO, staggered by poor performance in marketing and unexpected higher costs, was in even worse financial shape.

DMG had been forced, over the years, to incur higher levels of long term debt in order to cover its short term losses. Each time it did so, it became a less attractive partner for a business deal involving any suitor other than its current partner. Now, the only way out for the HMO and DMG, was a merger of the HMO with another entity. Given the financial status of both parties, only DMG's current partner was overtly interested in a merger. The insurer owned a staff model HMO subsidiary; it was decided that their Group model HMO would be merged with that product line.

The price of the merger would have to be DMG's interest in the HMO and the transfer of a larger proportion of ownership of the new clinical building to the subsidiary. In return, the insurer would pay DMG a large sum of money and convert the remainder of its short term liability into debt. DMG would survive, but with an even higher long term debt load and as a vendor in a relationship that provided it with less leverage than ever before.
for influencing its destiny. Adding to the risk, it was a cross cultural marriage. Staff model HMO's are definitively heteronomous in Organizational Tradition and their Market Response Strategy is usually highly proactive. By 1987, DMG had clearly chosen a proactive Market Response Strategy, but it had been unable or unwilling to move much beyond its individualistic-autonomous tradition. The new HMO's organizational culture, designed by its insurer owners to be rigidly hierarchical and management dominated, would probably be hostile to that of DMG's; it had certainly seemed that way during the merger negotiations.

The merger itself was to be effective on January 1, 1988. Due to the vagaries of claims processing and the absence of effective management information systems within DMG, the Group would not have a firm handle on the statistics of its first quarter hospital utilization and referral performance until the end of the second quarter. At that point in time, the failure (or success) of the Group, relative to changing the clinical behavior of its physicians, would become apparent.

If the Group had met its targets, it would make money. If the Group had failed to meet its targets, it would be facing a deficit that could range anywhere from $25,000 to $1,000,000. A deficit would require the Group to make a series of difficult management decisions almost immediately, decisions the Group was now entirely unprepared to make and enforce, if it was to have any chance of liquidating the first quarter's deficit and what would be an assumed deficit from the second quarter. The decisions would have to be harsh enough to ensure that the Group performed even better than its third and fourth quarter targets--or else it would not be able to liquidate the deficits from the first two quarters. If it could not do this, January 1, 1989 would find the Group insolvent. It had no reserves left; its insurer partner had made it clear during the negotiations that it would be unable
and unwilling to come to the financial aid of the Group again. If the Group could not perform as contractually agreed upon, it would cease to exist.

The physicians in the Group appeared to be very angry at events, although they seemed uncertain as to how and where to vent that anger. There was some talk of firing their CEO; other physicians preferred to blame the insurer, the management of the HMO and other external forces.

It was at this point in DMG's history that Dr. Blakeley asked if I had formed any opinions relative to the management of the Group.

**Notes on the Case**

In the presentation of the case which follows and, in fact, throughout the text of this paper, the names of the medical group, its physicians and staff have all been changed to preserve the principle of client confidentiality.

Throughout the narrative of the intervention, I have used "the consultant" as a replacement for the first person singular pronoun.

Blake and Mouton (1983), Lippitt and Lippitt (1986), Schein (1988) and Burke (1987) have all described the phases or steps of a consulting intervention and all of their models are slightly different. This paper structures the narrative of the intervention along the lines suggested by Blake and Mouton, since their model most clearly reflects the phases (or steps) which this consultation actually followed. I have taken the liberty of integrating the Planning and Implementation phases of their model in this narrative, since that also reflects the course of events that took place at DMG.

The literature search component of the research for this paper was accomplished by a review of four major indices: the Business Periodicals Index, the Social Sciences Index,
the Public Affairs Information Service and the Cumulated Index Medicus. Each was searched from 1979 to the present. Books in Print, the Institute Card Catalogs and Barton were also searched for relevant materials. Drs. Donald Schon and Edgar Schein were very helpful in recommending specific materials for the paper as well.

There is a great deal to be said for being able to surreptitiously observe the activities of one's research subject before it is aware that it is a research subject. Between June and December of 1987, I was able to freely interact with individuals from DMG. I was working on the HMO project and was therefore of no threat to anyone at DMG. Under those circumstances, communication was relatively unguarded; probably as unguarded as I would be able to obtain short of becoming invisible. It was an invaluable opportunity to gather data about the organization from avenues that would become more guarded and, in some cases closed, once I was engaged to consult with the Group.

In a formal sense, several lengthy interviews were conducted with Dr. Blakeley shortly after his acceptance of the proposal letter. These were used to generate background on the Group and covered past history, current operating status, organizational structure, critical issues before the Group, his perceptions of problems facing the Group and his goals and expectations for the consultation.

Subsequent to these discussions, between the middle of January and the end of February, partially structured interviews were conducted with each member of the Board (i.e. ten interviews in all); open ended interviews were conducted with each member of the senior management staff (i.e. six interviews in all). During the same period, a number of "corridor interviews" were conducted and informal discussions were certainly ongoing. These discussions were very helpful in clarifying, corroborating and evaluating the data obtained from the more formal interviews. I was also in attendance at meetings of the
Board and routinely met with Dr. Blakeley; there were no staff meetings, per se, to attend, although I did attend one Group-wide Utilization Review meeting.

Copies of all relevant organizational materials were requested and reviewed. Unfortunately, this meant a copy of the articles of incorporation and by-laws, approximately one year's worth of Board minutes, two years of audited financial statements and a few Board meeting handouts. There was very little formal documentation to review. The organization did not have a Mission Statement or any kind of plan (e.g. Strategic, Business, Long Range, Short Range, Contingency, etc). Since there were no regular staff meetings, there were no materials from these meetings to be reviewed.

Having worked on the merger negotiation, I was already in possession of a variety of documents relative to DMG and its relationship with the HMO.

A report summarizing the interviews, discussing results and recommending a series of activities was drafted in late February, reviewed with the CEO and submitted to the Board of Directors the first week in March. A special half day session of the Board was called so that I could present and discuss the report with its members. At the end of the morning, the Board adopted the report and established an Implementation Subcommittee to work through the recommendations. The Subcommittee was to report back to the Board on a regular basis. Dr. Blakeley, one of the most senior physicians within the Group, and two of the younger, more management oriented physicians were assigned to the Subcommittee.

One of the recommendations in the report called for the creation of a new senior management position within DMG. That position, Director of Management Services, was to be filled by Ms. Paula Wilson, a formally trained health care manager who moved over from the HMO staff to take that position. Between the middle of March and the end of May, Ms. Wilson and I worked with the members of the Subcommittee, discussing the nature of
the recommendations, working on implementation steps and reporting regularly to the Board.

During this time I increasingly distanced myself from the process, becoming a shadow consultant to Ms. Wilson, so that she could gradually assume responsibility for the process which had been set in place. I was essentially out of the Group by the middle of June, although Ms. Wilson would often call me informally to discuss a particular issue or problem and I did design and conduct a one day training session for the members of the Board elected at the end of June.

In January of 1989, I was contacted by Ms. Wilson and asked to attend a meeting at DMG to discuss an evaluation of the work done to date. I attended the meeting, as did Ms. Wilson and Dr. Blakeley, and we discussed a variety of issues, including timing, appropriateness (i.e. would it be better for another consultant to conduct the evaluation) and expectations. The Implementation Subcommittee had developed a set of questions they were interested in having answered; it was not anticipated that the evaluation would go much beyond those questions. We agreed that I would do the evaluation.

Following essentially the same interview process, supplemented this time by a large body of written material and interviews with newly chosen Department Heads, a report was developed and submitted in August of 1989. It was considerably less directive that the 1988 report. It contained few specific recommendations, concentrated on answering the questions posed by the Subcommittee and identified additional questions and areas that needed to be addressed. There was an open meeting of the Board and management staff at the end of August, during which I answered questions about the report. The Board then chose to instruct its new in-house staff to follow-up on the report.
The Consultation

Entry

The process of entering DMG probably began in June of 1987, when the consultant was retained to assist with the HMO merger negotiation process. While Dr. Blakeley's presence in the process was sporadic, he was, in essence, the chief negotiator for DMG's interests. For six months, Dr. Blakeley was able to watch the consultant interact with the staff of the HMO and the members of the negotiation team; of course, the consultant was watching Dr. Blakeley as well.

Formal entry began in November of 1987, when Dr. Blakeley stopped by the consultant's office and, in the course of conversation, asked if the consultant had formed any opinions on the management of DMG in the six months he had been on the premises. Recognizing both the technical (absence of a prior data gathering effort) and political (conflict of interest and self preservation) problems inherent in the question, the consultant replied that he had formed several impressions--nothing quite as formal as an opinion--but that his primary goal had been to work through the merger process, not to assess the management of the Group.

Dr. Blakeley replied that several members of his Board were pushing him to retain outside assistance; they were concerned with the management of the Group. The consultant asked Blakeley if he thought there were, in fact, problems with the Group's management. Blakeley replied that he didn't see any real problems, although he did think that an outside consultant might be appropriate to help "reorganize" the management of the Group, now that its relationship with the HMO would be changing. He asked the consultant to send him a letter outlining the "impressions" gathered to date on DMG's management. The consultant
replied that he had a few issues to think through before he could commit to such a letter, briefly noting both the technical and political issues involved. Blakeley replied that (1) he understood the impressions would be just that, but he needed the input to help him think through whether or not there was any basis for retaining a consultant and (2) since the merger project was coming to a close, the conflict issue seemed marginal—he would be willing to wait a few weeks for the letter.

On December 16, 1987, the consultant submitted a four page letter to Dr. Blakeley. It reiterated the technical concerns, noting that the views were "impressionistic" in nature and constituted generalizations based on two specific incidents that had come to the consultant's attention. The letter recounted the specific incidents in detail.

One of the incidents had occurred during a DMG Board meeting at which the consultant had been present and involved the way in which the Group responded to negative results from audits conducted by the U.S. Health Care Financing Administration and the state Blue Cross plan. Both audits, one focused on the Group's Medicare patients and the other on elderly subscribers to a Blue Cross Medicare Supplemental Insurance Plan, had determined that the Group had provided and was reimbursed for significant levels of medically unnecessary care; both required the payback of substantial revenues already received by the Group.

Management had simply informed the Board of these findings. There was no attempt to place the findings within any specific context or to suggest that they required either a policy or programmatic response. The Board members seemed angered by the findings, but comment was devoted to (1) the inability of bureaucrats (i.e. auditors) to correctly evaluate the practice of medicine, (2) physician perception as to the lack of technical sophistication involved in the audits and (3) the notion that many of the claims in the audit
sample were rejected on the basis of technicalities (e.g. incomplete medical record, failure to include the diagnostic code on the claim form, absence of a physician signature on a claim form) rather than on the basis of actual inappropriateness of care. Management did not respond to this discussion. Finally, the Board voted to authorize the Finance Director to pay the necessary sums.

The second incident involved the manner in which Group dealt with an oncologist who had been in default of his contract with the Group for more than a year. The contract specifically required (among other things) the oncologist to (1) see DMG patients at DMG—not at his own office, (2) to be on site for 1.5 days per week and (3) to have all necessary Lab and Radiology work done at DMG. The oncologist had consistently violated these provisions, costing the Group money and inconveniencing its patients.

In this case, management had let the issue linger for approximately one year, even though non-compliance was costing the Group thousands of dollars. The President had sent several letters to the oncologist and had met with him as well; promises were apparently made, although nothing was committed to writing, but none of the promises were kept. Enforcement of the contract continued to slip between the cracks.

Finally, the President decided to open negotiations with a major teaching hospital, hoping to persuade its oncology service to enter into a referral arrangement. After several months of negotiations, a mutually advantageous agreement was reached and the Board was informed that execution of a new contract for oncology services was imminent. Within a short period after the Board discussion, a delegation of internists and family practitioners appeared at Dr. Blakeley's office to inform him that (1) they "liked" the current oncologist and (2) they would refuse to refer their cancer patients to the teaching hospital service; they would continue to use the current oncologist. Dr. Blakeley then had a staff
member call the teaching hospital to inform it that DMG was pulling out of the agreement. The current oncologist, hearing that the Group had negotiated to replace him with the teaching hospital service, canceled his referral agreement with DMG, leaving it without coverage. The situation was resolved only when it was noticed that an internist recently recruited by the Group was also an oncology sub-specialist; she had not yet started work with the Group, but she was contacted and agreed to serve as the Group’s oncologist.

The consultant's letter sketched his perception of the negative consequences incurred by the organization as a result of the ways in which the two incidents had been addressed, consequences that had been, in fact, quite costly from an organizational, financial and patient care point of view. The consultant suggested that the incidents indicated "inadequate and ineffective management of the organization's policy development and implementation processes". He also cited a "lack of appreciation, understanding and/or acceptance of the proper role of management in directing the organization, the possible unwillingness to accept the need to change individual behavior for the benefit of the organization as a whole and the absence of management trained expertise at the management team level" as possible complicating factors (Slavin 1987).

Dr. Blakeley called the next morning, quite angry. He insisted that the consultant had misrepresented the incidents discussed in the letter and, in any event, had reached conclusions far beyond the scope of those two cases. The consultant directed him back to the introduction to the letter, where the cases had been fully qualified and where the analysis had clearly been described as impressionistic. He then asked the President to describe how the incidents had been misrepresented. Dr. Blakeley responded with a list of additional details related to each incident, most of which were already known to the consultant and had been deliberately omitted from the letter in an attempt to capture the essence of each
case. In the consultant's mind, the additional details were extraneous. Dr. Blakeley seemed to believe that the impact of these details was such that, once known, the consultant would feel compelled to change his impression of the cases. Blakeley also wanted to know who had told the consultant about the oncologist situation.

The consultant replied that the details were interesting, and that he could see how important they were to Dr. Blakeley, but that he, the consultant, tended to be more impressed by the details, and particularly the outcomes, already described in the letter. Perhaps, the consultant suggested, this was a classic case of a physician's view of a situation versus a manager's view of a situation; perhaps it would be worth getting together to discuss why the two views were so far apart. The issue of source was avoided. Dr. Blakeley noted that the letter was not very helpful to him and terminated the call rather abruptly.

The consultant went about wrapping up his involvement in the merger negotiations. He did not particularly expect to hear from Dr. Blakeley again, at least not relative to a consulting engagement. A week later however, Dr. Blakeley telephoned the consultant and suggested a meeting. The consultant agreed to meet with him and suggested that Ms. Paula Wilson attend the meeting. Ms. Wilson had been the Director of Planning at both the HMO and the Group for several years. Although a theoretically joint position, her office was at the HMO building and the bulk of her work had been HMO related. She was expected to move over to the Group and assume new, as yet unspecified, management responsibilities. The consultant had worked with her on the merger negotiations and had been impressed with her intelligence, management ability, and interpersonal style. If there was going to be an organizational development effort within the Group, she would be the best possible in-house contact. Dr. Blakeley agreed to invite her.
The meeting was held a week later. Dr. Blakeley was somewhat sharp--he had apparently not forgotten the letter, but he did not want to discuss it either. He disagreed with it and was willing to argue at length about why it was wrong headed, but the argument was one sided--nothing short of capitulation on the part of the consultant was going to be satisfactory. The consultant asked about the purpose of the meeting, hoping to shift to more positive ground. Dr. Blakeley said that the Group was going to need to draft a few job descriptions and inquired as to whether the consultant would be interested in the work.

There was an hour or so of discussion about the job descriptions and about the need for a broader look at how the Group managed its affairs. Ms. Wilson supported the consultant, noting that the Group had never had a consultant in before and that it might be worth the results. Blakeley continued to be unclear about just what a consultant would do and how s/he would go about doing it. The consultant suggested several potential processes, noting that there was no one right approach: he explained that this was more like exploratory surgery than a straight appendectomy. Two preconditions however, were that the consultant needed reasonably free reign to move throughout the organization as necessary and that he would need the support and participation of top management for the project.

In discussing the proposed consultation, it seemed clear that Dr. Blakeley was threatened by the potential of someone "looking over my shoulder and second guessing my decisions". It was also clear that he believed the problems of the Group to be minimal and primarily caused by events and actors external to the Group. The consultant assured him that whatever the issues turned out to be, they could be explored jointly--that issues, findings and interpretations would be brought back to him before they were distributed elsewhere in the organization and that there would be ample time to think through what
was being said and what needed to be done. The consultant noted that, in fact, a joint process was preferable—that the consultant did not want to be perceived as being out there in the organization on his own. The consultant reminded Dr. Blakeley that either party could walk away from the process at any time and suggested that he develop a letter summarizing the approach he was proposing to the Group. Dr. Blakeley agreed and the meeting ended on an amicable note.

**Contracting**

It is generally accepted, within the literature, that the contracting phase of a consultation process involves the development of both a psychological and a services contract.

The psychological contract had been in development for some time, yet it was far from satisfactory. Dr. Blakeley was shaping up to be a considerably less than ideal potential client. After the meeting, the consultant had described the situation to a colleague, one with a great deal of experience working with physicians, who had responded by suggesting that DMG sounded like “the original client from hell.” Reviewing his notes, the consultant understood the characterization. While Dr. Blakeley seemed open to the idea of a process that went beyond the drafting of job descriptions, he was certainly less than enthusiastic about the notion and was still unclear about what that process could possibly achieve. He had certainly not committed himself to participating in anything.

There was also his denial and defensiveness to consider.

During the negotiations, Blakeley had essentially blamed the insurer and the HMO for DMG’s predicament. Even though the Group had lost millions of dollars by not meeting mutually agreed upon utilization targets, Dr. Blakeley was either unwilling or unable to
accept responsibility for those losses on behalf of the Group. He consistently became angry at implications that physician behavior had been problematic and would vehemently catalog a list of other factors which he viewed as more relevant to the financial status of the Group. His response to the "impressions" letter had been typical in that regard. While he had specifically requested the comments from the consultant, his reaction to them was clearly defensive. It seemed almost impossible for him to accept that either he or the physicians in the Group bore a portion of responsibility for the disarray at DMG.

His comment about second guessing decisions seemed most to the point: he neither wanted nor needed a consultant acting in ways which might further deteriorate his position with the Shareholders.

The only psychological contract the consultant was willing to enter into, was that there would be no surprises for Dr. Blakeley; the President would know what the consultant was going to do before the consultant did it, he would see written materials before they went anywhere else within the organization and he would have an opportunity to comment and suggest alternative interpretations and/or wording, if he saw the need to do so.

Blakeley's psychological contract however, appeared to require the consultant to be as protective of the President's position as possible. While the consultant was, in fact, willing to be somewhat protective of the President, he was not willing to accept as reality those perceptions of the President that seemed to be formed primarily by denial. The consultant was reasonably certain that Blakeley would view any course of action not reflecting his (Blakeley's) sense of reality to be unprotective of his position.

Drafting a letter agreement was difficult as well. There was ample reason to believe that the Group could benefit from some form of consultation process. It also seemed clear
that Dr. Blakeley thought of that benefit primarily in terms of a few job descriptions. The consultant decided to (1) draft as specific a letter as possible, given the circumstances, as a way to try once more to convey a sense of what Dr. Blakeley could expect from the consultation and (2) include the job description tasks as part of a three phase process. While the consultant would negotiate specific elements of the letter if necessary, he also decided that he would withdraw from the assignment if it became clear that Dr. Blakeley was solely interested in the job description segment. The consultant was not interested in rearranging the deck chairs on the Titanic.

On January 7, 1988, the consultant delivered a two-page proposed letter agreement to Dr. Blakeley's office. The letter outlined three areas of activity for the proposed consultation process:

1. Position Assessment and Job Description Development

This would involve the assessment of existing management positions and their amendment, where necessary; the articulation of new organizational charts for DMG; the development of new job descriptions and the implementation of these positions through a process which would effectuate employee understanding of the new roles and responsibilities.

The goals for this phase would be to ensure that (1) all of the functions thought to be necessary for the optimal management of DMG are defined and allocated to key management staff through their job descriptions and (2) the job descriptions are clear, concise and accurate representations of the responsibilities held by the respective incumbents, upon which their performance can be fairly reviewed on an annual basis.

2. Assessment of Board-Management Staff Interface

This would involve observation of Board meetings; the review of agenda development processes and issue follow-up processes for such meetings; the conduct of a partially structured interview with each Board and Management Staff member; the development of a report that identifies Board-Staff interface issues which exist, if any and the presentation of that report to the Board and management staff,
perhaps in a retreat setting.

The goals for this phase would be to (1) assess whether Board-Staff interface issues exist which hamper the optimal management of DMG and (2) address these issues in a coherent manner and attempt their resolution through both individual and group processes.

3. Interactive Observation of the Management Process

This would involve observation of both general and issue related management meetings; the suggestion of appropriate goals, objectives, strategies, tactics or processes, either during meetings or for discussion after meetings; the dissemination of support material for management process issues identified during this phase and, if necessary, the development of a report which summarizes and suggests longer term approaches for addressing these issues.

The goals for this phase would be (1) the assessment of the cohesiveness and efficacy of the organization's management processes and (2) to provide management development services by interacting directly with line management staff (Slavin 1988a).

There was additional language in the letter reiterating the consultant's need for access to the organization and for the support and participation of top management.

Dr. Blakeley called on January 10th. He wanted the exploration limited to the management level; he saw no need to involve staff throughout the organization, but he agreed that the consultant would have complete access to anyone and everyone at and above the Director level. Dr. Blakeley also designated Ms. Wilson as the organizational contact for the consultation. The consultant agreed with both provisions and asked if he should rewrite the proposal letter. Dr. Blakeley replied that the letter was fine. It would be countersigned and returned in a few days; the consultant could start as soon as his convenience would allow.

Diagnosis

Burke (1987, 72) notes that the diagnostic phase of a consultation process consists
of the gathering of information and its analysis. The consultant had actually been gathering information relative to DMG since June of 1987. As an opening exercise, he drafted a memo summarizing everything he had learned about the Group to that point. The contents of that memo, for the most part, can be found in the "Description of the Practice and the Operating Environment" section of this Chapter.

The consultant had also been attending Board meetings on an intermittent basis since June of 1987. He continued to attend meetings and to supplement his data gathering with a review of the by-laws and Board minutes. Other facts relative to the operations of the Board would be brought out in conversations with Dr. Blakeley and through the interview process.

In theory, the Board was elected annually by the Shareholders and was composed of five departmental representatives, two at-large representatives and the President. Each of the five major departments (i.e. Internal Medicine, Family Practice, Ob/Gyn, Pediatrics and Surgery) would nominate one of their physicians as a candidate, the Shareholders would consent to those individuals and would then select two additional physicians for the at-large seats. It was understood that the departmental nominees were placed on the Board to represent the interests of their departments.

In reality, anyone who wanted to sit on the Board could do so. The only practical limitation on Board size then, was the utter lack of interest towards the process shown by most physicians. At the time of this intervention, there were ten physicians on the Board. Dr. Blakeley served as its Chairman on a de-facto basis.

On average, the Board met every two weeks, although there were long stretches where it met weekly. Many of the meetings lacked an agenda; support materials for the discussions were almost never available before the meetings and often just not provided.
Minutes of the meetings were kept, but they often failed to provide a clear decision record, even in those instances where decisions were clearly made.

The meetings themselves often seemed relatively unproductive, in terms of specific decisions being made or higher levels of understanding relative to a given problem being attained. They were held in the morning, at 6:30 or 7:00 A. M. and promptly at 8:00 A. M., in the middle of a sentence if need be, all of the Board members arose and left for their examining rooms. The President was clearly dominant at the meetings and would introduce the topics to be discussed, yet beyond that, he exercised little leadership. Board members would interrupt each other, discourse at length about a topic and change topics at random. They would involve themselves in the smallest of operational issues. It was often clear that the members had not carefully read the few meeting materials that had been provided. Few of the physicians had apparently ever learned how to listen to or hear what someone else had to say and there was a marked tendency to personalize issues.

Board members seemed completely unable to compromise on issues and an important proposal before the Board would often fail because the interested members lacked the skill necessary to move it through by amending its provisions until the proposal commanded a majority. The Board would spend weeks talking about an issue, careening back and forth between diametrically opposed approaches to resolving it, before finally deciding to take no action at all.

Perhaps more seriously, the Board members viewed themselves as having no authority to resolve major issues: these were routinely sent to the Shareholders for resolution, usually after weeks of acrimonious inaction, where the same dynamics would be played out with thirty individuals rather than ten--individuals who understood even less about the issue than the ten who had spent hours debating it before sending it there.
The consultant had also been gathering information on the Chief Executive Officer of the organization: Dr. William A. Blakeley. Dr. Blakeley had been born in a working class family and had worked his way into an Ivy League college, a prestigious medical school and equally choice internship and residency assignments. He was a very respected pediatrician who genuinely seemed to like working with children.

Highly intelligent, articulate and possessing great integrity, he could also be arrogant, insensitive and abusive. Perhaps worse, he seemed to have little or no insight into the impact of his behavior on people, although he was always sheepishly apologetic on those rare occasions when he was confronted by a victim of that behavior. He also lacked insight into what he did not know—a relatively serious problem for a non-management trained CEO in an increasingly difficult business environment.

He appeared to have a serious need for control and within the Group, held the positions of (1) Chairman of the Shareholders, (2) Chairman of the Board, (3) President & CEO, (4) Medical Director and (5) de-facto Chairman of the Pediatrics Department. On the outside, he was President of his temple and manager or coach of several of the local athletic teams on which his children played. Despite his heavy professional schedule, he found time to go to Little League Umpire school and would often talk about "great calls" he had made and "awful calls" other umpires had made. It seemed completely in character: he was not satisfied just telling his team members what to do, so he became an Umpire so that he could tell everybody what to do. He kept a copy of the Official Little League Rule Book at his desk; it was not unusual to walk by his office and see him absorbed in its intricacies.

Dr. Blakeley's social skills were underdeveloped and he would often not know how to politely interrupt a conversation, make his point without verbally assaulting the other person, offer advice without turning it into a command, listen to a different viewpoint
without interrupting or give a compliment for work well done.

During the merger negotiations, he was clearly in denial about the Group's contribution to the state of affairs; he was often highly defensive about matters which were relatively trivial in the grand scheme of the negotiations. Even worse, he could be erratic: on Monday, a given point would be a deal breaker and he would harshly insist that the other parties accept DMG's interpretation of that point—on Friday, he would nonchalantly give the point away, often without any visible gain to his negotiating position or prior discussion with the other members of his negotiating team. He seemed incapable of articulating and consistently following a long term strategy. Over time, the consultant became convinced that these were not situational responses: they were a fundamental part of Blakeley's personality.

While his managerial and personal skills were problematic, he was actually an excellent businessman. He understood the business side of medicine better than anyone else in the Group; he understood the mechanics of practice and could translate those mechanics into reasonably sound business decisions.

The consultant had not interacted directly with most of the DMG senior management staff. He knew that there were six such individuals: a Patient Services Director, a Finance Director, who had been involved in the merger negotiations, an Associate Medical Director, an MIS Director (also a joint position with the HMO), a Director of Physical Plant and Equipment and Ms. Wilson, who had served as the joint Planning Director and who was now to be added to this group as a senior manager.

Immediately after Dr. Blakeley's phone call on the 10th, the consultant scheduled several meetings with the physician. During these sessions, Dr. Blakeley provided background details about the organizational structure of DMG, its group and intergroup
processes, the Board election process and the current configuration of the Board; the consultant provided a set of questions he wanted to use as the basis for interviewing members of the Board and a sample memorandum which he suggested be sent to the Board members in advance of their interviews. The consultant told Blakeley that he preferred to use an open ended interview process with the Group's managers; Blakeley raised no issues about either point and promised to send a memo to the physicians which was, in fact, done.

During the discussions, the consultant again made it clear that he needed Dr. Blakeley's participation if the process was to be effective. The consultant volunteered to share a summary of the interview results, if Dr. Blakeley thought that would be helpful; Blakeley accepted the offer.

It was the consultant's goal to be as non-directive as possible during these interviews, although he had also decided that no purpose would be served if he had to frame each question carefully and omit others in order to minimize the possibility of a confrontation with Dr. Blakeley. There were times however, when even a relatively neutral question would trigger a defensive outburst from Dr. Blakeley, as in the following example:

Consultant: I'd also like your permission to look over DMG's strategic or long range plan, if that would be acceptable. I understand that it's probably proprietary information; it will be held in the strictest confidence.

Dr. Blakeley: We don't have one.

Consultant: Well, perhaps a one year plan then; an operations or contingency plan?
Dr. Blakeley: Ah...we don't...ah...have any of those either.

Consultant: All right...well...do you have a plan of any kind
then...something that looks at your operating
environment and your internal operations, sketches
the issues that the Group is facing and ...

Dr. Blakeley: Look...we don't do that here. (Voice rising) Is this a
problem? Are we supposed to have these things? Is it
supposed to be some kind of problem that we don't?
We're not AT&T here; we're physicians...we practice
medicine, we don't make widgets.

Consultant: (Silence) Well...OK...you ask me if this is a problem.
There are two issues here. I would have used the
documents to help familiarize myself with DMG. That
isn't really a problem; I can compensate for their
absence with other approaches. The other issue, is
whether or not it's a problem for DMG, as an
organization, that it doesn't have them. I don't have an
answer for that yet; hopefully, we'll decide on that
answer together. I will say that, at first blush, it is
surprising that an organization this large, in this
competitive a market, has no such plans and,
apparently, no institutionalized planning process. I
agree that you are not AT&T; but surely you'd agree
that you're not Pete and Tilly's variety store
either...wouldn't you?

Dr. Blakeley: I was afraid of this...you don't understand the practice of medicine. You don't understand how we do things around here. You're going to try and turn us into some mindless bureaucracy.

Consultant: If you really think that's why I'm here, then you should ask me to withdraw now. We're just going to waste each other's time if you think I'm out to "do" something to you or the Group; I'm trying to do something with you and the Group. I'm willing to agree that I do not understand the practice of medicine, but we're not talking about practicing medicine...we're talking about running a $30 million a year business. It doesn't require a medical degree to see that this organization has had some difficult times the past few years. I understand that, on some level, you'd rather not have me here. I am trying to be helpful though. I am trying to work with you...not against you...and the sooner you accept that, the greater the chances of this engagement being productive for everyone involved.

Dr. Blakeley: (Calming down) All right...I get your point. Let's get on with this. I have to be in the clinic in a half hour.

Blakeley often appeared this defensive; he would often interpret the intent of a
question or comment negatively, as implied criticism, and then launch into a rebuttal of a point that had not actually been made. The consultant had observed this behavior at Board meetings and had noticed that it often had the effect of silencing a critic in mid-sentence. It was not clear to the consultant whether Blakeley's behavior in these instances was a conscious tactic—a form of emotional extortion—or simply an ingrained response. It certainly made disagreeing with him unpleasant enough so that many people in the organization appeared to avoid disagreement at all costs.

The consultant, on the other hand, was not predisposed to shy away from conflict, even if that meant a more directive and unpleasant interchange than initially planned. He also thought that Blakeley needed to learn, among other things, how to have a disagreement with someone without turning it into a nasty exchange, although he was not sure that engaging him—as in the instance above—was an effective strategy for achieving that objective. If it was a conscious strategy on Blakeley’s part—one adopted to prevent or terminate an inquiry Blakeley found discomforting—then engagement would remove the payoff associated with that strategy and hopefully change the behavior; if it was an ingrained response, then Blakeley would have to relearn how to communicate under conditions of disagreement—something the consultant was not very hopeful about.

There would be, in fact, many other times the consultant felt forced to engage in an unpleasant exchange after Dr. Blakeley became upset over a question, comment or suggestion. There was some reduction of tension however, over time, and there is no way to know how many other additional times there would have been a conflict if the consultant had not been willing to engage Blakeley when that appeared necessary. Overall though, there was friction in the air, to the very end of the consultation, whenever the consultant asked about a particular issue that Blakeley really did not want to discuss, made a comment
that Blakeley interpreted as critical or articulated a view that Blakeley did not agree with. The relationship between the two never really took hold; Blakeley never fully embraced the consultant or the process.

Fortunately, the relationship with Ms. Wilson, built on the foundation of shared adversity during the merger negotiations, became highly productive. Equally fortunate, she quickly became a major force within the Group, was seen as being able to exert influence over Dr. Blakeley and was thus able to generate support for the consultation process when the absence of it from Dr. Blakeley would have doomed the entire undertaking.

After the two sessions with Dr. Blakeley, the consultant moved on to the members of the Board and management staff. Over the course of several days during the last week in January, each Board member was interviewed for approximately an hour and a half; senior management staff interviews were completed shortly thereafter. The questions were generic, except for several Department Head questions used with the Board members and a job description question used with members of the staff; they asked the interviewee to talk about his/her perceptions relative to the major organizational units, the relationships between those units and the problems that the organization was facing. Each interviewee was also asked if s/he had any specific issues or comments that s/he wanted to contribute to the discussion.

The Board member interviews were as informal as possible. The consultant had sat in at several Board meetings during the merger negotiations and the Board members knew him by now; several were openly friendly when they came to see him. Each Board member was told that the conversation was confidential; that summaries of answers would be prepared, but that there would be no direct quoting or attribution of comments made in the
session. They had been provided with copies of the questions a few days in advance, so that they would have had some time to think about the issues. The questions focused on (1) reactions to the possibility of creating formal Department Head positions, (2) evaluation of Board operations, (3) assessment of Board-staff interaction and (4) characterization of DMG's decision making processes. There was a final question that asked each member if there was anything else to be discussed or if s/he would like to return and discuss other issues not covered on the questionnaire. There were no volunteers.

As a group, the Board members had been angry, confused and scared during their interviews. Unlike Dr. Blakeley, there was little denial in this group that things had somehow gone seriously wrong. In fact, several of them blamed Dr. Blakeley and asked how they could fire him. Three physicians also asked for personal advice: two wanted to know if the consultant thought they should stay with the Group or leave before it fell into bankruptcy and a third wanted to discuss a management problem his father was having with a limousine service. These inquiries were gently turned aside.

The Board members generally endorsed the Department Head concept and they were relatively clear on roles and functions for that position. There was no agreement on how the incumbents for those positions would be chosen.

From the interviews, it became clear that Board member experience with the Board had been almost uniformly negative, with only one physician confessing that he was "satisfied". Other comments ranged from "moderately disillusioning" and "not great" to "disappointing" and "frustrating". Several themes occurred consistently throughout this segment of the interview process: (1) the Board did not have much real work to do--things either did not get brought to the Board, or, if they did, there was a clear expectation that the Board should do nothing more that rubber stamp the decision made by
Dr. Blakeley, (2) the Board functioned badly when it did have real work to do--decisions were perceived as often being half baked at best and (3) there was a serious problem with lack of follow-up--Board decisions would go unimplemented, although it would often be weeks or months before that was noticed, and issues that were scheduled for further discussion by the Board would simply disappear.

There was also some understanding of why these things seemed to happen. Board members noted that the role of the Board versus that of management was unclear, that physicians were loath to shoulder individual responsibility--things were generally left for someone else to take care of, that the Board reflected the power struggles of the Group as a whole--particularly those of the Departments, that the issues the Board was faced with were too diverse and that the Board's agenda was poorly developed and managed.

Board members had relatively little to say about the management staff; what they did say was generally positive but extremely vague. This confused the consultant until he realized that (1) Dr. Blakeley was the only person from management to routinely speak at Board meetings--most of the Board members therefore had no understanding at all of what the management staff did for the Group and several physicians could not even name the individuals who made up the management staff and (2) Dr. Blakeley was not counted as management staff--he was counted as a physician, even though he was the President--so the Board members could feel hostile towards him, but positive towards the management staff, since Blakeley was not a member of that staff.

There was also uniform disparagement of DMG's decision-making processes by the members of the Board and almost no comfort with the way in which policies were discussed, adopted and implemented. Board members variously characterized decision-making as "crisis oriented"... "directionless"... "random"..."untimely"..."not
focused on reality"... "haphazard"... "disjointed"... "disorganized"... and ... "parochial".

None of the Board members understood the concept of fiduciary responsibility. The consultant had been prepared for that and had brought a one paragraph written definition to the interviews. Once acquainted with the concept, six of the ten Board members decided that their fellow members generally failed to act in accordance with their responsibilities; three felt that they generally did and one was not sure what to think. Summaries of these interviews are contained in Appendix 1.

The interviews confirmed many of the perceptions the consultant had formed as a result of his attendance at Board meetings. More importantly, they provided the first evidence that a significant number of Board members perceived the organization as problematic as well. There was a will to change in the organization after all; the Board members were clearly upset and frustrated and had some rudimentary sense of why the organization was not functioning well.

They had not, for the most part, discussed those thoughts and feelings with each other nor had they confronted the President with their thoughts and feelings. Many appeared to find the interview a cathartic experience--two physicians came back specifically to say that they felt a lot better having said what they had said and another came back to say that he had not realized how angry he really was about everything until he found himself answering the questions for the consultant. Many had also expressed the hope, dismaying from the consultant's point of view, that he would quickly find a way to "cure" the organization.

The staff interviews were considerably more open ended and much less productive. The consultant sought comment on four specific issues (1) the fit between their current job description and their actual duties, (2) evaluation of Board functionality, (3)
evaluation of management staff functionality and (4) their view of the problems the
organization was facing.

There were no job descriptions for the President or the Finance Director nor had
there ever been; there were descriptions for the other managers though and they seemed
reasonably drafted and accurate. A job description would have to be developed for Ms.
Wilson as well, but there would have to be agreement on her responsibilities before that
could be accomplished.

Two of the management staff members did not routinely interact with the Board; they
therefore had no comments on the Board. Ms. Wilson had not been attending Board meetings
on a regular basis; she was unwilling to comment extensively. That left the Finance
Director and the Patient Care Services Director, both of whom regularly attended Board
meetings.

The Finance Director, a CPA by training, was contemptuous of the Board and of the
management of the Group in general, although he would not comment directly on Blakeley.
His perception was that the members of the Group did not understand how to make
non-medical decisions; they did not trust people who were not physicians--so they would
not accept advice from those who did understand business issues and they were all too
involved with their own individual practices to have any sense of the needs of the
organization as a whole. He pointed out that the Group had been losing millions of dollars
year after year because it could not reach agreement on the necessity of or technology for
enforcing utilization and referral targets among the Group's physicians; he also noted that
the Group lost a great deal of revenue because many of the internists "hated" the surgeons
and referred patients needing surgery to surgeons practicing outside the Group---yet
there had never been a discussion at the Board level about that issue. It would be better if
management did not bring serious issues to the Board because the Board was incapable of dealing with them, he noted; it was better for management to do all the thinking on an issue and then notify the Board, asking for final ratification before implementation.

The Patient Care Services Director, a nurse by training, was also highly critical of the Board. Her view was that they were incapable of doing anything but seeing patients, which was fine, because that is all they wanted to do anyway. The Board members, and physicians in general, were not unlike whining little children and management's responsibility was to protect them from themselves. In her view, there were no problems on the management side of the house.

The MIS Director's comments were particularly scathing, but they applied to the entire organization, not just the Board. She found the physicians impossible to work with, completely uninterested in anything non-clinical and too indecisive about critical organizational issues. She found the staff undisciplined, disorganized and preoccupied with their own little corners of the organization.

For the most part, the members of the management staff were satisfied with their own work; most seemed to believe that the organization's problems were all due to the the fact that the organization was run by physicians. "Dr. Blakeley (and by extension, thought the consultant, the management staff) does what he can--it isn't his fault that the other physicians in the Group keep getting in his way"--seemed to be the dominant expression among staff, although the MIS Director and Ms. Wilson had clear and reasonably balanced perceptions of the problems inherent in the entire organization.

Perhaps the most interesting point to come out of these interviews, was that the management staff rarely met as such--it had been more than a year since the last meeting. There was apparently no such thing as a "senior staff meeting", per se. No member of the
management staff knew, specifically, what another was working on; there was no set of goals or objectives to guide their work. Decisions would be made on a one-to-one basis between a given staff member and Dr. Blakeley. These decisions did not appear rooted in any careful consideration of the actual needs of the Group, as much as they appeared to be rooted in the intersection of idiosyncrasies between a particular staff member and Blakeley.

The consultant had promised Dr. Blakeley a copy of the summary of the Board interviews and had been carefully preparing him for what that would look like. He was not sure whether Blakeley knew what lurked in the hearts and minds of his colleagues, although he knew that most of the physicians on the Board had not confided their opinions to Blakeley; the consultant did not know if the interview results would be as readily dismissed by Blakeley as had other negative thoughts about the organization from non-physicians. The consultant scheduled a meeting with Blakeley to present the summary and to review it in person; he wanted to observe first hand the President's reactions to the comments.

Blakeley appeared devastated by the summary (Appendix 1). He read the first few pages in a cursory manner and then locked on and began a word by word review. At the end of the summary, he sat back in his chair, clearly upset.

Dr. Blakeley: There must be some mistake---

Consultant: (Silence)

Dr. Blakeley: These guys never said any of this stuff to me. Never.

Any of it. Why would they tell you this stuff?

Consultant: I think that's a fair question to ask of them. Perhaps one of the Group's problems is that you folks don't
Dr. Blakeley: Communicate well with each other about problems. If it's of any comfort, it's not unusual for people in an organization, particularly one undergoing a period of prolonged stress, to talk freely to an outside consultant.

Dr. Blakeley: Look at this stuff--I don't believe it. Do you believe it? Some of these guys just like to bitch you know, just to hear themselves talk.

Consultant: I believe all of it, in the sense that it was all said to me. I think the interviews were cathartic for some of the physicians, so there is some venting in here to be sure. I also think that many of the comments are on target--particularly those that seem to recur. You should read the summary with your eye open for patterns. A psychologist friend of mine once told me: "The first time a person tells you that you're an ass, you're under no particular obligation to believe him. When a second person tells you that you're an ass, you should at least consider the possibility. When a third person tells you that you're an ass--you should go looking to buy a saddle." The point being that there is some degree of consensus here and that needs to be addressed. Whether you agree with it or not, the fact that a number of the people on your Board think
that a given thing is true is very important.

Perception is almost everything.

Dr. Blakeley: I just can't believe this. I think I should resign. I'm going to resign. This stuff is crap.

Consultant: (Silence)

Dr. Blakeley: Do you think I should resign?

Consultant: I think you should ask yourself why you want to resign all of a sudden. What do you think it would accomplish and how would you feel about it in the long run?

Dr. Blakeley: I'm not going to wait until they fire me.

Consultant: I don't believe that there are enough votes to fire you. There is some unhappiness with you and with the circumstances the Board members find the organization in—but there is also a lot of respect and affection for you. Besides, we both know that none of these guys are going to "step up to the plate", as you would say. That would mean an outsider coming in.

Dr. Blakeley: Do you think I should resign?

Consultant: I think that's your decision to make. I think you need to weigh your own interests against the interests of the organization. I can't speak to your interests. I can tell you I think this organization needs to make some fundamental changes very quickly, so that it is in a
position to take immediate action if the first quarter financial results are negative. Given that fundamental reality, I think one of the last things this Group needs is the turmoil of the political mess your resignation would cause alongside of a frantic search for your successor. You may not see it that way though. As I said, I can’t speak to your interests.

Dr. Blakeley: So say I stay on. Where do we go from here? What’s the next step?

Consultant: I’m thinking about that now. I’m not sure what the next step is. Let me get back to you next week.

Part of the exchange surprised the consultant. Blakeley appeared to be genuinely startled and hurt by the summary. Perhaps he was only surprised that others were clearly aware of problems he believed to be successfully covered or that fellow physicians would talk like this to a non-physician outsider.

On the other hand, Blakeley had not actually accepted the substance of the comments made by his Board members; during part of the discussion, he certainly seemed to be looking for ways to disown them. He seemed to want reassurance more than anything else. It was not clear what Blakeley would end up concluding about the summary.

Notes in hand, the consultant retired to his study to think through his next steps. The completion of the data gathering effort brought to the surface a dilemma the consultant had been wrestling with since the beginning of the engagement and it was time for a decision.

A believer in the principle of joint diagnosis, he had hoped that Blakeley would warm up to the process after a while and would become the chief participant for the Group in the
diagnostic effort. The consultant had made an effort to keep him informed on a routine basis about progress with the process. Blakeley had not warmed up however and the consultant no longer believed that he would warm up; he had to accept that on this issue he had been seriously wrong. Now that Blakeley had seen the interview data, the consultant worried that he would retreat to his bunker of denial and the consultant would be forced into either fighting a point by point pitched battle with him, with all of the resources on Blakeley's side, or giving up entirely and abandoning the Group. There was no way of knowing how Blakeley would react once the initial shock of the interview summary had passed.

It was also becoming clear that any serious attempt to resolve the organizational problems within the Group would eventually entail removing some measure of power and control from Blakeley. The consultant was beginning to understand, somewhat belatedly, the issues at stake for Blakeley and why he had not been anxious to sign on to a project that could upset his carefully controlled environment. Attempting a joint diagnosis with Blakeley then, appeared masochistic and potentially destructive to any attempt to help the Group.

The Board certainly seemed more open to the issues. Its members were not as defensive or denial oriented as Blakeley, but then, neither were they as business oriented. They exhibited many of the managerial and interpersonal problem traits which Blakeley had and none of his business acumen. Having sat in on their Board meetings, the consultant knew that their attention span for organizational and management issues could be measured in seconds, unless it was directly related to physician reimbursement. They each knew there were problems, but no one physician could articulate a clear analysis of what those problems were; they seemed incapable of thinking in systems terms. The thought of trying to work on a joint diagnosis with the entire Board was intriguing, but impractical.
For several days, the consultant considered terminating his relationship with the Group. It was a tempting thought, but it seemed potentially destructive and ultimately irresponsible. The process had come too far to be unilaterally abandoned.

Finally, the consultant decided that there was no way out: he would do the diagnosis alone. At the same time, he decided that the diagnosis would be contained in a written report and that he would also prepare recommendations to address the elements of the diagnosis. A written report with recommendations, even if submitted to Blakeley for review, would be harder to suppress in the long run than a series of charts and overheads developed for meetings that never went anywhere with a CEO who could not accept the reality of the problems within the Group.

The consultant was not happy with this approach; it seemed imperfect at best, manipulative at worst and in utter defiance of the principle of non-directive intervention. He did not see any other way out however. A report would be developed and submitted to Blakeley for review, with a note that it would be sent to the Board within 24 hours, unless he had a serious, substantive objection to any of its points. Once at the Board, the consultant would ask that an Implementation Subcommittee be named to work on reviewing the analysis and implementing the recommendations; the consultant would provide assistance to that Subcommittee, reviewing the elements of the diagnosis at that point, altering the diagnosis and recommendations as necessary and establishing a joint process after all. It was an ex-post-facto approach to joint diagnosis--and one that would occur after the consultant had already shaped the organization's thinking about the problem by presentation of the report--but it seemed preferable to any of the alternatives.

Turning to his notes, the consultant was alarmed at how seriously dysfunctional the organization itself seemed to be. It had no Mission Statement--no clear, articulated
concept of why it existed as an organization and what it hoped to accomplish as such. It had no plan of any kind; nothing to link its goals as an organization, assuming it had any, with objectives, strategies or tasks that needed to be implemented in order to achieve those goals and it had no process, formal or informal, to consider such issues.

The Board election process had the effect of ensuring that the staunchest advocates of individual Departmental interests would be placed on the Board; the process ensured that organizational interests, as a whole, would be poorly represented. In fact, there was no concept of the organization, as a whole, within the collective consciousness of the Board. Board operations were poorly supported by staff and dominated entirely by the President. Its members lacked a working consensus as to Board role and responsibility; their ability to communicate with each other and with management was marginal, as was their ability to negotiate resolution to serious issues.

The Board would consistently abdicate its authority by refusing to decide a major question, referring it to the Shareholders for resolution. Many Board members had no working knowledge of the role management played within the organization. They were angry and dispirited as a group and had very little sense of where to turn next. There were at least four votes for firing the President and their was a great deal of anger with him, but most of the members readily admitted that they would not want to take on his responsibilities, after all, "they were only doctors--not businessmen."

The President himself was proving to be a very difficult man in his own right. His need for control appeared to dictate many of his actions and while he apparently had a great need for power, he was not capable of using it effectively to move the organization. His assumption of responsibility for five major positions within the organization was counterproductive: it ensured that necessary functions were being ineffectively and
inefficiently performed, it prevented other physicians from stepping forward to develop their leadership capabilities or at least to accept their share of the responsibility for the governance of the organization and it made Blakeley a large target for disgruntled physicians, allowing important issues to become more readily personalized.

Blakeley's domination of the Board, which to him appeared essential, was but another cause of the anger Board members felt towards him. His lack of sensitivity and insight into the impact of his own behavior on others was unremarkable to most of the Board members, since, as physicians, they too suffered from some of the same personality characteristics, but its impact on staff was dramatic. He had surrounded himself with a group of passive, acceptant people, who looked at him for both the definition and resolution of most management problems within the organization and who generally went out of their way to support his perceptions.

The senior management staff was also clearly problematic. Its members had no tradition of working together as a team, which probably accounted for much of the discussion during the interview process about "things always falling through the cracks." Their activities, whatever they were, were not guided by any agreed upon set of organizational needs. The management staff's work seemed almost entirely ad-hoc and self-defined in nature. Most of the managers had clearly formed dependent relationships with Blakeley, abdicating their professional responsibilities for self motivation and growth.

The consultant recognized much of this as symptomatic--he was looking at effects, not causes. Causation went back to the time that the Group decided to become involved in the HMO joint venture.

Prior to the advent of the HMO, DMG existed as a medium size, fee-for-service
Group practice. As such, it had little need for formal management structures or processes. There was little need for the physicians in the Group to view themselves as one part of an organizational whole and, indeed, the daily clinical reality must have been such that it could only have negatively reinforced such a perception. Perhaps they could have successfully stayed in that niche for another decade or so, before the market forced them to change.

The decision to enter into the HMO joint venture with the insurer however, and the subsequent birth of that HMO, irrevocably altered the operating reality within which DMG functioned. On one level it led to unprecedented growth for the Group, in terms of patient volume, revenue and new physicians. On another level it required, for the first time, that DMG take itself seriously as an organization: contracts would have to be signed which bound everyone in the Group and the Group would have to deal with the policies, procedures and conflicts which entry into a more complex organizational form bring.

While the environment in which medical care was provided changed dramatically as a result of the joint venture decision, attitudinally and organizationally, DMG still existed as a medium size, fee-for-service group practice. It was this confusion, over whether DMG was a business organization which employed physicians or whether DMG was little more than a collection of individual physicians that happened to be known as DMG, that was at the heart of its organizational problem.

It is not clear whether the physicians never understood that their organizational way of life would have to change or whether they thought they could control the rate and direction of change once the HMO had been established; there were probably a number of physicians of both minds. What is clear, is that a sizable segment of the Group resisted change, either fearing it or resenting the incursion on autonomy that it represented, and
the remainder of the Group, bound by traditions of collegiality and an abhorrence of interpersonal conflict, was not able to bring itself to take the steps necessary to preserve the organizational and financial integrity of the enterprise. This deadlock had brought the Group to the edge of bankruptcy and, unless the issue was resolved and appropriate controls instituted, it would probably do so again.

When it is not clear that the interests of the organization as a whole must win out over the interests of a given individual or group of individuals, the existence of the organization itself is threatened. Effective decision-making at DMG became impossible, because this conflict was embedded in every major decision: a conflicted organization cannot make clear and effective policy decisions.

If one starts out with this conflict and then adds to it a poorly organized, ill trained and confused Board and an inadequately staffed management structure operating within a policy vacuum with weak management processes--then one begins to get a sense of the operational reality at DMG.

The decision to enter into the HMO joint venture created the context within which these problems would arise at DMG. The Madison-Konrad typology assumes symmetry between Organizational Tradition and Market Response Strategy. A given Organizational Tradition would establish a certain range of options for any group practice contemplating a particular Market Response Strategy; they would be appropriate options, not containing requisites in conflict with the organizational traditions of the group.

Choosing an option outside of this range would break the symmetry and create a variety of organizational problems for the practice. As an individualistic-autonomous Group, DMG's most appropriate market response would have been to remain reactive. By entering into the joint venture, it chose one of the most inappropriate market responses
possible; one that would require a sense of organizational commitment and discipline and management structures and processes far beyond that possessed by DMG at the time.

Entry into the joint venture was an important part of causation; but it was not the proximate cause. The consultant found it difficult to isolate a specific cause. The circumstances of the joint venture, the low management skill level of the President, the chronic inability of the Shareholders and Board members to recognize the extent of the problem and reach consensus on a solution, the tendency of the insurer partner to repeatedly bail the Group out of the financial problems created by the Group's own behavior, the absence of a strong management infrastructure, the "every man for himself" notion that seemed to be a motivating force within the Group--all of these elements played a role in giving birth to and sustaining the management problems the Group was now facing. The consultant believed that there was probably not a sine qua non explanation for it all.

The consultant also realized that there was certainly no single or simple solution either. The organization would have to take a variety of steps to (1) ensure a more effective Board of Directors, working on election, structure, process and behavior issues, (2) expand the management structure of the Group, while addressing the issues of management process implicit in a staff that had not met in more than a year and (3) acknowledge, accept and demonstrate its existence as an organization having needs and interests which superseded the needs and interests of any one individual practitioner or group of practitioners.

The consultant began to draft his report along those lines, analyzing the status of the organization and providing sets of specific recommendations to address each of the three change areas.
The final point of attack was unquestionably the most important. As the consultant noted in his report:

> An organization demonstrates its seriousness of purpose by making a decision, widely publicizing the decision and consistently enforcing that decision. DMG desperately needs to decide, in an effective sense, whether it is and can function as a corporate entity or whether it will remain in limbo, torn between its contractual and business obligations and its solo practitioner mind set. The clearest statements of intent on this issue, would involve the development of a mission statement for the organization and the adoption of physician compensation, administrative time and sanctions policies which effectively identify and protect DMG's organizational and financial interests (Slavin 1988b, 13).

The report was submitted the first week in March. Dr. Blakeley had a problem with one point regarding separation of the Medical Director responsibilities from those of the President. The result was compromise language which merely suggested that the Board study the issue within a year. Surprisingly, Blakeley had no other issues with the report. He was not enthusiastic about it--his only comment was that it seemed "even handed"--but he did not appear to be hostile to it either. Since the interview summary session, he had become very quiet. He was still not able to engage the consultant constructively, but in many ways, he no longer seemed to be fighting the process as much.

The report went to the Board and a special Saturday meeting was scheduled to review the report and to listen to a presentation from the consultant. It was a thoughtful meeting that lasted half a day; the report had been appropriately sobering. The meeting got off to a rocky start though, with the second most senior physician in the Group immediately asking who needed to be fired" because of this". The consultant, because of this physician's comments during the interview process, knew immediately that this was an attack on Dr. Blakeley. The question provoked an animated discussion.

Dr. Peters: All right. I read the report and I've just spent a half
an hour listening to your summary. You still haven't
answered the question I have on my mind: who do we
fire because of this?

Dr. Blakeley: (Standing--begins to leave) I'll wait outside.

Consultant: I don't think it's necessary for you to leave. Unless
the Board thinks that it is, I would like you to
remain.

Board: (There was general consent that he stay)

Dr. Blakeley: All right. We've always discussed personnel matters
with me out of the room.

Consultant: Dr. Peters--who do you think the Board should fire?

Dr. Peters: Well--the people responsible--the people who got
us into this mess--the people who aren't doing their
jobs.

Consultant: You believe that if people do not do their job, they
should be fired?

Dr. Peters: Sure I do. If a coach loses too many games, he gets
fired; if a company goes south, the CEO gets
fired. If you mess up too much, its out you go. I'm not
a manager, but I know that much. So who goes?

Consultant: Well--I'm not sure that's a fair question to ask me.

I honestly can't think of the name of another
consultant who would answer that question--you see,
it takes too much responsibility away from all of you.
The decision about who stays and who goes is a matter of judgement--judgement that each of you must exercise. That being said, I will give you a formula for firing people. It's a formula that seems to be agreed upon by many reasonable people in the management world. The formula is this: if there is a mutual agreement between an employer and an employee about the duties and responsibilities of the employee, and, if the employee is apparently failing to adequately perform those duties and responsibilities, and, if after several attempts at counseling the employee, and notifying the employee of the consequences of continued failure, there is no improvement, then the employee should probably be terminated. Of course, this does not include such things as criminal behavior--termination for cause, as its called.

Dr. White: So--I'm not clear on this. Just what are you telling us now?

Dr. Andrews: I think he's telling us we're not in a position to fire anybody. Is that it--is that what you're saying?

Consultant: Well...think about it. What employee reports to you?

Dr. Andrews: All of them--they're all our employees.

Consultant: Well--if that's true, I want my report back--I have
a few more pages to add.

Laughter

The President--he reports to us.

That's right; the President reports directly to the Board--at least that's what your by-laws and organization chart tell me. Every other member of the staff however, reports to the President. Your chart tells me that too; so do the job descriptions of the Directors.

So we can fire Blakeley.

Yes--the by-laws give you that right. Do you think he has violated his part of the agreement?

What agreement?

The agreement between Dr. Blakeley and the members of this Board--the agreement that identifies his specific duties and responsibilities--the agreement that lays out the expectations which the Board has of him--his job description. Remember the formula--it requires an agreement. You do have an agreement, don't you?

Of course we do--I think we do.

We absolutely do not.

We have to have something--what about the--

I should know if we have an agreement or not--
Consultant: If I may interrupt gentlemen. I was unable to find a written job description for the President’s position; he also has no contract that I know of. As far as I can tell, there is no written description anywhere of what he is expected to do as President. I can tell you all, on the basis of the interviews, that each of you has an idea of what he should be doing. Unfortunately, they are not all the same idea. While many of you have specific problems with his management of the Group--not one of you has ever approached him to address those problems. I won’t ask if the Board has ever met to review his performance, because 1) I’m sure you haven’t and 2) even if you had met, you would have had no standards to review his performance against.

Dr. Peters: Whose responsibility is it to develop that agreement?

Consultant: That differs from organization to organization. It’s often a joint process between the President and a Board Subcommittee--but its adoption is up to the Board. The President is your employee--it is your responsibility to decide what he is to do and what he will be held accountable for.

Dr. Andrews: I think you’re telling us we ought to fire ourselves.

Board: Laughter
Consulting: (Laughing) No--not yet. Use the same formula I just gave you. Now that you know your responsibility in the matter, if, in two years, I come back here and there is still no job description and no regular performance meetings with the President then yes--you probably should all fire yourselves.

Seriously though, right now, I don't think it's fair to judge yourselves, or someone else, on the basis of standards that have not existed until this moment. If you look at the suggestions in the report, a lot of the work that needs to be done here involves reaching clarity and consensus about what it is people are expected to do in this organization and how the organization should react when those expectations aren't met.

After that discussion, there were general questions, but no serious disagreements. The general sentiment, summed up by one of the most senior members of the Group, was that: "we've been screwing up--we can't afford to screw up any more--it's time we tried to change something".

It was also clear that the Board lacked the wherewithal to seriously debate anything of the size and nature of the report. At the end of the meeting, the Board voted to accept the report and to establish an Implementation Subcommittee to review the report in detail and to develop recommendations for consideration by the Board.
Planning & Implementation

The acceptance of the consultant's report by the Board and the establishment of the Implementation Subcommittee were watersheds in the life of the consultation. They represented a high degree of Board support for the process, they effectively removed Dr. Blakeley from a position where he could have quietly and effectively blocked change if he had so desired and they provided a broad group of organizational representatives to work with in reviewing the diagnosis and turning a set of recommendations into reality. Dr. Blakeley's presence on the Subcommittee was studiously neutral for the most part; he was neither determinedly negative nor overwhelmingly constructive. The other three members of the Subcommittee were quite enthusiastic.

The consultant and Ms. Wilson prepared for the first meeting by incorporating the report recommendations (Appendix 2) into a proposed work plan and by drafting a memo outlining a suggested process for Subcommittee operations. It recommended an aggressive timetable. The consultant was committed to working non-directively with the members of the Subcommittee as they reviewed the diagnosis and worked on change strategies, but this proved to be a continuing illusion. It became very clear after a relatively short period of time that the consultant and Ms. Wilson were going to have to do most, if not all, of the conceptual work.

In fact, the same process would repeat itself time and time again: the consultant or Ms. Wilson would begin a discussion on a topic and ask for thoughts or questions from the members. There were usually none. They would begin to ask questions, hoping to stimulate discussion. That usually did not work either. They would ask if a Subcommittee member would take the time to work up an outline of the issue. There were never any volunteers. Finally, one of the physicians would suggest that either the consultant or Ms. Wilson...
develop a draft document for discussion by the group. Given the alternatives, they always agreed. This approach worked however; as long as Ms. Wilson or the consultant did the initial conceptual work, framed the issues or drafted a memo, the members of the Subcommittee could be counted on to respond with suggestions, questions and amendments. Their input on that level was quite good. The discussions were animated, well informed and productive. Throughout the process the physicians remained, paradoxically enough, both enthusiastic and reactive.

The consultant and Ms. Wilson would privately debate at length whether or not they were simply enabling the members of the Subcommittee to abdicate their leadership responsibility for the intervention. The consultant finally decided that assisting a paraplegic out of his wheelchair was not enabling him/her to remain paralyzed and that, for all practical purposes, these physicians were organizational paraplegics. He stopped worrying about the problem.

After the Subcommittee finished work on an issue, the consultant or Ms. Wilson would turn the work into a Board report. The reports, in general, were well received by the Board; not one single proposal submitted by the Subcommittee was rejected, although the Board did amend several of them and sent one back for further study. Between March and December of 1988, the Subcommittee proposed and the Board adopted:

1. A one Regular meeting a month rule, to be held in the evening with dinner provided as an added incentive to come on time.

2. A specific Regular meeting format that required: adoption of the agenda, disposition of the minutes from the previous meeting, the President's report, a report from each of the senior managers and old/new business, in that order.
3. A policy statement making the Regular meeting open to any DMG physician and DMG senior staff member.

4. A policy statement noting the responsibility of management for the production and delivery of a proper agenda and support materials for each Board meeting, well in advance of that meeting.

5. A policy statement noting the responsibility of Board members to review Board meeting materials, attend scheduled meetings and be prepared to engage in a discussion of the issues on the agenda.

6. A policy statement limiting Board membership to six physicians plus the President, setting two year staggered terms and requiring candidates to nominate themselves, run at-large and pledge to work for the interests of the organization as a whole, rather than their Department. A physician could not be a member of the Board and a Department Head at the same time.

7. A rule requiring election to the Board be contingent upon agreement by a candidate to attend and participate in a Board Orientation Program.

8. An outline of the Board Orientation Program, including a list of the issues to be discussed and samples of the materials to be used.

9. The election of a Chairperson from among its members and the adoption of a specific job description outlining the duties of the Chairperson.

10. The establishment of permanent Board Subcommittees on Finance, to deal with the Financial issues facing the Group, and on CEO Relations, to foster better understanding of the needs of management and the interests of the Board and to deal with the CEO's annual salary review.

11. A policy statement requiring Board Subcommittees to be established by
majority vote of the Board after the review and adoption of a Subcommittee charge which specified Subcommittee title, proposed membership, nature and scope of the responsibilities, permanent or ad-hoc status, and reporting expectations.

12. A requirement that Board minutes be rendered in greater detail and with greater clarity.

13. A policy statement that Board and Subcommittee meetings be properly staffed and supported by management.

14. A job description for the President position which clarified the specific responsibilities which he was to hold with respect to the Board and the organization as a whole.

15. An employment contract for the President, providing him with a two year term in office, a compensation formula designed to hold him harmless for income loss due to a reduction in his medical practice caseload and graduated buy out provisions in the event that he wished to return to the full time practice of medicine or if the Board wished to remove him from office.

16. A job description for the Director of Management Services, the position filled by Ms. Wilson, assigning her responsibility for supervision of the organization's management processes, strategic planning, research and evaluation and contracting.

17. A job description for the Department Head position, along with a job specification which clearly delineated issues of term, selection process, reporting responsibilities and removal.

18. A policy statement to the effect that senior management should begin to act as
a team, at least within a Senior Staff meeting format.

19. A policy statement on Administrative Time, ensuring parity compensation for physicians who devoted time to the administrative work of the organization, specifying those positions eligible for AT compensation and defining a formula upon which compensation would be based.

20. A sanctions policy for physicians that defined unacceptable behavior and provided for graduated enforcement (i.e. counseling to financial penalties) and processes for enforcement and appeals.

21. A Mission Statement, included in an Organization Orientation manual, provided to every physician practicing at DMG.

22. A policy statement suggesting that senior management be located on-site, in comparable offices, as soon as possible (N.B. at the end of the year, only the Finance Director remained off-site).

23. A policy statement requiring DMG's audit firm to prepare a detailed management letter and to review the audit results with the Board of Directors.

24. A policy statement requiring the Finance Director to provide monthly financial reports to the Board, in standard format and complete with explanations.

25. A policy statement requiring management to adopt a modified Management By Objectives (MBO) program.

26. A set of evaluation criteria to use in assessing the impact of the reorganization on the organization.

This work represented not only a substantial investment of physician time in
organizational matters—it represented almost a complete break with the past. By the end of the year, even Dr. Blakeley seemed pleased with what the Subcommittee had accomplished, although he would privately tell the consultant that "it didn't matter—when push comes to shove, these guys will do what they want to do, regardless of policy." The consultant would always respond that it was often management's job to see that everyone played by the rules, particularly when everyone had been involved in making the rules.

The debates on the Mission Statement and the Sanctions Policy were the most critical discussions generated by the consultant's report—and some of the stormiest. The consultant, wanting this work to belong entirely to the Group, did not attend any of the Board or Subcommittee meetings on these documents. The draft statements prepared for the Subcommittee were developed by the consultant, but the Subcommittee was told that they were the work of Ms. Wilson. They represented the strongest possible statements of the need for organizational primacy. The Mission Statement defined DMG as an organization—a group of physicians who have decided to work together to practice medicine. The Sanctions Policy emphatically established the right of the Group to take punitive action against an individual physician for a variety of administrative, behavioral and clinical reasons; it vested primary enforcement of the policy with the Department Heads, provided a penalty structure and defined an appeals process.

The debates were contentious. While there was no negative comment on the Mission Statement, the Sanctions Policy was sent back to the Subcommittee with along with instructions for the members of the Subcommittee to meet with three physicians who had argued vehemently against the policy at the Board. The meeting took place, the policy was slightly modified and it was again sent to the Board where it was adopted without further change. The final policy, very similar to that drafted by the consultant, was sent to each
physician practicing at DMG; they were asked to sign a sheet of paper indicating that they had read the policy and understood its terms. It remains to be seen whether the policy will ever be needed or effectively used. Its adoption however, sent shock waves through the Group; it seemed to underline for many the reality that things were going to be different from now on.

During this time period, five new Department heads (Internal Medicine, Family Practice, Ob/Gyn, Pediatrics, Surgery) were elected by their departments and accepted by the Board. A new Board was elected using a new election process. The senior management staff began the long, slow process of learning to work together. Management began to implement an MBO program modified to de-couple the process from the annual performance review: it was designed to be used as a work planning tool, a team building exercise and a vehicle for disseminating program and operations information to each other and to the Board.

Perhaps most importantly, Ms. Wilson assumed her new position as Director of Management Services. While it had been clear that she would be offered a Director level position after the merger, there was only a sketchy concept of the responsibilities which that position would entail. Her supervisor at the HMO, accustomed to seeing her in a more junior role, had recommended to Dr. Blakeley a series of responsibilities that were consistent with her abilities, but which ignored a variety of her personal and professional strengths which the Group desperately needed.

The consultant began a slow process of changing Dr. Blakeley's cognitive map about that position, a map which had been formed by Ms. Wilson's former supervisor. In the end, the job description assigned her responsibility for supervision of the organization's management processes (e.g. Board agenda and materials development, coordination of the
senior staff meeting process, supervision of the MBO process, etc), strategic planning, research and evaluation, and contracting.

Remarkably, at the end of the year there was only one issue remaining from the March report that had not been addressed by the organization. Not so remarkably, it was the issue of physician compensation. That issue had been transferred to the jurisdiction of the Finance Subcommittee. While that Subcommittee had met on the issue and had worked on several options, it proved to be too thorny to resolve within that time period. It was the most difficult organizational issue the Group had to face, since it has the effect of underscoring, in stark financial terms, the interdependence of the physicians within the Group.

There were two other areas of implementation that engaged the attention of the consultant during this period: management staff process and individual work with Dr. Blakeley.

Almost immediately after the management staff interviews, where the consultant determined that the senior managers had not met formally as a management team in more than a year, he recommended to Dr. Blakeley that some type of senior staff meeting be initiated at once. After some discussion, Dr. Blakeley agreed to try for an every two week meeting schedule. The consultant attended these meetings, but he tried to not involve himself interactively, thinking it better that the group find its own legs at first.

Describing these initial sessions as awkward would be an exercise in understatement. Each of the senior managers had worked out their own private relationship with Dr. Blakeley; each was used to dealing directly and exclusively with him when they had a serious issue to resolve.

The Patient Care Services Director, a nurse by training, did not appear to enjoy the
decision making prerogatives of management. She would lie in wait for Dr. Blakeley, catch
him as he entered his office, rattle off a half a dozen questions to him, obtain her answers
and then leave to see that his will was implemented. She seemed confused about the
meetings. As a very social person--the sponsor of numerous Valentine, Birthday,
Christmas, St. Patrick's and Happy Day parties, not to mention the annual office cook
out--she appeared to welcome the opportunity for collegial interaction; but it seemed
clear to the consultant that she was afraid of dumping her issues on the table for everyone
to see. The consultant assumed that, in the first place, that would leave her less time to
interact directly with Dr. Blakeley--a clear priority of hers and a symbol of her primacy
within the organization. In the second place he might, incredibly enough, raise his voice
and verbally abuse her in public, which he managed to do at the second meeting of this
group. Her way out of this bind was to submit agenda items of only moderate substance and
almost no compelling interest. At least initially, she continued to do business as usual,
taking the interesting and important issues to Blakeley directly.

The Finance Director, located in an office building in the next town, was an enigma. A
CPA by training, he was one of the most disorganized financially trained individuals the
consultant had ever met. He simply could not be relied on to do anything in a timely
manner and accountability was clearly one of his least favorite concepts. He never
submitted an agenda item in the time the consultant was in attendance at the meetings; he
never spoke at the group unless he was asked a direct question. He came late and often left
early. It was not entirely clear why Dr. Blakeley tolerated his indifference and lack of
cooperation; it would, in fact, never be clear. He too, would continue to do business as he
always had with Dr. Blakeley.

The soon to be Director of Management Services, Ms. Wilson, was the third and
newest of the senior managers. She understood and appreciated the need for process, was equally appalled that the senior managers had not been meeting and were generally unaware of what each were doing, and recognized the extent to which her fellow managers had allowed themselves to become dependent on Dr. Blakeley for direction. She also recognized the extent to which Dr. Blakeley may have encouraged that process. She participated actively and tried to facilitate the activities of the group as much as possible. Assuming responsibility for the MBO program, she brought it to the meetings, determined to use it as a team building exercise--an approach that was moderately successful. She represented the best chance for the members of the group to break out of their isolation and work to build synergy as a team.

There were two lesser senior managers in the group. They were lesser in the sense that they were seen as technical managers, with a very narrow range of responsibility. The MIS manager was a pleasant and detailed oriented individual; she too could be counted on to take the process seriously and to work with it as much as possible. Then there was the Physical Plant and Equipment Director. His issues seemed to exist at the level of how many tulip bulbs the Group should order for spring planting and how much DMG should pay a driver for mileage--22 cents or 25 cents, yet he insisted on taking these issues up at the meeting. In private with Dr. Blakeley however, he would discuss equipment purchases and capital projects.

The consultant undertook only one deliberate intervention within this group--that involved a direct, private confrontation with the President. At the second meeting, the consultant had watched as the President had raised his voice and slapped the table, expressing displeasure at something one of the Directors had said. The Director did not respond to the outburst, but it clearly embarrassed her and the consultant was worried
about the cumulative effects of this behavior on the group's process. No one enjoyed being loudly reprimanded in public; the consultant believed that fear of triggering that kind of outburst would tend to suppress participation, or, at least result in the selection of the most innocuous items possible for the agenda. The consultant was so startled that it had happened however, he said nothing at the time of the incident.

During the fourth meeting, the group was discussing a sensitive problem concerning patient care. Dr. Blakeley turned to the consultant, raised his voice quite loudly and said: "I'm going to be really pissed off at you if this turns up in some report to the Board--do you understand". The consultant replied: "Our agreement is that you will see everything that goes to the Board before it goes there." Blakeley replied, still loudly: "Fine--I just want you to know how I feel." As the meeting ended, the consultant asked Dr. Blakeley to stay a few moments and the following discussion ensued:

Consultant: I'm curious as to why you found it necessary to raise your voice to me in the middle of this meeting.

Dr. Blakeley: I don't want the Board seeing this stuff; they won't understand it. I need time to deal with it before it goes to the Board.

Consultant: We have an agreement that nothing will go from me to the Board without you seeing it first. Did you forget that agreement or do you not trust that I will keep my part of that bargain?

Dr. Blakeley: (Silence)

Consultant: Are you angry with me about something else?

Dr. Blakeley: I just didn't want that information going to the Board.
I see. Well...I think there is something you need to understand. In this culture, it is socially acceptable for an adult to yell at a child--although even that is changing. It is not socially acceptable for an adult to yell at another adult in a normal business setting.

When you did that to me, I felt very angry with you. I felt that you were treating me like a child. I suspect that your managers feel the same way when you yell at them, and there is probably more embarrassment involved for them than there is for me.

Now you're...

I'm not through yet; please wait until I finish what I am saying. The other issue, aside from the impact of your behavior on my feelings, is the impact of your behavior on your managers, relative to me. When you attack me like that in front of them, it is a way of communicating to them that we are not working together as a team. They will feel less compelled to be cooperative with someone if they believe that person is an annoying pain in the ass that their boss dislikes.

Do you understand what I'm saying?

Yes. Now you're telling me that I can't even be human--that I can't let my feelings show. These are my people. They know me. They don't mind it when I
yell at them. It's over in a few seconds and everyone goes back to work.

Consultant: I'm not suggesting that you become inhuman. I'm suggesting that you try and develop some insight into the impact your behavior may have on people and that you change your behavior where necessary to avoid damaging people. To me, that is eminently human behavior. You're a pediatrician...what would you tell a mother with a temper tantrum child...that it's human for him to let his feelings out? Like hell you would.

You'd recommend that she put him in a quiet room for time out, so that he would understand that his behavior was not acceptable. And I do not buy, for one microsecond, that your people do not mind being yelled at. I've seen you yell at several people on staff and during the merger negotiations; their physical reactions were not those of people who did not mind. You do not, as a manager, have a right to abuse and infantilize your staff. Good managers find ways to communicate their needs and wants without resorting to that approach.

Dr. Blakeley: I'm late; I have to get over to the clinic.

Consultant: Fine--but try and think over what has been said here. If you really think I'm off the wall, find a
colleague you know and respect and ask him or her for an honest opinion. This is an opportunity to detach, gain some insight and take a step towards looking at what other people see.

The exchange highlights the political elements involved in the intervention at that phase--approximately halfway through the process in terms of time. Blakeley had endured the Board interview summary session and the Board meeting at which the report had been presented--a meeting which the members of the Board had almost unanimously liked; the report itself could have been read as at least implicitly critical of Blakeley's management (although it was careful to assert that all parties appeared to be equally responsible for the circumstances which the organization faced, to the extent that responsibility was a relevant variable) and now Blakeley was chairing a meeting that was being held for no other reason, that he could probably see, other than the fact that the consultant suggested it be held. The consultant was sitting there across from him, taking more of those "damn notes". This was not the world he was used to.

In short, there was a stranger in his organization, doing things that were attracting attention from his Board and undermining his position and that stranger seemed to be slipping even further beyond his control.

The consultant viewed Blakeley's attack as an acting out of anger at the circumstances and the consultant and a need to reassert his dominance, at least in front of his own staff. Blakeley would not have acted that way in front of the Board; he could not have afforded to. The outburst seemed best explained as a demonstration of power--a way of asserting that the consultant still worked for him; that the consultant could be "instructed" by him.

The consultant's response to the outburst was informed by one perception and
motivated by three issues. The perception was that he was now reasonably protected within the organization. The Board had adopted the report, appointed a Subcommittee to work with the consultant and seemed enthusiastic about the process that was about to commence. From this point on, it would be extremely difficult for Blakeley to move against the consultant, in the absence of some gross impropriety. Having a Subcommittee to work with also freed the consultant from having to depend upon Blakeley; the process now had a life of its own and Blakeley was one participant in that process. In some sense, the consultant had given up on Blakeley—if he did not want to play, fine—the game would go on without him.

The first issue, at least in the consultant's mind, was that Blakeley's behavior had been problematic. Verbal abuse of people is generally considered to be an ineffective management style. Blakeley needed to be called on that behavior and there was only one person in the organization who could do that then (Ms. Wilson would eventually become a second—although for different reasons).

The second issue, was that Blakeley needed to be made aware of the linkages between his behavior and events within the organization. He needed to understand that his behavior sent signals to his staff—signals that he could choose to control or moderate to achieve broader goals. This had been an ongoing project with the consultant and this incident seemed like another good example to use.

The third issue involved maintenance of the political advantage. The consultant had successfully moved his work to the Board's domain, reducing the leverage which Blakeley had in the process. The outburst was, at least in the consultant's mind, an attempt to regain some measure of that leverage. The consultant blocked that to some extent and there were several factors involved in his response.
The consultant had at first been patient, then mystified and finally, increasingly angry, at Blakeley's arm's-length treatment of both himself and the process. It was not the reception the consultant was used to or wanted and while individuals who go into consulting as a profession appear to have fewer needs for collegiality than others, they are used to getting those needs met by the joint enterprises they embark upon with their clients. The consultant realized after the Board interviews that some of this was related to the circumstances of the engagement: the Board may not have given Blakeley much of a choice. Even beyond that though, there was an unwillingness on Blakeley's to interact on a peer level with the consultant. The consultant eventually came to understand and accept, much later, that physicians only interact collegially with other physicians; Blakeley would not have come around. The consultant however, was going to draw the line at letting Blakeley abuse him in front of staff. Collegiality was one thing; respect was another.

The other issue was that the consultant wanted to reinforce the need for Blakeley to work within the newly established process. To the extent that Blakeley's outburst was an attempt to reclaim some measure of jurisdiction over the consultant, the consultant used it as an exercise to reinforce his measure of independence. The Subcommittee would now be the arena within which all of the issues would be considered and addressed; Blakeley would have to get used to working within that process. The consultant now worked for the Subcommittee.

The consultant stopped attending the senior staff meetings shortly thereafter. The group had a lot of work to do getting to know each other, learning to work cooperatively and dealing with the emotional issues beneath the surface. He felt that his presence was a distraction at the moment. He trusted that Ms. Wilson would be skilled enough to coax the process along, now that it had been established.
The other process involved trying to work with Dr. Blakeley. Early in the consultation, the consultant suggested to Dr. Blakeley that managers and physicians think about the world in different ways and discussed some of the research findings on differences. Dr. Blakeley accepted that the world views were different. The consultant then suggested to Blakeley that it might be valuable for him to understand more clearly how managers think about given problems and situations; the consultant "promised" to be as clear with his thinking as possible and to verbalize his thought processes as much as possible, throughout the engagement. To that end, the consultant spent a great deal of time talking through the various recommendations with Dr. Blakeley, identifying the variables involved, describing his assumptions about how they interacted to produce the problem and sketching how he thought the recommendation would change the situation. Blakeley would usually listen intently, occasionally disagree or ask a question, but otherwise never provide any specific feedback. It was not joint diagnosis, but it was Blakeley's first serious exposure to a management oriented thought process.

There were two other specific attempts to intervene directly with Dr. Blakeley. After some thought, the consultant had developed a list of management topics on which he thought Blakeley could use come conceptual input. There were five topic areas: the nature of management, management style, executive leadership, motivating people and tools (e.g. running a meeting, time management etc). He then carefully selected several Harvard Business Review articles on each topic area. Finally, the consultant suggested a weekly luncheon get-together between Dr. Blakeley, Ms. Wilson and himself. The luncheon discussion would focus on an article or two that everyone had read. The consultant described it as a joint study group. Ms. Wilson was enthusiastic; Dr. Blakeley had said "sure--why not."
The first session was a disaster. Blakeley had been on call all night and was present only in a physical sense. The session probably should have been canceled, but lunch had been ordered, so the group plodded along with the discussion. The second and final session contained many long silences, as both Ms. Wilson and the consultant left space for Dr. Blakeley to participate in the conversation. It was not to be. Towards the end of the discussion, Blakeley asked if there was some way to give him one specific management problem at a time and then instruct him precisely on how to fix that one problem. The consultant said that he did not believe so, not about any important management problems anyway, but that he would think about it.

The consultant thought about it. Blakeley, in an earlier discussion of how he had learned to do a C-section, had characterized medical education as a process of "see one, do one, teach one." The consultant realized that not only had Blakeley been thoroughly socialized with respect to professional values and behavior; he had been socialized with respect to learning process as well. Management education does have a skill base to it, but it is primarily a process of building a conceptual context within which judgment can develop. Judgment is necessary because management issues and problems are not often discreet, tangible things sitting on a table for all to see; they do not come with a set of specific symptoms or a diagnosis code that triggers a precise sequence of steps and countermeasures. The consultant realized that there was a lack of fit between the learning process he was trying to use and the learning process that was obviously ingrained within Dr. Blakeley. After a discussion with Ms. Wilson, who supported the analysis, and a conversation with Dr. Blakeley, who just seemed happy to be out from under, this intervention was terminated.

An interesting side effect however, was the realization that Dr. Blakeley's best
chance for improving his management ability was by watching a management professional at work over a period of time. The consultant raised this analysis with Ms. Wilson and with her concurrence, spent a considerable amount of time encouraging and supporting her as she attempted to emerge as an in-house management mentor for Dr. Blakeley. Over time, she was able to do so and her role essentially changed to that of consultant. She would provide Blakeley with her "take" on a given situation, confronting or encouraging his perceptions as necessary. Alone among staff, she interacted with him as a peer and interestingly enough, Blakeley seemed to enjoy the interaction. She did not always win her point, but she often did win and in all cases, Blakeley had the benefit of having been exposed to a management thought process.

Finally, there was one specific problem with Dr. Blakeley's management behavior that the consultant decided to attempt to change. On numerous occasions, the consultant had watched in astonishment as a variety of people, including senior managers, brought issue after issue to Dr. Blakeley's door. Each needed his immediate response and for the most part, each issue should have been addressed by the individual appearing at the door. It was not clear whether these people were always that dependent on Blakeley or whether his need for control had beaten them into submission over the years, but it was clear that little or no staff growth was going to occur as long as that process continued.

Oncken (1974) developed a time management allegory using monkeys to represent given management issues. These monkeys (issues) lurk on the back of subordinates, just waiting for a chance to leap onto the back of a passing supervisor. A monkey does so every time a supervisor stops to talk with a subordinate and ends up agreeing to make a decision for a subordinate or acts in ways which remove initiative for resolving the issue from the subordinate. The article makes the point that a manager who ends the day with an office
full of hungry monkeys that do not belong to him and that need to be fed will, in fact, feel very busy—but s/he will not be busy doing the things s/he is supposed to be doing and, in fact, will have less time to attend to those.

While used as a classic time management instruction tool, the article is also relevant to the empowerment of staff. The consultant told the monkey story to Dr. Blakeley during one of their routine progress report sessions. To make sure the lesson stuck in his mind, he dramatized the point, pulling invisible monkeys off of his back and feeding invisible monkeys around the office. The consultant then commented that Blakeley's office was a veritable zoo and that he hoped the monkey population would decline soon. Blakeley actually laughed. He apparently liked the allegory.

A few days later, the consultant dropped off a copy of Oncken's *Harvard Business Review* article. From time to time, after watching an interaction between Blakeley and a staff member, the consultant would start pulling at his back or ask if Blakeley had enough monkey food in his office. On several occasions, the consultant revisited the interaction with Blakeley, suggesting alternatives that Blakeley could have used to ensure that the initiative for problem resolution had remained with the manager.

The Planning and Implementation process had begun in March. By the end of May the consultant was functioning as a shadow consultant to Ms. Wilson, helping to empower and support her as she picked up the role of change agent within the organization and carried on with the intervention process. The consultant provided a one day orientation session for the new Board during the summer, focused on (1) the respective roles and responsibilities of the Board versus those of management, (2) effective meeting etiquette and (3) negotiating differences. It was to be his last formal act with DMG that year, although Ms. Wilson kept in steady but informal contact.
Critique and Evaluation

Evaluation technology is fraught with peril. Burke (1987, 130-142) provides a detailed discussion of these problems and concludes that, daunting as they may appear, evaluation is necessary for the field to grow. What follows, unfortunately, is hardly a formal evaluation of the DMG intervention. It is a look, more experiential than empirical, at how the Group seemed to have changed--and not changed--a year later.

The consultant had suggested, during one of the Implementation Subcommittee meetings, that the Group adopt a set of standards and criteria for the "reorganization", so that when it was over, the members of the Subcommittee could evaluate whether they had accomplished what they had set out to accomplish--if the organization had, in fact, changed the way they had wanted it to change. The Subcommittee members discussed the idea and eventually adopted a document which contained three broad standards framed as questions:

1. Is the Board of Director's constructively involved in DMG's business?
2. Is management organized and functioning sufficiently to define, preserve, protect and advance the business needs of the organization?
3. Has the organization been able to evolve to the point where individual interests and needs are understood, not only on their own terms, but in relation to the interests and needs of the organization as a whole?

Each standard was followed by a set of criteria which were to be used in determining whether or not the standard had been met (Appendix 3).

In January of 1989, the consultant was asked to attend a meeting at DMG with Dr. Blakeley and Ms. Wilson. After some discussion, the consultant agreed to conduct another interview process in order to evaluate how well the organization was doing with its
"reorganization". Following essentially the same process as before, adding interviews with the Department Heads and reviewing a large volume of written materials, a report was developed and submitted in August.

The first goal of the reorganization was to ensure that DMG's Board was constructively involved in the business of the Group. The evaluation indicated that some progress had been made to that end. The flow of information to the Board had become timely and predictable; the information itself seemed substantive, detailed, generally well presented and consistent with the established agenda. Board process had become more routine and less frenetic; there was less antagonism, in general, between the members of the Board and the CEO, there was a greater shared understanding of the responsibilities and roles entrusted to the Board versus those entrusted to management and most of the members expressed a degree of optimism and satisfaction with the work of the Board. The Board no longer refers decisions to the Shareholders. It either makes the decision or not and informs the Shareholders of its decisions on a "for-your-information" basis. The differences between the Board comments obtained in February of 1988 (Appendix 1) and those obtained July of 1989 (Appendix 4) were striking.

It also seems fair to say however, that the net effect of this progress has been to ensure that the Board is less destructively involved in the business than it was before; the Board's involvement in the business is still not constructive in nature, unless one is willing to define constructive as doing minimal harm. It's members are apparently finding it difficult, from time to time, to take the issues as seriously as they need to be taken and to take the time necessary to fulfill their responsibilities. This is much less destructive to the organization than it has been in the past, because management has assumed much more power, relative to the Board, and is exercising this responsibility fairly well.
The Board appears to have become very passive, except in the case of financial
issues; there was almost no serious questioning of the materials submitted by management
for each Board meeting and Board discussions were often relatively short and uninformed;
from the Board member interviews, it was clear that several Board members were still
unfamiliar with the nature and scope of management work, which means that they had
either not read or not understood the MBO materials which had been submitted to them for
review and approval throughout the year.

The Board's handling of Sub-Committee work was also problematic and has had a
Keystone Kops quality to it, resulting in wasted time and energy and the production of
unnecessary anger and frustration on the part of Subcommittee members. The
Implementation Subcommittee has fared very well with the Board; the Finance and CEO
Relations Subcommittees have had a variety of negative experiences. Some of the Board
members apparently remain either unwilling or unable to detach themselves from their
personal and/or Departmental interests and biases for the good of the organization. The
Chairperson, unfortunately, has not emerged as a strong, effective and positive force,
providing discipline, direction and cohesion to the activities of the Board and, continuing
with an established pattern, none of the physicians on the Board had communicated to the
Chair their negative perceptions of his performance, prior to the evaluation.

While the Board seems headed in the right direction in many ways, it would be
stretching reality to characterize its current relationship to the organization as
constructive. The reduced meeting load, a preestablished agenda, and the removal of
operational issues from Board discussions, among other changes, have reduced the
possibilities for negative Board impact on the organization; the problems with the Board at
this point seem to be ones of attitude and capabilities, not mechanics. It remains to be seen
whether this situation is just a function of experience, transitional in nature, or whether more fundamental dynamics exist which are preventing the Board from reaching the desired goal of optimally constructive involvement in the business.

The second goal involved the operations of the management staff and the sufficiency of those operations. There were significant achievements made in the management of the organization; there was widespread recognition of that reality as well, on the part of both Board and staff members.

The Department Heads have been successfully integrated into the management life of the organization and they have enthusiastically begun to work with their Departments; the Director of Management Services has done an outstanding job of breathing life into a new and difficult senior management position; new internal management processes (MBO, Strategic Planning Process, Senior Staff Meeting, Department Head Meeting) have been introduced and existing processes (Board and Subcommittee meeting agenda setting and preparation processes) have been tightened up; the organization has finally developed a sophisticated technical capacity to assess its hospital utilization and outpatient referral experience and senior management is in very positive team building process. The President has a Board negotiated job description and a contract which should offer him sufficient protection to perform the functions of his position.

There are still management problems which need to be addressed, particularly in the Finance Department, but at least one gets the sense that they will, in fact, be addressed. Management now seems sufficiently organized and functional to address the business needs of the organization on an ongoing basis: that is a significant statement for this Group.

The final goal was concerned with how far the organization has evolved with respect to being able to distinguish individual needs and interests from those of the organization.
There was some progress here as well, although there was also a great deal of controversy.

If nothing else, each Board member was able to freely articulate the concept of fiduciary interest during the interview process. The language of the goal does not ask that the members of the Board always adhere to the strictest interpretation of their fiduciary responsibility. That would be unrealistic. It does ask that there be an awareness of interests and needs that exist beyond the realm of self interest; that each member of the Board be able to understand that what s/he wants is only what s/he wants and is not necessarily "good" relative to another set of competing organizational needs and interests. On average, the end results of Board activity should support the needs and interests of the organization.

The Board has been able to adopt a Mission Statement that clearly establishes the primacy of the organization; it was able to adopt a Sanctions Policy that establishes the right of the organization to take action against a physician who is acting to the detriment of the Group. It has at least begun to debate the issue of physician compensation--almost a taboo subject for many years.

The controversy arises because there was considerable disagreement over the Board's compliance with the fiduciary principle. Most members of the Board tend to believe that they have been very faithful to the principle--that they have invariably acted with the interests of the organization at heart; several members of the Board and the majority of the management staff (who now attend and speak at Regular Board meetings) do not accept that as being true. The feedback that has gone back to the Board, is that they are not focusing enough on the organization's interests. It will be interesting to see how they respond to that feedback in the long run.

In many ways, this has been a very important year for DMG. Internally and
externally, the organization has had to operate in an environment of almost constant change. Overall, the results have been quite good.

There is an increasing awareness that the organization has needs and interests that have to be taken into consideration if it is to survive and prosper; there are processes in place that at least ensure that critical issues are placed on the table to be addressed. There is much less unresolved anger at the Board--its members seem content with the changes in the organization and with the role they have played in making those changes, even if others view their role as entirely too passive. The senior staff has begun to work well together--there is not a great deal of synergy there yet, but it seems to be in sight. The Department Heads have been invaluable in organizing their Departments and in working with the Associate Medical Director to deal with physicians who are creating utilization problems for the Group. According to the Finance Director, the organization saved approximately $500,000 last year on the basis of outpatient referral contracting reforms and new data analysis approaches developed by Ms. Wilson's staff and implemented by the Associate Medical Director; hospital utilization targets are finally being met and the Group is in the black for the first time in several years. There is a very clear sense, from many within the organization, that things have changed for the better. There is a sense of optimism that was not present in 1987. Some of that is undoubtedly due to the Group's survival of the merger and to the positive financial results, but some of it is also due to the feeling that things are finally somewhat under control--the organization is not as "crazy" as it was before. Financially, the organization is in better shape than it has been for some time; organizationally, DMG is in better shape than it has ever been.

There are certainly issues which remain to be addressed; problems which need to be resolved. The changes at DMG to date have been oriented to structure and process--there
are still a number of behavioral issues that will need to be addressed as the organization continues to evolve to maturity.
CHAPTER 3
ASSESSING THE CONSULTATION

Thoughts on the Downtown Medical Group

Effects of the Intervention

The intervention at DMG has effected the medical group in a variety of ways; it has also put into place a number of elements that will continue to effect the organization as time passes. Many of the specific changes have been discussed in the preceding chapter. This section will focus on those changes that have more subtly altered DMG or that promise to do so in the future. It will also attempt to sum up the net impact of these changes on the organization.

Perhaps the single most important effect of the intervention is that the concept of DMG as an organization, having interests that are more than just the sum of the interests of its individual physicians, has begun to take hold. Both Board members and staff report that the question "Is this good for the organization?" is beginning to be asked by a variety of people in a variety of settings. The Mission Statement and the Sanctions Policy both make it clear that individual and professional autonomy, while of critical importance, will no longer be allowed to contravene the interests of the organization as a whole. Granted, these policies have not yet been invoked, but their adoption alone represents a breakthrough for the Group. The Board would have been unable to adopt such policies two years ago.

Acceptance of this principle was the first step that allowed the organization to go further and adopt structural reforms and policy changes in order to deal with the lack of fit between the Market Response Strategy which the Group had chosen to follow and its
Organizational Tradition. The Board opted to change the tradition rather than the strategy, a realistic choice given that the Group's financial position precludes an attempt to back away from its market commitment any time soon.

There is a lot more work to be done, particularly with encouraging the physicians in the Group to fully embrace this philosophy and to implement it in their daily routine. This stance however, if maintained, will allow the Group to develop the collective will to challenge those physicians who consistently act to the financial detriment of the Group as well as those whose interpersonal behavior continues to be unacceptably destructive. It will give the organization the ability to explore other business opportunities, secure in the knowledge that the Group can effectively manage outcomes.

The interventions at Board level—particularly the requirement that a physician may not serve as both a Department Head and a member of the Board—have begun the process of altering the distribution of power within the organization. Before the intervention, the Board was made up of older physicians who could be counted on to protect their Departments and a group of younger, more management oriented physicians, who were often upset about the direction in which the Group seemed to be headed. Not having been "raised" in a purely fee-for-service world, they were philosophically more adaptable to the exigencies of the managed care climate. The deadlock at Board level often seemed to be generational in nature; the younger physicians would disagree with their seniors but, in the tradition of collegial deference, there would be no rebellion. Neither however, would there be consensus; effective decisions could not be made.

Whether a conscious strategy or not, these younger physicians, with one exception, all chose to run for the Department Head positions within their own Departments and won their seats. They are now operationally in control of major segments of the organization, strategically positioning themselves for the future and gaining experience in the nuts and
bolts of management that few of their peers will have and none of their seniors appear to want. They meet as a group with the President, on a biweekly basis, and they have begun to openly challenge him when that appears necessary; they are enthusiastic about their new jobs, intensely supportive of each other and are looking forward to making an impact on the Group.

The Board is now composed primarily of senior physicians and their allies; it is a fairly passive entity. The newly structured Board no longer meets weekly; its agenda is carefully managed to ensure that operational issues and matters that are more appropriate to management remain in management’s hands--its members focus on longer range policy issues. While they are meeting less often and responsible for fewer issues, the Board members are actually accomplishing more than before and feeling better about their work.

If physicians thought in political terms, and at least at DMG they apparently do not, it would not take many of them long to realize that the younger physicians at Department level are now in a better position to affect the day to day reality at DMG than the senior physicians on the Board. The intervention may, in fact, have allowed the next generation of leadership at DMG to emerge in its own right. These physicians at least seem comfortable with management and they seem to accept the necessity of managing their fellow physicians: something the senior physicians in the Group have never really been able to countenance.

The intervention has also led to a redistribution of power away from the President. The Board has its own Chairman; there is an Associate Medical Director; there is a Director of Management Services and five new Department Heads. The organization is much less of a “one-man show” than before. This was eminently necessary for the health of the Group although it has had the effect of narrowing the President’s options on any given issue. It is a complex set of tradeoffs, but in general (1) there is less for him to do
directly but (2) much more for him to supervise; (3) his authority to act on those issues that are clearly in his domain has never been stronger but (4) he has to work things through with more people now in order to get anything done. On any given issue, he can be challenged by the Chairman of the Board, the Director of Management Services or the Department Heads; not in a negative sense necessarily, but in the sense that they may express disapproval of his chosen course of action and he will have to take that into consideration.

The intervention has also resulted in a net increase in management resources available to the Group. Prior to the intervention, most of the organization’s general management matters were handled by the President. He would interact with the outside world, with the members of the Board, with the 111 physicians on staff (in his role as Medical Director) and with his own management staff—all on a part time basis. The overall effectiveness of this approach was less than optimal.

The intervention created a new senior management position, accurately described as a Vice President’s position by a Board member. Ms. Wilson’s job description was designed to functionally complement the President’s job description and to ensure that work the Group needed done would get done. By the end of the year, she had been able to build a competent five person staff. In addition, the intervention created five physician Department Heads, interposing a layer of management structure between the Medical Director (President) and the 111 physicians on the premises. Finally, an Associate Medical Director’s position was created, adding a .30 FTE to work on the difficult utilization review issues critical to the financial success of DMG. This is a significant increase in management resources for a relatively small organization, yet is a probably a testament to how under-staffed the organization was initially.

By accepting the necessity of the functions which these positions address, the
organization took a critical step towards the definitive alteration of its culture. As
managers, and as physicians interested in being seen as managers, the individuals who hold
these positions will act to counterbalance those elements within DMG's culture that would
like the organization to revert back to its individualistic-autonomous status. The
organization will not change overnight--this is an evolutionary process at best--but it
has taken a necessary step towards getting on with that evolution.

Perhaps more importantly, the addition of these resources will allow the
organization to take some action towards establishing a modus vivendi between the need for
management and the imperative for autonomy. In the absence of these resources, there was
no need to work out an arrangement; with them in place, there is probably no longer a way
to avoid having to do so.

Finally, the management staff has clearly begun to function as a team. The senior
staff meeting is becoming a serious setting for the discussion of problems and issues facing
the organization. Even the Finance Director, who seemed determined to not participate in
any management team activity, is now a full participant in the senior staff meeting. The
MBO process has been joined by a Strategic Planning process, both managed by Ms. Wilson.
Both activities give the management staff a chance to work together in the service of the
organization and they provide Dr. Blakeley a chance to observe how professional
management processes are supposed to function in an organization. It is not at all clear,
alas, that he appreciates having that chance.

The development of a strong management infrastructure within this kind of
organization may be critical to its survival over the long run. Without such a structure,
the organization is solely reliant on the management skills of its physicians; with such a
structure, the physician-managers at least have management resources in-house to learn
from and even during long periods of physician inattention to the organization, there is
still a hand on the steering wheel. Unfortunately, if DMG is representative, physician-managers may choose professional managers less for their management credentials and skills than for their passivity and deference to the medical culture of the organization.

Downside Issues

As a result of the intervention DMG, as an organization, seems to have clearly changed for the better in some important ways. In other areas, changes have been less than impressive and the failure in these areas raises a question, at least in my mind, as to whether these kind of organizations will ever approach optimal functionality.

The physician collegium itself remains relatively untouched by the intervention. The work that has been done has been done with no more than a dozen physicians--less than half of the Shareholders. As organizationally passive as some of these physicians have been, they represent a considerable advance over the rest of the Shareholders; they are beyond doubt the most organizationally tolerant physicians within the Group. I have attended several Shareholder meetings and the impression one gets is that the organization remains essentially transparent to the rest of the Shareholders; in the past, their sense of reality began and ended at the door to their examining rooms, although there is some hopeful change in that regard.

This is problematic only to the extent that (1) the attitudes of the currently uninvolved Shareholders remain unchanged by contact, over time, with their peers who have chosen to play a more progressive role in the organization and adopt a more liberal stance with respect to the need for tighter management (2) at some point the currently uninvolved Shareholders begin to assume positions of power within the organization. That would be a retrograde development, one that would probably halt the process of evolution
the Group has begun and plunge it into a period of instability. There is no way to objectively assess the probability of this happening, although, given their past willingness to ignore the organization, it certainly does not seem likely.

The Board's deliberations remain problematic as well, as evidenced by the controversy over fiduciary responsibility that emerged during the evaluation. Board meeting dynamics have certainly changed. There is always an agenda and materials, provided in advance; the meetings are presided over, more or less, by the Chair; Blakeley's domination of the meeting is not nearly as overt as before; the members spend much less time off on tangents; it can be said that the Board is actually making decisions now, rather than sending issues off to the Shareholders, and there is a palpable sincerity among Board members about "doing a better job".

Unfortunately, they just do not seem to know what "a better job" means within an organizational context. They have spent years thinking about organizational issues only when absolutely necessary and then, only within the context of how a given decision would affect their individual practice. Most, if not all, have apparently come to accept that being on the Board requires more of them, but they seem to lack the conceptual base necessary to meet the new standard of behavior. Fortunately, the organization is no longer governed primarily from the Board room. The Board members have time to learn their new roles if, in fact that is possible, without jeopardizing the interests of the organization, as their deliberations have in the past.

Dr. Blakeley remains a cause for concern. Despite almost two years of relatively intensive work going on all about him, Dr. Blakeley's stance relative to the organization remains essentially unchanged. It is true that there are more people sharing power. It is also apparently true that he has become better about letting his staff solve the problems they are being paid to solve; while his patience definitely has its bounds, he is clearly
feeding fewer monkeys these days. He has also become more somewhat sensitive to the feelings of people around him.

In two respects however, he has not changed measurably and these involve traits which seriously impede his ability to manage the Group and retard the overall progress of the organization.

Despite the push of Department Heads from underneath and the pull of Ms. Wilson from the side, Blakeley remains an essentially reactive manager. He rarely takes the initiative in a matter and even when there has been relative agreement between him and his senior staff about a course of action, it will sometimes take him weeks to finally implement the decision. Ms. Wilson has noted, with some frustration, that "when his in-box is empty, he thinks he's done--he goes back to the clinic."

He responds to problems that have been brought to him--as physicians are trained to do--and he often responds decisively and forcefully--as they are also trained to do. Yet he lacks a well developed ability to anticipate the future, to identify and move towards opportunities for the Group, to define a vision of what the organization can be and to motivate its members to adopt and work towards that vision. This imposes an opportunity cost on the organization; the dimensions of the cost are unknown.

Blakeley's need for control also remains an issue. Part of the consultation process involved helping him see that he was over-participating in the affairs of the Group and that that allowed others to under-participate. He seemed to understand that point and did not fight the loss of the Board Chairmanship or the addition of other managers to the organization. Yet he placed himself on the Finance Subcommittee established by the Board and essentially assumed its Chair; he has also recently taken over the newly formed Strategic Planning Subcommittee.

There are two problems here.
First, if the physicians in the Group are serious about their stated goal of maintaining control over their own destiny (i.e. not turning management of the Group over to non-physicians again) then they need to invest themselves in the management of the Group. Leading them to make this investment is a very slow and essentially strategic process; the Subcommittees should be playing a significant role in this process. They are composed not only of Board members, but of non-Board Shareholders--physicians who, in the past, have rarely participated in organizational activities. The Subcommittees should be prime opportunities to allow these physicians to work in a guided management process, to develop confidence in the organization and to invest in the management activities of the Group.

Blakeley's over-participation however, tends to preclude that; no physician in the Group would contest his desire to Chair a Subcommittee and he can be quite intimidating once in that Chair. Even when he does not mean to be intimidating, he can not help himself; his knowledge of the organization can be overpowering to physicians whose contact with it is peripheral at best. The Subcommittee then, instead of becoming a learning experience for the other physicians, becomes a showcase for Dr. Blakeley. What the physicians do learn, is that they are not necessary; that Dr. Blakeley has it all under control. This is unlikely to be a successful approach to getting these physicians invested in the management processes of the organization.

The second problem, beyond the issue above, is that Dr. Blakeley is not an effective Chair. He is certainly capable of defining the issues, or at least most of them, but he lacks the skills necessary to work through the group dynamics and broker consensus. He has no patience with the mechanics of meetings and even though he now knows the difference between "good" meeting process and "bad" meeting process, his need to control the meeting has allowed him to conclude that meeting process is all relative and that he can pretty
much do what he wants to do. Of course, his meetings are often disasters: there is no structure to the discussions, no attempt to frame the issues on the table in terms that can be voted upon and no documentation of the work of the group.

For example, the Board established the Implementation Subcommittee and the Finance Subcommittee at approximately the same point in time. Dr. Blakeley chaired the Finance Subcommittee and staff support was provided by the Finance Director. Dr. Wexler chaired the Implementation Subcommittee and staff support was provided initially by Ms. Wilson and me and then solely by Ms. Wilson.

Both Subcommittees met frequently to address their respective charters. When it came time for the evaluation, the Implementation Subcommittee had a complete set of files to review: agendas, minutes, draft--revised draft--final draft copies of proposed policies and statements and a set of formal reports to the Board, each containing a set of detailed recommendations. The Finance Subcommittee had a single four page memo, dictated by Dr. Blakeley in response to my generic request to Ms. Wilson for all documentation relative to Subcommittee work. The memo constituted the entire record of months of discussion; it was unsupported by minutes or formal reports, so there was no way to verify whether it was an accurate representation of the work of the Subcommittee or a systematic presentation of Dr. Blakeley's biases. It was impossible to derive any specific policy guidance from the memo; it had never been submitted to either the Subcommittee or the Board for review.

The members of the Implementation Subcommittee felt very satisfied with their work; they felt that they had accomplished something very significant for the Group--and indeed they had. The Finance Subcommittee members felt that they had, in general, wasted their time--and valuable clinical time at that. I doubt if the physicians who volunteered to serve on the Finance Subcommittee will be in any hurry to volunteer again.
This issue, like the issue of his reactive management style, also imposes opportunity costs on the organization.

The final area of concern relates to Ms. Wilson. While formally a member of the senior management staff, her role within the organization is more accurately understood as that of consultant. One of her terms for taking the position, was that the organization would have to change--that there would have to be a commitment to organizational growth and development. She has carefully worked out her role with Blakeley so that she has been at the forefront of that growth. Alone in the organization, she is able to confront him on almost any issue; her interpersonal skills, her status as his employee and the fact that she has produced serious results for the Group, allow her to do that in a manner that he apparently does not find threatening, although there have clearly been times that he has found it annoying.

The role of in-house change agent within an organization this retrograde however, is possibly one of the most difficult consultation roles available. Her relationship with Blakeley, while giving her a relative degree of freedom, is still difficult because she can not afford to become perceived as a purely negative reactor within the organization. After two years of biting her tongue on numerous issues so that she has the political capital necessary to intervene on issues that matter, she is very clearly near burnout.

A decision on her part to leave might halt or damage the Board management process, the process of management team development and the progress Dr. Blakeley has been making on his management style. This may be a short term adjustment or it may be permanent. If she is not replaced at all or if she is not replaced with another as skilled as she, a major impetus for change from within the organization will vanish. It is not clear whether there has been sufficient change within the organization to allow it to perceive the need for the services which she provided. Her leaving will probably be the first test as to
whether the organization's culture has actually changed or whether the changes were essentially cosmetic.

In the final analysis, the most significant result of the intervention may well be the reinforcement of the existing management infrastructure with additional management personnel. Their presence has already had some of the desired effect of stabilizing and structuring the decision making processes of the organization. Their input into those processes should, over time, increase the relevancy and quality of the decisions being made by the Board and President. They, or their successors, will probably be with the organization long after the physician's new found enthusiasm for management reform has been lost in their preoccupation with clinical life.

I sometimes have the persistent feeling however, that instead of helping to cure an acutely ill organization, I have merely been a party to turning it into one with a treatable chronic illness. As long as Dr. Blakeley--or perhaps any physician--is Chief Executive Officer of DMG, the organization will continue to accrue a variety of opportunity costs; it will always be operated on a sub-optimal basis. It will probably not fail--the management staff should be in the position to direct physician attention to key issues before it is too late--but it will probably not excel either.

The reality is that Blakeley, or his physician replacement, will always view management as a side-line; medicine will always have first call on the energies of the physician-managers in the Group. Perhaps that is as it should be; but it means that the organization will always receive second best from those responsible for generating management initiative. It will probably never be a "well managed" organization, as most management theorists or practitioners would define that term, although that might be said of most organizations.

Perhaps the truest statement that can be made about the intervention is that it helped
to bring DMG's Organizational Tradition into line with its choice of Market Response Strategy. DMG should now possess the structural and procedural requisites necessary to fulfill its contractual obligations and protect its current interests. As the forces of competition continue to impact its regional health care system, DMG may find it necessary to change again; to continue on a path towards an even more heteronomous organization or to leave the competitive market entirely (assuming they ever pay off their long term debt) for a fee-for-service practice. Hopefully, the changes now in place will allow the Group to make those decisions in a considered manner and without undue costs to the organization.

The Experience of the Process

Expectations and Reality

In the first chapter, it was established that consultation processes were helping processes; that consultants were individuals who intervened "between or among persons, groups or objects for the purposes of helping them" (Argyris 1970, 15). Over time, a consultant develops his /her own view as to how that help is offered and rendered.

In terms of the Lippitt and Lippitt typology described earlier, my typical role definition is close to the Joint Problem Solver role which occurs a little more than half-way through the typology. While I have acted as an Information Specialist and Advocate as well as a Process Counselor and Fact Finder, my normal practice usually seems to focus on that role; I tend to gravitate towards those kind of assignments. I do not believe that there is a particular model, role or style of consulting that is universally appropriate; I just recognize this as my "natural bent". Sensitivity to the needs of the client is universally appropriate and the ultimate selection of role should be a function of
those needs and the ability of the consultant to act within the constraints imposed by the role. With most of my engagements, it has been both possible and desirable to work jointly on solving the problem with the client.

There have been several engagements where I chose to act as a Process Consultant. These engagements have had a series of common characteristics. In each case, there was more than one individual and/or unit of the organization involved and the organizational environment itself was acrimonious. Attempting to work jointly with one or both individuals would have left me open to the perception that I was "taking sides"; my effectiveness would have been severely and perhaps irreparably compromised. In each case, the survival of the organization was not an issue. While the stakes were high to the individuals involved, it was more or less the kind of intramural warfare which occurs with regularity even within well managed corporations. It could have damaged a career or two, but organizational life would have gone on. In each engagement, there was no one side whose position was obviously and overwhelmingly the only logical position for the organization to take. The substantive issues were of a "six of one, half dozen of another" kind; the real problems were with issues of security, prestige and reward. Also, in each case, the problem could have been resolved immediately if necessary. In these cases, there was a senior manager who could have terminated one or more people if the problems had not been worked out and promised to do further damage to the organization.

I initially expected that Process Consultation would be the role of choice at DMG. I knew that there was more than one individual and organizational unit involved; I knew that the internal environment of the organization was acrimonious. Non-directive intervention seemed to be the best tactic in order to avoid being labeled and discarded early on by a particular combatant.

My first contact with Blakeley though, was hardly non-directive. There was no way
to respond to his request for comments on the management of DMG within the terms of the PC role. "Impressions", even if clearly labeled as such, obviously require some level of commitment on the part of their author and implicitly constitute a set of directions. My comments may have been "impressions", but they were my impressions. He had asked for the comments as a personal favor, however, not as a prelude to an engagement. He had wanted "input" into whether or not the Group needed to retain outside assistance. On that issue, he got a very directive opinion from me. I suspected that he might not like it, but I chose to focus on two specific incidents and to provide a critique of organizational performance with respect to those two incidents. I did not know which physicians in the Group were pushing for an outside consultant, but I wanted to go on record as agreeing with them: the Group had some problems that needed to be addressed.

I did not expect Blakeley to call back after his angry telephone call. I did not expect him to request a meeting with me. I did not expect him to agree to my suggestion that I draft a proposal going beyond the review of senior management positions. I did not expect that he would consent to that process once he finally read the letter. His attitude at each of those points in time was either so neutral or so negative, that it seemed inconceivable to me that he would allow an outside consultant within his organization—particularly one who had already been quite clear that he thought there were serious problems with the way decisions were made and implemented within the Group.

It was not until the Board member interviews were underway that I understood, or at least had a theory about, why I had been engaged under such improbable circumstances. Blakeley did not want an outside consultant within the organization; key members of the Board wanted an outside consultant. Of that much, I am certain. In all probability, I was retained to appease the members of the Board who were suggesting that Blakeley be fired and a real manager be recruited to run the Group. It was a middle ground step; he needed to
do something to blunt the mounting criticism.

In the interviews with the members of the Board and management staff, I stayed with a non-directive stance. After the interviews were over, coincident with the decision to develop the organizational diagnosis alone, I reached several conclusions about the Group:

First, it was clear that the physicians were deadlocked and had been deadlocked for some time. One group believed that DMG's problems were related to the absence of effective management within the Group. They were willing to do whatever was reasonably necessary to ensure that utilization and referral targets would be met and that "bad" physicians would be confronted and dealt with appropriately.

The other group of physicians, primarily the more senior ones (with one critical exception), believed that DMG's problems came from external sources: "they" did this to us--they being the insurer partner, the state government, the HMO marketing staff--anyone really. These physicians were highly defensive and saw "management" as a code word for someone telling them how to practice medicine: they were rooted in another time and in the medical culture of that time, a culture where the physician was supreme and had stopped having to justify his medical decisions the day he left residency. The two sides had been talking about the issues for more than five years; no consensus had emerged. There was, in fact, no natural point of consensus.

Second, continued deadlock would probably be fatal to the organization. The Group had signed and was expected to perform under the terms of its HMO contract. Yet it had neither the data systems necessary to accurately monitor its hospital utilization and referral performance nor the management capacity to effectively address performance problems, particularly with respect to problematic physicians. The risk was clear; the organization's financial vulnerability was also clear. If DMG continued to perform as it had for much of the preceding five years, it would fail financially.
Third, even among the more liberal management oriented physicians, there was a serious knowledge deficit with respect to even basic management technologies. Organization charts, job descriptions, strategic planning processes, meeting etiquette—the nuts and bolts of organizational life—were mysteries to most of them. It was going to be difficult to address management issues with a Group that had neither the theoretical nor experiential base to understand the discussion.

Fourth, Blakeley would probably continue to be unhelpful, at best. My presence had probably been forced upon him; he had been resistant from the beginning, I was beginning to understand why and there was little I could do about it. In a very real sense, the "organization" would have to be my client. Theoretically, that had always been true anyway, although it usually makes sense to view the client's immediate agent as a proxy for the "organization". In this case, that no longer made sense.

All of which led me to rethink my expectations as to role and expectations for the intervention. While the relationship with Blakeley was probably too muddied to attempt to revert to PC at this point, my relationship with the remainder of the organization had been minimally intrusive; it would have been possible to attempt a Process Consultation at Board and Subcommittee level.

Blakeley clearly failed to meet the use criteria for PC—his unwillingness to admit to the existence of organizational problems was only the beginning of that failure. Averaging the responses I received from the Board members however, it seemed to me that the Board did not meet the criteria either. While there was agreement that there was a problem somewhere, many in the Group saw that problem as being external to the Group. While Board members were willing to criticize various aspects of the organization, it was not clear that there was a will to explore those criticisms and direct energy at addressing the problems. There was little beneath the surface agreement that there may be a problem
except the fingers of each Department, all pointing at each other.

Beyond the issue of use criteria, it seemed to me that Process Consultation would do little in this environment except highlight the nature and depth of the deadlock between the contending forces within the Group. This was not a polite discussion regarding means; this was a political struggle involving ends. The struggle at DMG was the struggle of a dying medical culture trying to retain control long after its usefulness to the organization had ended. If the organization was not capable of giving birth to a new culture, one which would bring the Group's assumptions and beliefs into line with the needs of the organization and the demands of the marketplace, then the organization would fail.

There was also the possibility that PC's non-directive nature would anger and demoralize the more liberal pro-management physicians, who, like most physicians, wanted answers almost immediately. They tended to view me as an "ally", primarily because it was their pushing that had resulted in my presence within their organization. Quite a few physicians were waiting to see what "the consultant" had to say about things before they committed themselves any further. PC could place me in the position of being rejected by the very people who needed to prevail if the organization was going to have any chance to survive.

A set of reasonably directive recommendations would get the organization moving, be viewed as supportive of the pro-management group of physicians and buy some time for further refining the analysis. Fortunately, since the organization was operating in defiance of some of the most basic principles of management, creating a set of recommendations embodying needed reforms was a relatively easy and low risk task. PC would also prevent me from trying to get across to the Group some basic principles of management. Without this substantive education, my recommendations would appear to be random thoughts without any apparent connections; they needed to see the
whole picture, both to confirm my diagnosis and to feel comfortable with implementation of the recommendations, and they needed to be told specific things in order to reach that understanding.

I decided that my goal for the intervention had to be having the organization in a position to effectively act on the first quarter’s financial results, when they became available in June. To that end, I also decided that I would do everything possible to support those physicians in the Group who sought significant management change. The role would have to be an eclectic one; there would be room for non-directive behavior, particularly with respect to Ms. Wilson and her planned staff, but the organization seemed to need someone to forcefully intervene in an effort to break the deadlock. That seemed to imply the necessity of acting as an educator, information specialist and advocate, more often than not. My organizing principle thus became: I would try to be as non-directive as possible but, in all cases, I would be as directive as necessary.

The Board meeting discussion on termination is a good example of this approach. I would refrain from making decisions and drawing conclusions, always pointing out the nature of the physician’s responsibility, but I would provide a principle or formula or fact, suggesting that it was a key to the problem they were attempting to solve. I would then work through that discussion, if necessary, to make the management point I thought needed to be made.

Theoretical Perspectives

The first chapter also discussed the literature with respect to interventions within health care organizations. All of the literature suggested that health care settings were difficult consulting environments; some of the literature suggested that OD interventions within health care settings had been disappointing at best. The applicability of these
analyses to large, physician managed, multispecialty group medical practices was not clear. In many cases, it was possible to distinguish between the characteristics of the organizations described in the analysis and the generally acknowledged characteristics of group practices.

Weisbord (1976) defined the existence of three social systems within health care organizations--Task, Identity and Governance. He noted that these systems "pull and tug" at each other and that the Task system is both at odds with the other two systems and the least influential of the three. The result was a difficult environment for the successful completion of organizational change activities.

I had initially argued that the lower complexity level of physician managed group practices (N. B. Weisbord's analysis was based on his work within academic medical centers), physician staffing of the Task system and ownership of the practice by its physicians would result in a less competitive, more interdependent internal environment, increasing the probability of successful intervention within group practices.

The experience with DMG suggests that the argument is correct, but that the reason for its accuracy assured at least an equally difficult consulting environment. There was, in fact, very little competition between the three social systems within DMG's internal environment, but the result was actually more chaos--not less. Weisbord was right--the three social systems do pull and tug at each other--but they do so in opposite directions, keeping the organization located somewhere between complete anarchy and total hierarchical control. At DMG, the Task system was staffed by physicians who, even in the name of self preservation, were unable to let go of physician behavior and values long enough to effectively manage the business of the organization. Since they were unable to effectively switch back and forth between roles, the goals, values and methods of the Task system became indistinguishable from those of the Identity system. There was no
counterweight to the pull of the identity system and the organization spun out of control. Even physician ownership of the business was insufficient to overcome physician aversion to the discipline of managed interdependence. The result at DMG was a very difficult intervention within a very difficult organization.

The first chapter also identified the dualism within the literature relative to process versus structural interventions within health care organizations. A discussion of the Process Consultation (PC) model of intervention lead to a question as to the appropriateness of this approach within large, physician managed, multispecialty group practices; another question was raised with respect to the applicability of Plovnick's hypothesis suggesting the primacy of structural interventions within health care organizations to these practices.

Appropriateness needs to be assessed in terms of probable effectiveness, keeping in mind the reality that these organizations are subject to an evolutionary process, as described by Madison and Konrad. Heteronomous group practices, with well developed management structures and operating policies, may be a more hospitable environment for process interventions than individualistic-autonomous practices, usually having little or no management structure or self identification as an organization. It should be noted that DMG was an individualistic-autonomous practice in transition.

The experience at DMG, a large, physician managed, multispecialty group medical practice, suggests that (1) these organizations may fail to meet PC use criteria at the entry and/or contracting phase of the process, (2) they may not have the capacity to retain the diagnostic and remedial initiative necessary for PC, (3) lacking trained managers, these organizations will have a high level need for consultation services best described as educational in nature, a relatively directive stance and (4) these groups will probably be organizations in deadlock, caught in transition between an old culture that no
longer served the manifest needs of the group and the emergence of a new culture that will. In short, these organizations may not have the minimal requisites necessary to support the use of PC for the intervention and the needs of these organizations may go beyond what PC is reasonably designed to accommodate.

The entry phase of the consultation process is composed of various events or thresholds, which have to happen or be crossed before the process moves on to its other phases. Each theorist and practitioner define these elements differently.

Schein is considerably more prescriptive regarding activity in the first phase of a Process Consultation than any of the other theorists or practitioners. There appear to be at least eight conceptual underpinnings in Schein's first phase: (1) the contact is made by the client—there is no attempt at solicitation, (2) the client believes that his/her organization has an unresolved problem that needs to be addressed, (3) the consultant's response to the initial contact should be to listen carefully, agreeing only to discuss the problem at an exploratory meeting, (4) the consultant must attempt to assess the prospective client's "openness, spirit of inquiry and authenticity of communication", (5) the consultant should look for barriers, such as client certainty about the nature of the problem, the client's view of the consultant as an expert, client misperception about the role of a consultant trained in organizational psychology, a client motivation based on a need for assurance relative to a previously chosen course of action or a quick solution to a surface problem—the consultant should be wary about proceeding if these responses arise, (6) the consultant should schedule an exploratory meeting if no barriers are found, (7) the consultant should remain indifferent about whether or not s/he obtains the client and (8) the actual process should not start until and unless someone within the organization "accepts the assumption that relationships and interpersonal processes that accompany organizational problem solving are important targets for learning" (Schein
Schein constructs a similar set of conceptual hurdles for the exploratory meeting and the psychological contracting phase of the process. Process Consultation apparently requires that the client be in a particular state of mind, best characterized as flexible, self-critical and intellectually curious; Schein does not hesitate to pull away from a client that he believes does not meet these criteria at this phase of the process:

If I feel that there is hedging, unwillingness to be critical of his own organization, confusion about his motives and/or confusion about my potential role as a consultant, I am cautious. I suggest that nothing be decided without more exploration, or I terminate the relationship if I am definitely pessimistic about establishing a good relationship (Schein 1988, 124).

Nothing in this narrative seems even remotely descriptive of Dr. Blakeley's behavior during the entry and contracting phases of the process. In all probability, Schein would have terminated the relationship on multiple grounds, including (1) failure to directly admit that there was an organizational problem that needed to be addressed, (2) lack of openness and spirit of inquiry in communications with the consultant, (3) relative client certainty about the absence of a significant problem, (4) unwillingness to be critical of his own organization, and (5) confusion relative to the consultant's role. The consultant certainly never estimated his chances at forming a good relationship with Dr. Blakeley at any greater than 50-50.

One could argue that these responses were merely a reflection of Dr. Blakeley's personality; that there would be no reason to expect this response from similarly situated organizations and CEOs.

Perhaps—but I do not think that is correct.

Dr. Blakeley was a part-time physician CEO, without management training, responsible for a large organization that had clearly slid into near terminal financial
trouble over a period of several years, despite, presumably, his best efforts. It would take
an extremely well balanced individual to not react with confusion, defensiveness and denial
to such an event; some would slip into depression as well, as the only way to deal with the
ever present sense of failure and dread that kind of eventuality must generate.

In short, these reactions, while perhaps not consistent with complete mental health
and certainly not consistent with the requisites of PC--are probably to be expected. Dr.
Blakeley’s own personality quirks, for example, his use of anger and his overt
defensiveness, may have exacerbated the tone of his response, but not its fundamental
nature. Consultants called into this kind of organization in this kind of difficulty are going
to be dealing with individuals who are under enormous stress, from the impact of events
they may only vaguely understand, that have the potential to do great damage to a practice
many have spent their lives building. Unfortunately, I do not think these organizations
will contact a consultant until they are in the same degree of difficulty faced by DMG. Given
the degree of commitment to tradition and respect for seniority I found at DMG, I would
think that only a crisis of terminal proportions would to be capable of creating a scenario
in which the older medical culture is compelled to give way to a successor.

Even beyond Blakeley, the organization did not seem to meet the use criteria: there
was no agreement on whether the problems the Group had been experiencing were
internally or externally derived, and there was no outright commitment to direct the
necessary time and energy towards resolving the problem (s).

This is not, incidentally, to fault Schein for terminating in these situations. It is not
clear to me how many of Schein’s requisites for PC are essential to the success of the
intervention, as opposed to merely necessary to preserve the consultant’s state of mind,
but that does not seem to matter. There is a time for long term psychotherapy and a time
for crisis intervention and PC seems eminently more suited to the former; DMG was going
to have to make and implement some difficult political decisions in a very short time frame and, if things did not work out financially, those decisions were going to have to get harder. PC seems ill suited for this kind of consulting environment. Organizations exist in many states of disrepair; consultation technologies invariably make a number of assumptions about the organizational status of their putative subjects. This seems to suggest a choice matrix involving organizational status, however defined, and consultation technologies, however specified. There may be no universal approach to consultation; only technologies that are more or less likely to work than others in a given set of organizational circumstances. Certainly, the dynamics at DMG did not seem to support the introduction of PC at that time.

Another key element of the Process Consultation approach is that the client must retain the initiative in both the diagnosis and remediation of the organization's problems. Even if this kind of organization survives the screening criteria in the entry and contracting phase of the process, there is a significant possibility that it will not possess this initiative to begin with and that most of the consultation will involve efforts to develop and inform the organization's management infrastructure so that it is capable of addressing the structural, procedural and behavioral problems which face the group.

Process Consultation seems to assume the existence of organizationally sophisticated clients. The notion of ensuring that the client retains the initiative for the intervention assumes that the organization has that initiative—that it has the readiness to initiate action and that there will be no times during which the consultant will have to assume that readiness on behalf of the client.

Again, this was not the case at DMG. At the point of initial feedback, the sole choices for joint diagnosis were Dr. Blakeley—who had so far been defensive and non-participatory with respect to the process—or the Board of Directors—which had
exhibited a complete absence of the characteristics one would associate with the ability to engage in a fruitful exercise in organizational analysis. I felt compelled to develop the analysis. If I had not done that, the process would have floundered and perhaps terminated at that point.

After the Subcommittee had been established, both Ms. Wilson and I tried repeatedly, without success, to enable its members to take the initiative in working through the initial diagnosis and recommendations. The response of the physicians on the Subcommittee was never any better than reactive and three of these physicians were relatively enthusiastic about the process and the role they were playing. Ms. Wilson and I were always careful to define the broadest range of options for the Subcommittee members to choose from, and although there were a number of times that I would advocate a specific approach, the process was far from unilaterally directive.

This advocacy would occur, more often than not, because of the third reality at DMG: the organization had a high level need for an intervention with educationally oriented approaches. Lacking propensity and training for management, the physicians were in no position to evaluate the problem definitions offered by staff; they often did not comprehend the context within which problems occurred and they had no experience crafting solutions to the problem once a definition had been agreed upon and placed within proper context.

The functionality of the Board of Directors issue was a good example. All of the Board members viewed the Board as dysfunctional; none of them viewed that dysfunctionality in systems terms. Most would have settled for a new Chairperson as the answer. The report however, listed a dozen or so recommendations directed at improving the operations of the Board. Over the course of weeks of discussion at the Subcommittee, I made the case--a proposition, as I referred to it--for the linkages between the way in which physicians were elected to the Board, the lack of staff support for Board deliberations, the absence of
defined leadership (Chair) within the Board itself, the failure of the physicians in the Group to self-identify as members of an organization, the weakness inherent in dealing with difficult on-going technical issues as a Committee of the Whole--and the poor outcomes which the Board was achieving. In the end, there was considerable understanding of what I was saying and why I was saying it; only then could the Subcommittee members examine their own views to see if they agreed or disagreed and only then could they proceed to work intelligently on the recommendations.

The point being that it would have been at least inefficient and perhaps even impossible, to achieve those results within the constraints of PC. The organization needed to be provided with options, and ways to think about and choose from among those options, in the shortest possible timeframe. Didactic interaction is inherently directive.

The experience at DMG illustrates one final efficacy problem with PC: deadlock. The Group was clearly in transition. In terms of the Madison-Konrad typology, it had made a series of Market Response Strategy choices that were out of line with the realities of its Organizational Tradition. As the implications of those choices became clearer, in dollars and cents terms, some physicians understood the need to change the way in which the Group's physicians related to the organization as well as the way in which the organization related to its individual physicians. Others were unwilling to accept the need to change; they externalized the problems and took comfort in the fact that the losses were an every other year phenomena.

There was no way for the Group to break this deadlock on its own: its members had been trying for five years, suffering more serious financial losses every year. PC would have allowed the values and assumptions of the contending parties to come into somewhat clearer view, but I do not believe it would have changed anyone's mind about those values and assumptions. The Group needed to break the deadlock or it would not survive. The
responsibility of the consultant, as I conceived of it, was to help break the deadlock in a way which would increase the odds of the Group surviving. To me, that meant that the more liberal, management oriented physicians had to "win" the debate. My role was to provide them with management insight and proposals specific enough to shift the discussion within the organization off of the more philosophically inflammatory issues like physician autonomy, and onto the details of specific nuts and bolts proposals that few would find inherently offensive. I think that adoption of a PC role for this intervention would have precluded me from acting this directly and I believe that the organization needed this degree of direction. The Group was giving birth to a new culture; it needed a midwife to push and pull, not engage in discourse about the process of pushing and pulling.

None of which is to say that a PC approach is inherently inappropriate for these groups at all times. As already noted, there is a natural evolutionary process to consider when intervening within these organizations. Successful interventions within individualistic-autonomous organizations are going to be long interventions. Effective structures will have to be designed, argued through and implemented; organizational policies will have to be drafted, debated at length and adopted; management processes will have to be defined, nurtured and evaluated. At some point in all of this, the organization will become structurally sound enough and will have sufficient processes in place, to justify the commitment of resources for a Process Consultation approach.

Much of the intervention effort in these organizations, which in reality have often been organizations in name only, will be oriented towards creating structures and processes within which the physicians and management staff can constructively work. If these individuals have been with the organization for any length of time, they will not be used to working within such structures; physicians, in particular, can be highly disruptive in group processes. While no research on large, physician managed,
multispecialty group medical practices was found during he literature search period for this paper, one study of a staff model HMO was discovered and provided me with a moment of deja-vu. In the study, physicians in the HMO were casually invited to participate in a work group to assist a consultant with a work satisfaction measurement project at the HMO:

Twenty-five active, vocal, impatient doctors showed up for the initial meeting of the questionnaire-design work group. The meeting was a rude awakening for the consultants. Although they knew the nature of many physician's groups and were fairly well prepared for a lively meeting, they found themselves elbowed aside early. They watched from the sidelines as an interesting political game unfolded.

The doctors, knowing only that they had been asked to help develop a questionnaire, came loaded for bear. Their pet questions, many of which were designed to elicit the responses they wanted to hear on hot issues of governance and power, were carried like swords into battle. Each doctor was going to make sure his or her questions got into the final document or know the reason why. One of the most adamant even brought copies of his own questionnaire for everyone and lobbied for adoption of his approach by the group or the withdrawal of the groups' support for the effort. His motion carried (by then the group was resorting to a steamroller version of parliamentary rules) but was immediately forgotten. Several hours later, after everyone's points had at least been presented (although not necessarily heard) and duly recorded in the notes of the meeting, things began to calm down (Stebbins, Hawley and Rose 1982, 105).

As one can imagine, antics like these make working with physicians a challenging experience. PC could be invaluable in providing physicians within these groups with the insight necessary to adopt more constructive behavior patterns.

There will also be potential problems with shareholders, who may have a difficult time adjusting to the changes in their colleagues on the Board and in management roles; there will be--and at least at DMG, are--problems at Board level where, now that the crises are over, it is apparent that communication is quite poor and ineffective and there will be problems at staff level, which will need additional team building efforts to overcome years of practiced isolation.
PC will not always be inappropriate in these organizations; it should be highly productive if used with a sensitivity as to when the organization is ready for it. Perhaps this means not using it as a model, per se--these organizations appear to demand an eclectic mix of consultation styles--but as a role or technique, it could be invaluable once the organization is restored to functional status.

Finally, the first chapter discussed Plovnick's (1982) structural primacy hypothesis and questioned its applicability to these organizations. Reviewing the literature, Plovnick concluded that structural interventions may be more effective than process interventions in health care organizations. His rationale for that conclusion focused on characteristics within health care organizations that he believed acted to neutralize the impact of process oriented interventions. As with Weisbord (1976), I questioned the applicability of the analysis to large, physician managed, multispecialty group practices. It was quite apparent that the internal dynamics of these groups created a different set of circumstances from those which Plovnick believed responsible for limiting the effectiveness of process based interventions.

Interestingly enough, the experience at DMG suggests that Plovnick's hypothesis relative to the need for structural intervention is correct, even though his rationale is not. The structural problems encountered at DMG were pervasive and serious; there was, in fact, often no practical context within which to begin a process oriented intervention. In many cases there were no processes to investigate (e.g. senior staff meetings, MBO processes) and in other cases, a concrete structural solution (e.g. having the Board elect its own Chairman to organize its activities) seemed to provide a more immediate and permanent answer to a problem (e.g. the complete domination of the Board by the President) than would have a process solution (e.g. process consultation with the members of the Board). As noted in the above discussion of PC, it was also apparent that the
immediate needs of the Group seemed to require more than a process based approach
could promise to provide in the time frame the Group was facing.

Figure 3.1: Plovnick's Outline of Structural Interventions
and Related Activity at DMG

<table>
<thead>
<tr>
<th>General Activities</th>
<th># of DMG Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Planning, Goal Setting and Policy Formulation Activities</td>
<td>14</td>
</tr>
<tr>
<td>2. Organizational Chart Changes</td>
<td>2</td>
</tr>
<tr>
<td>3. Allocation of Functional Authority, Responsibility and Accountability</td>
<td>5</td>
</tr>
<tr>
<td>4. Information and Control Systems</td>
<td>2</td>
</tr>
<tr>
<td>5. Teams and Task Forces</td>
<td>2</td>
</tr>
<tr>
<td>6. Coordinating Councils</td>
<td>0</td>
</tr>
<tr>
<td>7. Coordinating Procedures</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Adapted from M. S. Plovnick, "Structural Interventions for Healthcare Systems Organizational Development", in Organizational Development in Health Care Organizations. Reading, MA: Addison-Wesley, 1982, 241

The only disagreement with Plovnick on this point, is with his notion that many problems identified as process problems are actually symptoms of underlying structural problems. Sometimes, as in the Board Chairman example provided above, it is possible to address a given issue with either a process or structure approach; that does not make the problem--Board domination--a symptom of either a structural issue or a process issue. It just means that there may be more than one means available to attain a given end. Most of the time at DMG, it was clear that there were a host of process problems waiting to emerge as soon as the structural issues were resolved. For example, even with the Board having its own Chairman, it is clear that its members do not know how to effectively interact with each other like normal members of a business Board. This process problem can now be approached however, because there is a Chairman who is, in fact, increasingly invested in seeing his Board act like a Board. It is now a good candidate for a team building
intervention; that would probably not have been the case as long as the President was acting as the Chair.

At DMG, it would have been a mistake to assume that the apparent process issues were merely symptomatic of the structural issues the Group faced; I suspect that that will be the case in most of these organizations, where even the added restraints of a clearer structure will not be enough to fully rectify the impact of physician insensitivity to process.

Which returns us to the issue of why Plovnick's hypothesis was correct even though his analysis seemed so misplaced. DMG was solely owned by its physician Shareholders. These physicians were not merely the dominant power group within the organization; they were the organization. There were no other competing power centers within the Group; no intense conflicts between the physicians and other professions within the Group and it would not have mattered if there had been--the physicians had the votes. The Group had every financial incentive to ensure that its operations were models of structural and procedural integrity. Yet the Group allowed itself to lose million of dollars over a seven year period; it allowed itself to slide to the edge of bankruptcy before it reached out for assistance. Why?

Physician autonomy is always one readily available answer: the members of the Group did not want to change because they perceived change as threatening to their traditional autonomy.

Unfortunately, the answer does not entirely fit the question. It might be a perfect answer as to why the Group failed to implement a given set of recommendations provided by a consultant--they may have interpreted the changes as being too intrusive upon their individual autonomy. There was no such set of recommendations though; the Group never sensed that there was enough of a problem to warrant contacting a consultant--until they
had come within an inch of losing their organization. They were always in a position to maintain their autonomy; they could always have rejected a consultant’s report. The answer may explain why they did not follow a suggested course of action, but it does not explain why they never reached out to obtain a suggested course of action.

It is also often suggested that physicians do not "value" management--or some other such word that pertains to ensuring that an organization works within some established standard of rationality. Perhaps not. One would assume, however, that they valued the millions of dollars lost because of poor management; one would also think that they valued the peace of mind involved in knowing that the business was at least breaking even, as opposed to the tension and anxiety that was clearly generated throughout the organization when it was losing serious money.

The "value" answer then, also fails to address the issue of why the physicians in the Group were apparently unable to perceive the nature of the problem and take some effective remedial action before the point at which it became obvious that they had no choice. Physicians may not "value" management--but there was enough at stake that these physicians presumably did value and that should have impelled them to action.

I would like to suggest that the answer may lie, at least in part, with how physicians perceive reality within organizations.

Herzberg (1959; 1966), reacting to Maslow’s (1954) construction of a five stage, single continuum need system (Basic to Safety to Belongingness to Ego Status to Self-Actualization), argues that there are actually two separate continua: Self-Actualization, and Ego Status comprise one continua and the lower-order needs--Basic, Safety, and Belongingness-- comprise the other. Unlike Maslow, who argues that obtaining a goal object associated with any need provides a level of satisfaction, Herzberg argues that the attainment of goal objects which meet the lower-order needs can only reduce
dissatisfaction—they do not generate satisfaction; only attaining goal objects related to the higher-order needs results in satisfaction. Herzberg calls the lower-order needs hygienic factors; the higher-order needs are referred to as motivator factors (Burke 1987, 33).

This brief summary of an infinitely more complicated analysis suggests another way of explaining physician behavior with respect to organizations in general and provides a firmer rationale for the hypothesis that structural interventions will often be primary in these kinds of organizations. The argument is contained in three points:

1. On a daily basis, through the practice of medicine, physicians are able to routinely obtain goal objects which fulfill their higher-order needs;
2. Organizational effectiveness and the sub-elements of that goal object, however defined (e.g. management), exists within physicians minds solely as a lower-order need--a hygienic factor.
3. The confluence of these two realities act to severely restrict physician perception of the organization.

It is the confluence of the motivator factor quality of medicine and the hygienic factor quality of organizational effectiveness (management) that act to narrow the physicians field of vision with respect to organizations.

Physicians experience high rewards by focusing on the practice of medicine and little or no rewards from focusing on the organization, so they do not, in general, stay focused on the organization. Caught up in the daily drama of clinical practice, all other events become trivial; some more so than others. Over time, the perceptual threshold of a physician is altered, perhaps permanently; the preponderance of their cognitive resources are devoted to the practice of medicine and few things seem significant enough to engage
their attention--to pass over that threshold.

Organizational events thus occur unnoticed, as physician attention remains riveted on the fulfillment of higher-order needs; organizational structure and process clues that would serve as danger signals even for non-management trained laymen, also pass unnoticed and unrecorded. Like the sound of a dog whistle to the human ear, a great deal of organizational life passes unperceived, including many of those elements that would be of critical use in correctly diagnosing organizational problems before they reached criticality.

Almost everyone has had the experience of being so involved with a book, that they became indifferent to their immediate environment--time, people and events passed--but they remained oblivious to it all, caught up in the intricacy of the plot before them. I suspect that this is how many physicians relate to their work. They are routinely preoccupied with the practice of medicine. When physicians are torn away from that and finally have to interact with the organization in a management capacity, they find--or more likely than not, others find--that their mental record of the organization, its "medical history" so to speak, contains serious omissions and misinterpretations. Their preoccupation has prevented them from clearly and continuously perceiving the dynamics of the organization within which they are working.

This would not be an insurmountable problem if physicians had a propensity for management, training in management or work experience in management. After all, the key elements of an organization's history or of an organizational problem are replicable, if you know what to look for and where to look for it--at least management consulting rests on that premise. Most physicians however, have neither the propensity, training nor experience in management necessary to detach from their clinical orientation, fill in the blanks in their organizational history, untangle their perceptions and reach valid,
organizationally useful conclusions. Physicians thus approach organizational problems relatively defenseless and, as also noted in the first chapter, often make the mistake of relating to the problem from the base of their clinical experience.

The practical import of this is that individuals become disoriented, at best, when they are forced to respond to problems within a context which is outside of the context within which they were trained to respond to problems. With physicians, problem solving skills learned in their home context of medicine do not translate readily to a management context. This leaves physicians with a discontinuous and at least partially erroneous impression of organizational reality and no practical tools with which to make sense of it.

It would seem that several corollaries follow from this discussion: 1) the absence of organizational effectiveness will create physician dissatisfaction only when it is significant enough to threaten their ability to continue the practice of that which fulfills their higher-order needs (i.e. medicine), 2) the presence of organizational effectiveness, regardless of the effort involved by others to achieve it, will generally be unevaluated and unremarked upon by physicians, 3) physicians themselves will not exert any significant effort to attain any reasonable degree of organizational effectiveness, unless statement 1) pertains, 4) when physicians are eventually forced by circumstances to pay attention to an organization, they will not know (a) what to look for or at, (b) how to correctly interpret what it is they are seeing or (c) what steps to take in order to address the problem(s).

Plovnick's hypothesis turns out to be correct for these organizations then; DMG's organizational structure was in a serious state of disrepair and its primary need was for a series of structural interventions. The rationale for his hypothesis does not seem to apply to group practices however and it may not even completely pertain to health care organizations in general. I would argue that these organizations are seriously
dysfunctional because (1) physicians retain management initiative within these organizations and yet (2) physician preoccupation with the practice of medicine precludes the accurate perception of day-to-day organizational reality. The effects of this perceptual problem are exacerbated by the fact that physicians generally lack propensity, training and experience in management.

The results are organizations wherein structural problems flourish because (1) they generally will not be seen or recognized as such by their physician managers, (2) even if these problems are seen and recognized as such, physician managers will generally lack the ability to evaluate their seriousness and develop a "treatment plan" for them and (3) lacking an estimate of seriousness and an approach for treatment, the physicians will return to their preoccupation with medical practice--allowing the problems to accumulate. This approach suggests that physicians will take a structural problem--or any management problem--seriously only when it reaches the stage where its critical nature can no longer be denied and the ability of the organization to survive becomes an issue.
WORKS CITED


Slavin, C. P. 1987. Letter from Cambridge, MA to Dr. William A. Blakeley, Downtown Medical Group, 16 December 1987. Relative to management problems at DMG.


APPENDIX 1: INTERVIEW SUMMARIES, DMG BOARD OF DIRECTORS, 1988
What do you think about the concept of Department Heads for the major services?

1. Excellent idea; there are things which need to be done, but no one has the time.

2. Important; has to be done, but the position needs clout--not just a titled position.

3. Depends on what is expected of individual; no consensus on concept at the present time; there is a need for someone on an administrative level.

4. Long overdue; Department heads usually the guy with the most gray hair--most senior person; currently more title than working position.

5. Necessary; every department's employees need guidance--employees need to know that they are cared about and for; there is no authority for unit manager to devise policy now.

6. Good idea--fantastic idea.

7. Good idea; need for someone to 1) take feedback from Department to the Board and 2) take feedback from Board back to Department; position is universally acceptable--not clear who wants to do it though--10 hrs a week is very time consuming, but 4 hrs a week would be manageable.

8. Time has come--need a designated person with designated responsibilities.

9. Necessary for a long time; great reluctance in the past to do it however.

10. Good idea; very difficult though--makes sense for Internal Medicine and Family Practice--no idea of how it would work though; may not make sense for smaller departments.
What functions do you think the Department heads should be responsible for?

1. Personnel problems and physician discipline; full range of problems from overutilization to drug-alcohol abuse; might be another avenue for non-physician unit staff; develop protocols; organize Department resources; counsel physicians; must not have hire-fire authority.

2. Partly administration--communicate Board decisions to Department and vice versa; partly regulatory--quality assurance, utilization review, development of clinical protocols and counseling of physicians.

3. Should serve as Department representative on the Board; should hold monthly meetings with the Department; dissemination of information to Department; provide direction; communication with other Department's; need to represent practice at the hospital; counseling physicians within the Department; administrative and medical protocols; utilization work with the Department Head would be more effective.

4. Utilization review and quality assurance; medical records; quality control; protocols within specialities; someone should keep in touch with what's going on at the hospital--someone should evaluate those cases to see if hospitalization was unavoidable.

5. Setting medical policies within specialities--police if necessary; resolution of disputes; utilization review function as well.

6. Policing role for clinical matters and behavior; utilization review function is a hard one and there may be a need for outpatient UR as well; Department Head may get things done at the Department level--now, problems are identified and recommendations are made but nothing gets done...there is no follow up; reimbursement for the position needs to be generous.

7. Utilization review; stepfather--grandfather role; responsible for conduct, behavior
and morals; should deal with complaints about physicians in the Department; position needs teeth.

8. On Department level--organizer, facilitator, responsible for quality assurance and utilization review; on Group level--should serve as a member of a Committee for the entire Group, perhaps the Board.

9. Credentialing process of physicians; orientation of new MD's to Department; assist utilization director in dealing with problems within Department; schedule and run Department meetings; traffic cop for information flow to and from the Department and Board; interact with unit manager to address and resolve issues; sit on internal patient care assessment committee.

10. Departments need to be put in line--Department Head should set standards and police them; purveyor of information between Board and Department; organization is currently not run in a business like way.
How should the Department Heads be chosen and how long a term should they have?

1. Chosen by the Department; it is a leadership role—not just a representative role.

2. Pure seniority would be a problem—Department Head needs to be respected by the Department; process should be 1) nomination by the Department and 2) ratification by the Board; 2-3 year terms with reelection to multiple terms possible; stagger the terms.

3. At least a 2 year term; no strong feelings about how they get there; some colleagues are resentful and afraid of the concept though—be careful.

4. Department needs to choose them; at least 1-2 years initially.

5. Department should have an open discussion—to see where sentiment is—and then elect the Department Head on an open ballot; 2 years with reelection possible; should be able to step down, but should also be expected to fill the term.

6. It will depend on who will take the job; election is probably the only answer; duration may not need to be defined—reassess it annually.

7. Board should choose Department Heads; no arbitrary deadlines for terms; the same people who are always involved are the only ones who will be interested anyway.

8. Voted by Department using a secret ballot; term should be for as long as people feel comfortable with the job he’s doing—continuity is important and people should be allowed to stay on; minimum term of 3 years; important issue is transition between administrative time back to clinical time—there are financial issues that will have to be addressed.

9. Seniority should be the key variable—younger people should not overstep more senior physicians; the term should be four years.
10. Chosen by the MD's in each Department, with concurrence by the Board; maybe for life--unless they screw up or no longer want to do it--I don't like the idea of limits.
To whom should the Department Heads report?

1. Medical Director.

2. Board of Directors.

3. Medical Director--although the Department Head should be a Board member as well.

4. President or Medical Director--distinction is artificial at DMG.

5. Medical Director.

6. Medical Director.

7. Medical Director--should be a member of the Board too.

8. Department Head's should be members of the Board; no idea who they should report to--can't get beyond the fact that Dr. Blakeley is both the President and the Medical Director.

9. Medical Director.

10. Medical Director.
How would you characterize your experiences with the Board?

1. Moderately disillusioned; it's been very hard the past year.

2. "Not great"--looking to get off; not much power; the Board does not accomplish a lot--it rubber stamps decisions made by Blakeley and the HMO Director; decisions that do not get made often do not get carried out--they get dropped or fall between the cracks--example of Dr. Peterson.

3. Educational at first--but things are half baked--people do not look carefully at the decisions they are making; the Board is just not a useful entity--when Blakeley is busy with one thing, everything else falls apart; Board members do not feel like they are really involved or doing something significant for the Group.

4. Unofficial; frustrating; unproductive; puppet-like; Board listens, its members talk--almost always on an unprepared basis; no one does homework--a lot of decisions are unfounded and lacking in teeth; the HMO Director does not belong at Board meetings; staff should not be at Board meetings either.

5. Disappointing--Board is supposed to oversee the business of running the business; I was interested in doing that, but since my election--everything has been presented to the Board as a fait d'accompli; fragmentation occurs because a) time constraints, b) the individual and departmental interests of Board members and c) the way in which things are presented to the Board by the management.

6. Only somewhat functional since 1983; authority of the Board is limited by the need to get everything approved by the Shareholders; frustration comes from the knowledge that there has to be change within this organization--but that change has not been forthcoming.

7. Frustrating; it has been eye-opening that a $15 million organization can fly by the seat of its pants.
8. Board has lost its teeth; things get done and the Board hears about it after the fact--like the throat culture billing decision; uneven; the Board rubber stamps decisions made by Blakeley; the HMO Director should not be at Board meetings.

9. Satisfied; there is a need for full time people at the top of the organization though.

10. Non-initiatory; sensitive primarily to individual interests; no sense of the organization as a whole; too much overlap between Board and Shareholders; non-participatory--people do not come to meetings; Board often sets Blakeley up to be shot down, because Board sees him as making all the decisions; Board work is secondary to seeing patients.
What roles and responsibilities do you think the Board should have and is it fulfilling these at the present?

1. Board needs to be a working group... it should demand information and it should spend energy thinking about the issues; the Board has a constituency, but it doesn't work at it.

2. Lead the organization; establish policies--medical and administrative; hire and fire; yeah...we do all these things and we do them well.

3. The Board should make the ultimate decisions in everything; the President should be nothing more than a figurehead; things are currently spoon fed to the Board.

4. More should be taken care of at the Board level; members of the Group should be made aware of what goes on at the Board and offered a chance to join the Board; not so many issues should go to the Shareholders--lab billing report example; there is no feedback--no follow-up to Board activity; Board is just not doing what it should be doing; we don't decide anything a lot of times--Board role should be, at least, to decide on the things that are brought to us.

5. "The Board is doing what it is allowed to do at the moment--which is not very much"; there has got to be a point where the Board becomes able to make decisions; there has to be a place for the Shareholders to express their views, short of voting the entire Board out of office--respective responsibilities are not defined.

6. Oversight; review and policy setting; there is a need for a Business Manager--not a President; the Business Manager and the Medical Director should report to the Board; current Board is trying to do too much, so it ends up doing too little--the Board rubber stamps things because its overloaded and Blakeley ends up doing everything; the Board is just not doing a good job right now.

7. Board should be aware of protocols--needs to recognize what needs to be in place and arrange for it to be there; there is a need to do "something"--either in-house or with
a consultant--this place just isn't working; decisions are currently made by Blakeley and the HMO Director; "This Board has not made a significant decision since I've been sitting on it"; great respect for Dr. Blakeley--but how does he explain that the Pharmacy contract was renewed at great savings once it was put out to bid--why hadn't that been done before--why did it take six years to think of that?

8. Setting policy for the clinic--and it isn't doing that; settling issues between the Departments--and it isn't doing that; UR and QA issues--and it isn't doing that either.

9. The Board is not functioning as it should be; it should be a decision making body--like a legislature; it needs to make policy decisions--to discuss and resolve policy problems; administrative time must be compensated; not everyone belongs on the Board though--lack of interest and talent; Board should always handle hire and fire issues, although perhaps not for salaried physicians.

10. Board should formulate direction and policy for the Group--subject always to approval from the Shareholders; Board should be responsible for overseeing quality of care issues; Board should ensure successful operation of the business--it tries to do this, but it is not too successful; Blakeley has been seriously remiss in agenda development and follow-up.
What do you see as the key variable(s) in explaining why the Board functions as it does?

1. Power structure in the Group is rigid--it has inhibited people from outside the "in" group from participating; Blakeley is very capable, but he likes to be in total control and that can inhibit creative thought and creative people; Board is a rubber stamp--approving what has already been decided by Blakeley and the HMO Director.

2. Role of the Board is unclear; it is expected that decisions will be rubber stamped; there are endless discussions without outcome--Family Practice upcharging example--everyone knows what's going on, no suggested policies have ever been brought to the Board, the physicians responsible have never been confronted.

3. Personalities; control issues; lack of clarity as to where responsibilities lie; failure of some to shoulder responsibility.

4. The President--he tries to do too much; there is not enough delegation here--one to one is fine, but there is no institutionalization of the role.

5. Lack of clarity as to proper role and function of the Board.

6. Stagnation; no real elections--no other MD's interested; protectionism among Departments; structure of the Board--the ways in which people move onto the Board; lack of organization; Blakeley's leadership is not bad--at least he makes an effort.

7. There is a need for a Business Manager; the Group had made a lot of mistakes--that isn't anyone's fault, after all, we're MD's, we have no business sense.

8. A certain sub-group controls the outcome and for the most part, that works well; those with the most input are those willing to put the most time into it--and that seems fair.

9. Issues too diverse; agenda is poorly developed and managed; President does not like
being challenged at meetings; some hard feelings about some MD's being more powerful than others; Board has too many members; there is a lack of clarity about what the Board thinks it is supposed to be doing; lack of ability to make and follow through on a decision.

10. Not a lot of organization; everyone is an individual--no thought of the whole.
How often does the Board meet; how often do you think it should meet?

1. It's been meeting weekly; every other week would be fine.

2. Once a week now; once a month in non-crisis times. We've been in crisis for a couple of years now.

3. We were meeting once a month; twice a month would be fine.

4. Once a week; weekly is the best idea.

5. Board meets weekly and it should meet weekly.

6. Usually--every second week; that seems fine.

7. Well--we're meeting twice a month now; that should be a minimum.

8. Now--we're meeting once a week and that's adequate; after the merger, once every two weeks would be fine.

9. Traditionally, twice a month; more recently, weekly; twice a month would be fine.

10. Lately, every week; every other week for the most part in other times; once or twice a month--maybe one two-hour meeting a month would be ideal.
Are you satisfied with the current configuration of the Board? If not, what changes would you propose?

1. There may be a need for proportional representation--two from every major Department, one from each sub-specialty; twelve members plus the President; just one representative from each Department does not seem to work.

2. A little smaller; one member from each Department and the Medical Director.

3. What is the configuration? There is a need for representation by numbers--perhaps proportionally; Department Heads will want to be members of the Board; UR guy has got to be on the Board.

4. In general--yes; Department Heads should be on the Board though.

5. I'm satisfied.

6. The configuration is fine.

7. Haven't really thought about it.

8. Group needs a Business Manager--that role does not exist now; the Business Manager should be on the Board; as long as the Board represents the Departments, its composition is fine.

9. Yeah--it's fine; it makes sense.

10. No--Board should be Department Heads from IM, Pedi, FP, Ob/Gyn and Surgery, plus the Business Manager, plus the President, plus two members elected at large.
Do you think the members of the Board generally understand and act in accordance with their fiduciary responsibilities?

1. Yes; a lot of personal stuff occurs too, but there is an understanding of the responsibility.

2. No, they do not understand; no, they do not generally act for the good of the organization as a whole--it's "me" first, "Department" second and "Group" third.

3. No--absolutely not.

4. No--generally not; Board members do not know how to be Board members.

5. As far as humanly possible, yes.

6. Not sure; people do represent their own interests and those of their departments--don't see that as grossly hurting the organization though.

7. Yes--everyone has the Group interests at heart.

8. No; there is not much understanding of the concept and certainly little action in accordance with it.

9. Not always; Board members do not understand the role of the Board; Board members see themselves as representing their Department's, not acting for the organization as a whole.

10. In general, people vote for themselves first and then the organization.
Do you think the management staff provides the Board with sufficient information, on a timely basis?

1. Generally, yes; they seem to provide us with what they have, but it is not clear that what they have is sufficient.

2. No--if an issue is to be discussed, the material is often presented at the time of the discussion, not before--we don't have a chance to understand what we are expected to discuss.

3. Can't answer this; have no thoughts about it.

4. Generally, yes; there have been lapses however.

5. Yes, in general; only objection is that the decision often seems to have been made before the material is even presented to the Board.

6. The information is there; the Board has no appreciation of what the management staff does for them.

7. Yes and no; when management becomes aware of something, they seem to bring it to the Board's attention--we still seem to fly by the seat of our pants though.

8. No ideas of whether or not it's enough, but there is little real information sharing going on in this organization.

9. No.

10. No problem with the information provided, but there is a problem with follow-up--issues are continually raised, but no progress seems to occur with them.
How would you characterize the relationship between the management staff and the Board?

1. Fairly good.

2. Cordial; cooperative; there is a lack of clarity as to responsibility though--it isn't clear as to who is in charge of what.

3. Workable; cooperative.

4. Cooperative; its hard to separate everything--"we're all a great big glob"--its a very interdependent relationship.

5. Non-adversarial; absence of communication though; we sometimes walk on eggshells with each other.

6. Suspicious at times; there is a lack of communication too; Board has no concept of the problems of management.

7. Friendly; trusting.

8. Respectful; appreciative; sometimes the Board doesn't appreciate the impact of its criticism on management staff; Board members should be happy that management is doing the things it does for them.

9. Sympatico; a non-adversarial relationship.

10. Affable; agreeable; mutually respecting; cooperative.
How would you characterize DMG's decision making processes?

1. Crisis oriented; undirected; too individualistic; lacking a group orientation.

2. Decision making "sucks"; severely lacking; everyone seems to do their best, everyone seems to have the Group's interest at heart, but the outcomes are just not good.

3. Ultimately fine--although the Board is not a part of the decision making process; there is no agenda beforehand--no material available beforehand; momentum for a decision is created and the Board just allows that to happen--it is fairly inert.

4. Directionless; lacking in insight; there is a failure to follow-up.

5. Random; untimely; disorganized; irrational--a lot of emotional, physician loyalty issues.

6. Poor; not very firm; insecure; not even legally sound at times--obstetrician example; not focused on reality.

7. Rational, in general, but sometimes random; "we seem to need to change directions frequently".

8. Predetermined; emotional; sketchy; haphazard; you get the feeling that you're only making 1/2 of the decision and that the real decisions do not get brought to the Board; some decisions are made there, some are settled at the Department level--this reflects an uneven distribution of power between Departments and individual physicians.

9. Poor; Board members do not sit down and think about the decisions they are making; decisions are uninformed.

10. Disjointed; disorganized; parochial--often made in a narrow, self-serving way.
Are you comfortable with the way in which policies are discussed, adopted and implemented? Why or why not?

1. Not at all; this Group isn't set up to run as an organization; people do not feel responsible to or for the organization as a whole.

2. Discussion and adoption--I'm comfortable with those two; implementation remains a problem; the only cliques are the Departments themselves--the problem is purely structural, except that communication is very faulty as well.

3. Things that get to the Board are usually well discussed; decision making is flawed though; so is implementation.

4. For the most part, yes; things seem to happen however, that I'm just not aware of--but that doesn't happen too frequently.

5. No--there is a lack of management here.

6. No--very frustrating; Shareholder meetings are just impossible.

7. No--for the reasons already provided.

8. Policies always seem set before they are presented to the Board; not at all comfortable with that.

9. No, not at all--too many personalities.

10. No--for the reasons we have already discussed.
APPENDIX 2: RECOMMENDATIONS, FIRST REPORT TO THE DMG BOARD, 1988
RECOMMENDATIONS FOR CONSIDERATION
BY THE DMG
BOARD OF DIRECTORS

I. RECOMMENDATIONS RELATIVE TO THE BOARD OF DIRECTORS

1. The Board of Directors should have no more than one Regular meeting a month. This meeting should occur at a set time and place; every effort should be made to isolate the meeting from the time pressures of medical practice. The Board can have as many Special meetings in a month as may be necessary.

2. The Regular meeting format should include (a) the adoption of the agenda, (b) disposition of the minutes from the previous meeting, (3) a President's Report, (4) a Report from each of the DMG senior managers and (5) follow through on the remainder of the agenda items.

3. The Regular meeting should be open to all DMG physicians and DMG senior managers; other participants may be invited, as necessary. As a matter of standard procedure, the Board always retains the right, upon adoption of a motion by any member, to go into Executive Session and to exclude non-Board members from the proceedings.

4. It is the responsibility of management to ensure that the agenda for the Regular meeting, along with any support material, is forwarded to the Directors well in advance of the meeting; it is the responsibility of each Director to carefully review the materials, to attend the scheduled meeting and to be prepared to address the issues on the agenda.

5. Election to the Board should be contingent upon agreement, by the nominee, to attend and participate in a Board member orientation program. Such a program would provide a mechanism for Board members to familiarize themselves with (a) their fiduciary responsibilities as a Board member, (b) the roles and functions of the Board, (c) proper conduct of and during a Board meeting and (d) Board interface with management.
6. The Board should seriously consider the election of a Chairperson from among its members. The general functions of the Chairperson would be to (a) call the meetings of the Board, either upon his/her initiative or at the request of the President or as otherwise specified by DMG's by-laws, (b) work with management on the development of the Board's agenda, (c) work with members of the Board, organizing their activity, keeping them informed and furthering the process by which consensus is developed, (d) to oversee the deliberations of Board Subcommittees and (e) serve as a communications conduit between management and the members of the Board.

7. The Board should seriously consider the establishment of permanent Subcommittees of the Board to focus ongoing attention and to develop Board expertise on issues which (a) are fundamental to the operation of the business and (b) require ongoing Board review or action. At this point, I would suggest a Subcommittee on Finance and a Subcommittee on Medical Practice.

8. Board Subcommittees should be established by majority vote of the Board upon development, review and adoption of a Subcommittee proposal which specifies (a) the title of the proposed Subcommittee, (b) proposed membership of the Subcommittee, (c) the nature of the proposed Subcommittee (i.e. permanent or ad hoc), (d) the functions which the proposed Subcommittee will undertake or the issues which it is to address and (e) reporting expectations.

9. Minutes of the Board meeting should be rendered in much more detail than at present. The minutes constitute the recorded history of a Board's deliberations and should reflect that level of discourse for future reference.

10. Board and Subcommittee meetings should be properly staffed and supported by management.

II. RECOMMENDATIONS RELATIVE TO MANAGEMENT

1. The position of "President" should be defined by a job description, adopted by the Board, which clearly delineates his/her responsibilities. This is important for both the
incumbent and the Board and would go a long way towards clarifying the respective roles and responsibilities of the Board versus those of management.

2. The position of "President" should be secured by the execution of an employment contract between the incumbent and DMG. This appears to be necessary given (a) the amount of time an incumbent needs to effectively fill that role and the effect of that time commitment on his/her medical practice, (b) the need for a process to allow a shift back to full time medical practice without financial penalty if the incumbent chooses to vacate the office or if the Board chooses to remove him/her and (c) the need to protect the incumbent from the pressures which come from functioning as an effective President.

3. At the end of the year, the positions "President" and "Medical Director" should be assessed and a determination made as to whether they should continue to be filled by the same person. This should not be taken as implied criticism of the incumbent. The recommendation is in response to DMG's need to (a) create new avenues of physician participation, (b) establish additional decision-making loci and (c) minimize the effect of placing all of its management eggs in one basket. This assessment should be made after the reorganization contemplated by these recommendations has been completed and a clear understanding of newly emerging responsibilities is possible.

4. The position of "Director of Management Services" should be defined by a job description adopted by management which clearly delineates his/her responsibilities. In general, these responsibilities should entail (a) supervision of the organization's management processes, (b) strategic planning, (c) research and evaluation and (d) contracting.

5. DMG should implement the Department Head concept and that position should be defined by a job description, adopted by the Board, which clearly delineates his/her responsibilities. Additionally, a job specification should be adopted which clearly delineates (a) term of office, (b) selection process, (c) reporting and (d) removal.

6. The management staff should begin to meet regularly as a team, within a senior staff meeting format.
7. Monthly financial reports, in a standard format and complete with caveats, should be distributed to the Board at each Regular meeting.

8. Management should adopt a modified Management by Objectives (MBO) program. The purpose of this program would be to (a) establish clear and concise annual and quarterly organizational goals, (b) allow senior management to develop objectives for themselves and with their subordinates, consistent with these goals, (c) clarify management responsibilities through task assignment and follow-up and (d) allow the Board to more clearly understand and participate in the management work performed on their behalf.

9. Management should specifically request that its public accounting firm prepare and submit a detailed management letter, coincident with the completion of the 1987 audit. This should be shared, as should the results of the audit, with the Board of Directors.

10. The members of senior management should all be located on-site, in comparable offices, as soon as possible.

III. RECOMMENDATIONS RELATIVE TO ORGANIZATIONAL POLICY

1. The Board and management should work on developing a Mission Statement for the Group. This statement should (a) define the reason for DMG's existence, (b) establish an organizational philosophy for use as a reference point by the individuals within the organization and (c) identify general organizational goals consistent with the above.

2. Management should propose and the Board should adopt a physician compensation approach which moves away from productivity as the sole criteria of payment and incorporates other variables such as performance and service. Maintenance of a pure productivity formula is inconsistent with DMG's continued existence as a business entity; it allows for a situation wherein individual initiative can be rewarded at the expense of organizational goals.

3. Management should propose and the Board should adopt a sanctions policy that
covers individual physician behavior which contravenes organizational policies. Such a
policy would (a) define a range of offenses, (b) provide for graduated enforcement, (c)
specify the process by which enforcement takes place and (d) provide an appeals process.

4. Management should propose and the Board should adopt a specific compensation
policy for those physicians who commit clinical time to organizational administrative
work. Such a policy would (a) define those individuals eligible for such compensation, (b)
delineate a specific approach for compensating those individuals and (c) establish a
monitoring plan to evaluate the policy in six months, adjusting it if that seems necessary.
APPENDIX 3: REORGANIZATION EVALUATION CRITERIA
DMG REORGANIZATION GOALS

Is the Board of Directors constructively involved in DMG's business?

a) Are its members provided with timely and accurate materials to facilitate their deliberations?

b) Are members provided with routine reports on the financial and operational aspects of the business?

c) Are Board meetings efficiently run; are the discussions civil, informed and constructive and are decisions clearly made and followed up on?

d) Is the Chairman of the Board adequately fulfilling the terms of his job description? Does the position, as described in the job description, adequately reflect the needs of the Board?

e) Is there a clearer sense among Board members that they are making a valuable contribution to the organization?

f) Is there a consensus between Board and management as to their appropriate respective roles and is there a sense that these roles are being properly maintained?

Is management organized and functioning sufficiently to define, preserve, protect and advance the business interests of the organization?

a) Are the Department Heads adequately fulfilling the terms of their job description? Does the position, as defined in the job description, adequately reflect the needs of the organization? Is the salary for this position appropriate?

b) Are problems being identified, addressed and followed through on; is there confidence that the business of the organization is being competently managed?
c) Is the MBO program providing greater clarity and focus, relative to individual and organizational responsibilities and objectives for the management staff?

d) Is the MBO program allowing members of the Board to develop a greater understanding of management staff activity?

e) Is there an increased level of communication and team work at the Senior Staff level? Is it adequate?

Has the organization been able to evolve to the point where individual interests and needs are understood, not only on their own terms, but in relation to the interests and needs of the organization as a whole?

a) Is there a sufficient awareness on the part of Board members as to their fiduciary responsibility and are Board actions and decisions generally consistent with an adequate understanding of that concept?

b) Has the organization adopted a compensation policy for its physicians which aligns the financial incentives for individual physician behavior with organizational needs and goals?

c) Has the organization adopted a sanctions policy that addresses individual physician behavior which contravenes organizational policy?

d) Are the shareholders adequately informed of the activities or the organization? Do they adequately understand the nature of the shareholder role? Are their actions generally consistent with that understanding?
APPENDIX 4: INTERVIEW SUMMARIES, DMG BOARD OF DIRECTORS, 1989
Do you think the new Department Heads are functioning well or poorly?

1. I don't think they're doing that well... don't see much change at all; would like to see more effort at organizing/running the Department; DH's have that responsibility, but they have not exercised it; can only speak about his Department though.

2. No idea; things seem OK though; DH's should not be paid... it's just a bonus; if you do pay them though, everyone should be paid the same.

3. No experience with other DH's; thinks his is completely superfluous; crazy to pay one person to do the job they all should be doing; not aware of any problems in his Department.

4. Experience seems to vary by Department... I like the concept; my DH has been very effective... the Surgery DH is a joke... the Internal Medicine DH job seems to be the toughest.

5. Something is missing... I don't know what, but something is just not there; the DH in my Department is functioning adequately though; my concern is more about the substance of the role.

6. Haven't had much experience with the DH; he seems to be doing well though; I don't know if there is a problem, but I don't know that there isn't a problem either.
How would you characterize your experience with the Board to date? (New Members)

1. Very rewarding; I like being where the action is; sometimes, it is very frustrating though... things don't move fast enough.

2. No different from years ago; we spend a lot of time doing nothing; nobody wants to change... Group has been failing to deal with the same issues for years; we appoint a sub-committee to work on a problem, they spend hours doing their homework and we trash it when it gets back to us; I just don't think were doing anything significant.

3. An education; a real learning experience; a very positive experience so far... I feel really involved in the organization for the first time.
What change, if any, have you seen take place in the functioning of the Board over the course of the last year? (Holdover Members)

1. Better... in the sense that there is more structure and communication; the operations of the Board are much more organized than they were before; meeting protocol needs to be reinforced however... Chairperson doesn't run a tight meeting, and he sometimes jumps into the fray; not sure if the Board would hold up under bad times though... not sure we'd make better decisions... there is still a residue of parochial thinking too; still... it's better than it used to be.

2. Overall... the Board now functions better; removing the requirement that Board members must represent their Departments has helped tremendously; individual realities sometimes get in the way of fiduciary responsibility, but that has improved; the Chairperson runs the meeting pretty well, but doesn't seem to do much else with the role; sub-committee's have been helpful, even if we have not always gone along with their results.

3. Tremendous change... for the better; Board members are honest, active and much more oriented to the needs of the Group as a whole... we fall back into our old ways at times, but we're human, so that's inevitable; its been a good year for the Board.
What legitimate roles and responsibilities do you think the Board should have and is it fulfilling these at the present time?

1. Board's role is to keep organization moving along as well as possible; keep finances in order; keep hands on control of the organization; I think the Board is doing its job fairly well.

2. Board should generate a philosophy about what we are/expect to do as a Group; Board should provide leadership; I don't think the Board does any of that very well, if at all; the Mission Statement doesn't mean anything; Board continues to function in its own interest; Blakeley makes all the decisions... Blakeley and Dr. Wexler or both or nothing gets done.

3. Board should sort out issue of independence of individual practitioners vs needs of the Group; define the future of the corporation; financial soundness... sorting through the Finance Director's data; past year has been like a tug of war at times... but in general, Board has been quite effective.

4. Board should represent the shareholders; there has been movement... the Board is probably fulfilling 90% of its responsibilities now.

5. The Board is doing what it was assigned to do... but it feels like something is missing... there is no long range context; we are getting answers now, but are we asking the right questions?

6. Board should decide, in the larger sense, what the Group should be; Board has final authority for setting policy... I think it is addressing the right issues; only area of concern to me is financial reporting.
Are you satisfied with the current election process and resulting configuration of the Board?

1. Very unhappy; the process is absurd; everyone should have the right to run for the Board... nomination by committee is a better idea; too many people from the same focus creates a problem.

2. Yes... satisfied with it; angry though that Dr. Peterson was illegally nominated and allowed to run for the Board... there is either a process that applies equally and fairly to everyone, or there is not.

3. Process seems okay; nominating committee makes some sense though.

4. Yes... it's fine; I don't see any problems.

5. Concerned about the process; worried that all Board members could end up being from the same Department... the Board should have representation from each Department.

6. The election process is fine.
How well do you think the Chairperson is performing in his role?

1. No comment.

2. He encourages participation, appoints people to sub-committee's; isn't much of a leader at meetings though... maybe he doesn't feel comfortable standing up to the powers that be; in general, he's done an okay job... I'm happy with his performance.

3. I don't think he's the right man... he has too great a need to be liked, tries to hard to be liked; not tough enough; still...he does seem to work at it.

4. Well... he generally adheres to the agenda, although he doesn't seem involved in its construction; he gets a little carried away from time to time... but then again, everyone does; he doesn't play any role with us outside of the Board meeting... at least he has never contacted me about a Board issue; he talks too much... no sense of judgment about what should be said about DMG outside of the building, so he can't be trusted with information; he appears willing to work hard at it though... assigns himself to each sub-committee; he's been okay.

5. I have mixed feeling about him; he comes with a lot of baggage, his personality gets in the way of his being truly effective and he is semi-retired... I think the Chairperson should be full time MD; ultimately, he may not be the right person for the job, still... he is the first Chairperson we've had and he'll probably get better; I'd vote for him again.

6. He keeps the meeting going although he loses it at times; he's doing okay though, considering that it's a new position.
Do you think that the members of the Board generally understand and act in accordance with their fiduciary responsibilities?

1. We have a much better understanding of that responsibility; takes time to break old habits though... Board terms may be too short.

2. Yes... I think we do; the concept is always taken into consideration now, although it is not always acted upon.

3. The members are informed about the concept, although we may not always know how to apply it; we take the responsibility seriously though.

4. No, they do not understand it; those that do, do not take it seriously; the Board follows the path of least resistance... period.

5. Yes... I think we understand it, for the most part; real test will come when it is time to decide where and how money has to be spent.

6. We're getting better... we are nowhere near perfect.
Do you think management team provides the Board with sufficient information, on a timely basis? (New Members)

1. Yes... I do; we have regular meetings and regular updates from all the managers.

2. I feel like I get enough information, it's generally comprehensible and helpful in laying out the issues for decision making.

3. Yes... No gripes about the administrative side of things; Board is basically a rubber stamp anyway... although I don't view that in a negative sense.
Have you seen changes in the quantity, quality and/or timeliness of the information provided to you by the management team? Is this information sufficient? (Holdover Members)

1. Information flow is much better organized; having Ms. Wilson has made all the difference in the world; seriously concerned about information relative to accounts receivable though.

2. Board is getting good information; my only concern is financial... Are we getting the information we need from that area; billing Department is a lot tighter than it was... but there may be a problem; FFS goes out... but we never seem to know how much of that comes back.

3. Yes... there has been great improvement.
How would you characterize the relationship between the management team and the Board? Are there any elements in that relationship which you believe need to be changed?

1. Great improvement... I really understand what management does now; they're worth the money we spend on them.

2. Administration is useful; relationship is cordial; I would like them to push more forcefully for policies they believe in though.

3. Mutually respectful; team approach; relationship is amicable; Dr. M still ruffles feathers from time to time though and I still don't know what the Patient Care Services Director does.

4. Good, solid relationship; everyone seems to do a good job.

5. Everything is fine... except the financial side; we need more accountability from the financial area.

6. There is respect for the work the management team does; I have a general feeling that we are overstaffed though... we may not be spending our dollars properly; organization is too big.
How would you characterize the relationship between the President and the Board? Are there any elements in that relationship which you believe need to be changed?

1. I think the relationship is essentially solid; there is room for give and take; sometimes Blakeley tries to direct the Board a little more than he should... we do have a Chairperson now.

2. Blakeley needs to learn that disagreement is not disapproval; he gets too defensive and angry; it is the only thing that stands between him being a great CEO, as opposed to a merely adequate one.

3. Good working relationship; I think this Board has worked better with Blakeley than previous one; Blakeley is very defensive though... it has always been a problem; he takes everything too personally, so it's hard to talk with him.

4. Blakeley is well liked and he's doing a good job; of course, the other MD's have no idea of what a "good job" is... there is a tendency on the part of some Board members to chew him up when things go wrong; Blakeley is too insecure though... too defensive... so sometimes he doesn't lay all the cards on the table; he doesn't realize how valuable he really is.

5. Blakeley needs to be less defensive, he needs to share his knowledge with us, he needs to be less aloof.

6. Blakeley is probably the only person here who can do what he does; sometimes, I think the position should be full time though; its good to have an M.D. as the CEO, but sometimes, maybe a hard nosed businessperson would be better.
How would you characterize DMG's decision making process?

1. Essentially logical; there are exceptions but, for the most part, things are well thought out.

2. There needs to be more effective communication between the Chairperson and the CEO, and between the CEO and the Board; talking at each other isn't communication.

3. Non-existent at the Board level; management decision making at the staff level seems efficient.

4. Pretty focused; at least we're talking about the major issues and we've made some good, solid decisions; no one bats 1000.

5. A lot better than it was; we need to stay on this course though.

6. Structured; we're doing better than in than in the past; seems to be a recognition that things need to change and we have been working on doing that; still, its been a good year... it's easier to say nice things in a good year.
Are you comfortable with the way in which policies are discussed, adopted and implemented?

1. I am now... a year ago, I would have said "no"; I understand what really happens here now; my philosophy has changed too.... I understand that the organization has needs too; the process has become clearer, more structured and more participatory.

2. Yes, for the most part; were doing better than we were.

3. Yes, generally; at least there is ample discussion these days.

4. I don't like the way in which policies are adopted... but I'm not uncomfortable with it; I think our policy decisions are often neither timely nor appropriate.

5. I'm fairly comfortable.

6. I'm 90% comfortable; I see a big improvement over 1987 and prior years; we're headed in the right direction.
Are there any other issues you think are important for us to discuss or are there any other comments you would like to make?

1. No... I think we've covered everything.

2. Yes... continuity of the Board is very important... can we do something about longer terms?

3. Just that I think we've made great progress.

4. One thought... There may be a need for someone beyond the Finance Director; I think we have real financial functions being performed, but I wonder if we have real financial management.

5. The Group has not dealt with any of its fundamental problems:

   1. Incessant backbiting.
   2. No sense of organization.
   3. The "I do what I want to do" philosophy.
   4. Lack of mutual respect among departments or between individual physicians.

6. DMG is a big organization; we need to keep our finger on the pulse at all times.