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CHALLENGES AND OPPORTUNITIES FOR COLLABORATION BETWEEN BEHAVIORAL SCIENCE CONSULTANTS AND HEALTH CARE LEADERS *

by

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SO NEAR AND YET SO FAR

Opportunities for creative collaboration between applied behavioral scientists and leaders of health education and delivery systems have never been stronger.

Changes in national priorities, community awareness, values around quality of care, health vs. sickness orientation, new educational priorities,--all pose requirements and challenges for health education and delivery leaders that cry out for use of the knowledge, values and technology of applied behavioral science.

More and more behavioral science practitioners, organization psychologists and other applied behavioral scientists are showing active interest and desire to work in the health field. There is an increasing interest in management and behavioral science schools for students to be aiming toward careers as facilitators, change agents, and workers in the health education and delivery field.

A paradox in the situation is that optimum progress toward this desired collaboration is blocked in many areas due to strong negative stereotypes, biases, and attitudes on the part of both health leaders and applied behavioral scientists. The desired help and collaboration can only occur after people look at their own blocks toward collaboration and "get in the heads" of those in the other area.

Systems Apart

It is easy for us to shed a sad and understanding tear,in our alienated

society, for the lonely apartment dweller who says, "I don't know anyone on my floor except that nice quiet Jewish couple and those two noisy party throwing 'queens' in 605." Unfortunately, there are too many parallels between that quote with its stereotypes and loneliness and ambivalence, and the situation between systems. To name a few: "Behavioral scientists I know are generally cooky humanistic philosophers who haven't the slightest interest in the practical economic facts of life or the science of medicine." Another: "The doctors I know are conservative, uptight establishment types that will probably never change."

Progress toward mutually desired collaboration will require major unfreezing of existing stereotypes, biases and attitudes on the part of both health leaders and behavioral science practitioners.

This paper is primarily directed toward applied behavioral scientists and practitioners who might be actively interested in further collaboration with health education and delivery systems. I do not propose to develop a theory of intervention or even a strategy of intervention in such systems. Rather, the attempt in this paper will be to share information about

- the current environment around health care
- the perceived needs of health care leaders
- some perceptions held by health workers of behavioral science and scientists; and some perceptions held by behavioral science practioners toward doctors and other health workers
- the kinds of knowledge, skills, and technology that could be shared and transferred
- some thoughts about what behavioral science practitioners can do to move toward further collaboration.

The basis for this paper is my experience in the last three years working in collaborative projects with deans of medical schools, with leaders of health education agencies, with a group of health workers, developing change agent skills for leaders in their hospitals, schools, or community health centers;* from working as a faculty member with a social medicine intern-residency program in a large teaching hospital. In all these situations I found tremendous and increasing interest in applications of behavioral science knowledge and technology to the problems of managing health education and delivery. I also found tremendous suspicion and doubt about the practical application and relevance of this knowledge, particularly as they have seen it practiced by some behavioral science practitioners.

It is from these experiences, and from my deep conviction of the high potential for synergy and social improvement that can occur through increased collaboration that I have developed these thoughts.

THE CURRENT ENVIRONMENT AROUND HEALTH CARE

In order to have a background for thinking about priorities for collaboration, it is helpful to look at the current condition around the health care field. I would like to suggest five categories in which this can be examined: societal values, political/economic conditions, management issues, delivery strategies, health education strategies.

Societal Values

1. There is an increasing trend toward comprehensive, preventive, physical/emotional/social care.
2. Health workers should be focusing more on helping patients manage their own health. There is an increasing educational role for all health workers, they should become facilitators

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in addition to being experts in technology. This emphasis is underscored, for example, in the first annual report of the Robert Wood Johnson Foundation, a major funding source in the health field. Dr. David Rogers, the President of the Foundation, in his statement of the priorities for the Foundation focused two of the three priorities on the quality of care and "strengthening caring and supportive functions of medicine."

3. Communities and community leaders are taking more active part in influencing the health care of their communities. Citizens councils, voluntary agencies and local governments are increasing efforts to influence the health field from the patient population itself. There is a growing body of people who are becoming activist toward increasing the "humanity" of health care. This body includes not only citizens groups and special interest agencies, but increasingly includes medical and other health students and health school faculties.
4. There is increasing pressure for high quality lifetime health care which puts many new demands on health delivery institutions.

Political/Economic Conditions

1. Health care availability is very differentiated between geographic areas, economic populations, geographic relationship to universities and teaching institutions, etc. While it depends on your view whether there is a total shortage of doctors in this country, there is clearly a skewed distribution of health workers. This means

that large segments of the population, particularly people in rural areas and in urban ghettos, are without adequate medical care.

2. Costs of health care continue to rise disproportionately to most other economic variables.
3. The funding of medical education has undergone radical changes — mostly reductions. Funds for basic research, underwriting of medical and other health students, development of research training programs, have been radically cut.
4. Due to the significant reduction of federal support, health education and delivery institutions must now find new sources of support at other government levels.
5. The growing efforts in all branches of government toward fundamental changes in public policy on the financing of health care, have many consequences. Issues of professional resistance, redistribution of power, quality of care are high priority problems today.

Delivery Strategies

1. New categories of health workers such as nurse practitioners, physicians assistants, and family health workers are emerging to take on some activities previously reserved for M.D.'s.
2. There is a great deal of energy going toward redefining those diagnostic and treatment activities that can be distributed among several categories of health workers.
3. Family medicine has emerged as a specialty. One can now receive residency training and certification in family medicine.

4. The family, in many situations, is being seen as the patient unit rather than the individual. This is particularly true in comprehensive primary health care practice.

5. The concept of "outreach" is being given increasing attention. In some family and community medicine situations instead of waiting for the patient to visit the doctor, positive effort is made to seek out patients. For example, if a member of the family visits the doctor with a particular problem, members of the health delivery team, in addition to treating the specific symptoms, visit the family and look at their total health situation, giving shots, physical examinations, etc.

6. Changing patient attitudes toward health workers, is a conscious strategy of some organizations. Educating the family to accept as valid a physical examination by a member of the health team other than the doctor, is a conscious part of some of the delivery strategies.

7. The role and functions of outpatient departments or clinics of hospitals is being enlarged. As hospitals are assigned a "catchment" area -- the potential patients in their community -- and the defining of patient populations becomes more specific (which will become a necessity under any national health plan), the outpatient department is increasingly called upon for a wider variety of services.

8. More and more delivery of primary health care is and will be done by interdisciplinary teams of health workers. These teams may be composed of only doctors and nurses, but in community

situations they may be composed of doctors, dentists, nurses, social workers, family or community health workers, and sometimes, even lawyers.

Education Strategies

1. Medical schools and other health schools are critically examining their total curricula. There is a trend toward adding to the curriculum some content on social awareness, understanding the family, community values, change, and interpersonal competence.
2. There are experiments underway related to the training of health workers across disciplinary functions. For example, there is an experimental project underway examining a new curriculum for training for primary care. Since so much primary care is delivered in an interdisciplinary team, it is proposed that it might be learned in an interdisciplinary learning team with the students in the "class" coming from medical, dental, nursing, social work schools from within the same university.
3. There is increasing interest among those planning medical school curricula towards including and increasing behavioral science content into these curricula.
4. Medical students are more heterogeneous in their expectations. There is more differentiation around values and priorities among different students than there used to be. There is much less of a concensus that medical education is solely clinical education of the treatment of disease.
5. There is a strong and growing movement among students and among various advocacy groups for increasing the numbers of women and

minority groups in medicine, and for providing better and more equal job opportunities for women in this field.

Management Issues

1. Changing income sources and financial controls are changing the power structure within medical institutions. This requires new sets of role relationships and clarification of decision making.
2. The necessity for systematic planning systems to cope with increasing complexity is becoming increasingly apparent to institutional leaders. Through the Association of American Medical Colleges, the Deans of academic medical centers are participating in a program of management development which focuses on this type of subject area.
3. The traditional independence and identity -- and hierarchy -- of the different health schools in the university: medicine, nursing, dentistry, allied health -- is being crossed. New administrative forms are emerging which change the relationship of these various schools. In many schools there is now a Vice President of Health Affairs. This role is administratevely responsible for all of the health schools. This changes the roles and responsibilities of the dean of the Medical School, the dean of the Nursing School, etc.
4. The organization design of medical centers, with their complex of schools and hospitals, is becoming more specifically related to the requirements of the individual institution. Traditional

forms and structures are being re-examined and new organization patterns are emerging. Paul Lawrence and his colleagues have recently completed a study of the large number of academic medical centers. The results of this study, and subsequent feedback to the institutions, have already produced some major structural changes. There is ample evidence that the organizational structure of different institutions needs to be differentiated. For example, the optimum structure for delivering care in the medical ward of a hospital is very different from an appropriate design for delivering primary care in a community health center.

5. There is an increasing desire among health leaders for management knowledge and skills. Educational programs to meet this need are being developed at a growing rate.

6. There is a growing need and an awareness of the need for understanding individual, group and organization change. I am engaged in a project with twenty-five senior health workers from academic institutions, hospitals, community health centers and public health agencies developing methods for creating increased capability in those institutions for managing change. I believe that change agent skills will be a part of the education and development of numbers of categories of health workers and leaders in the near future.

7. Problems of intergroup and interinstitution collaboration in conflict management are very much recognized. New patterns of interagency relationships within universities and between

schools and hospitals require high degrees of skill in managing intergroup relationships.

8. The overlapping roles of people in key positions such as the head of a clinical department in a medical school and chief of service in a hospital, increase the complexity of organizational decision making and communication. Administrators are more and more defining needs for help in this area.

9. The management of resistance to change is a key issue for health administrators. The conflict between the changing values toward a more humanistic approach toward delivery of care, and the strong values of science held by a majority of the medical people, require creative management. The medical profession is traditionally an autocratic technological profession. It is having to face a whole new set of forces toward people-oriented care. At the same time there is a continuing need for maintaining high level basic research. This is a complicated management problem.

10. The high political potency of health means that there is increasing and more complex governmental intervention. Skills in public relations, lobbying and general political skills are now part of the "job requirements" of any health institution manager.

As a symbol of the changing attitudes toward management of the medical institution, the recently appointed Director of the National Institutes of Health, Dr. Robert S. Stone, is a new type of leader for NIH, the principle scientific institution of the government in the biomedical field. Dr. Stone is best known as a medical administrator. As Dean and Vice President for

Medical Affairs at the University of New Mexico, he initiated a number of innovative, institution-wide organization development efforts. His appointment, although a shock to many in the scientific community, represents a change in direction for leadership. Charles S. Edwards, Assistant Secretary of Health, said at the time of the appointment, "The head of N.I.H. must understand the ingredients of science, but he need not be a great scientist himself. It is better that he be a good administrator who can provide a stable environment in which scientists can work." Dr. Stone, in describing his own concept of the role, sees himself as a man who must step into the situation, and try to get scientists and administrators to talk to each other. He sees himself as a translator. In an interview with Science magazine, he said, "My perception of this job, after being here for only a few days, is that there are enormous requirements for linkage."

It is clear that the trend in the health field is toward more linkage, between users and health care deliverers, between delivery and educational institutions, between faculties and administration, between schools and hospitals and between national institutions.

HELP!!??

In this section I want to describe very briefly some categories of potential "clients" and some of the kinds of problems that they identify.

1. Deans of Medical Schools and Academic Medical Centers

The dean of an academic medical center today manages one of the most complex institutions in our society. He manages a series of basic science departments, clinical departments, whose heads also frequently

serve as chiefs of service in hospitals and the control of whose resources are shared. The students are jointly managed from the school and from the hospitals.

He is involved with a tremendous number of complex relationships with other health schools, with the university, with the hospitals, with state and local legislatures, with funding sources, with government agencies of all kinds.

Areas for which needs have already been identified and for which there is a behavioral science contribution include:

- managing entrepreneurs
- developing reward systems that optimize rewards for individuals
- career planning systems
- organization and individual goal setting
- life planning
- team organization and development
- meetings management
- intergroup relationships -- conflict and collaboration
- conflict management
- managerial strategies
- the organization and its environment
- organization design
- role sets
- communication systems
- information systems
- developing OD capability
- diagnosing the organization

- handling resistance to change
- planning strategies for change
- planning political strategies
- curriculum planning
- curriculum development

2. Directors and Faculties of Other Health Schools

Leaders of nursing, dental, social work, and allied health schools are concerned with many of the same things as a medical school. Their highest stated priorities are problems of:

- managing change
- developing change agent skills
- increasing team effectiveness
- increasing interpersonal competence
- curriculum design
- curriculum implementation

3. Hospital Administrators

Although hospital administrators have had, generally speaking, more management training and tend to be more experienced in the management of complex organizations; the emerging emphasis on community health, new constraints on their freedom to manage their organizations, the emergence of community health centers, the changing role of outpatient clinics, etc., produce new problems. Their list would include many of the same things as the medical school dean.

4. Community Health Center Directors

This is a new breed of community oriented, primary care center leader.

Usually the leader has limited experience in management. They identify skill needs in:

- community relations
- managing in an intercultural setting
- problems of culture shock
- problems of conflicts of values -- between deliverers and patients
- team operation of management, organization structure, etc.

5. Delivery Team Leaders and Members

People who are in charge of care delivery teams, such as the team in a community health center, identify such issues as:

- leadership
- decision making
- communications
- interface problems -- health worker/patient
- role issues in a complex organization
- support -- performance
- communication systems
- career development

6. House Staffs

Currently identified issues include:

- issues of influence
- planning change
- managing change
- learning
- managing learning

7. Student Organizations in Medical and Other Health Schools

With the increasing role of students in health schools, in the management of their own learning, there is the increasingly expressed need among these students for understanding of:

- group dynamics
- intergroup dynamics
- curriculum planning
- influence
- social intervention

8. Professional Associations

They identify needs for help in the following:

- developing new curricula
- process of introducing new curricula
- dealing with resistance to change
- management of development
- transfer of technology

9. National Service Groups

For example, the National Health Service Corps, which has several hundred interdisciplinary teams working in underserved areas of the U.S. to provide additional health delivery resources, has established a contract with NTL to provide help to these teams in their functioning as change agents, team deliverers, community developers, etc.

SO --- ?

With all these needs among health workers and health institutions, and all the resources in the behavioral science field, the obvious question is: "Why isn't more activity occurring?" "Why aren't more behavioral consultants

located in health education and delivery institutions, either as inside or outside resources?"

I think the answers to these questions lie in a complex series of traditions, stereotypes, attitudes, and inappropriate behavior -- that has created suspicion and resistance on the part of health workers and health managers to the use of behavioral science. There have also been some stereotypes of the medical and health field held by some of our colleagues. They have defined it as a system not worth much investment of energy. It might help to get an overview of some of the stereotypes that still exist in considerable force among health practitioners, and among some applied behavioral scientists. Let me look at it from each point of view.

A. From the point of view of health practitioners

1. Behavioral scientists are soft and fuzzy -- it is not a real science.
2. Behavioral science interventions consist solely of sensitivity training, group dynamics and other quasi-psychological techniques.
3. Behavioral scientists aren't scientists -- they are missionaries trying to provide a humanized nurturing approach to everything.
4. Behavioral scientists are too value oriented. They undervalue technology in clinical practice.
5. Behavioral scientists are too process oriented. They don't seem interested in the task or mission of the organization, but only on <u>how</u> things are happening.
6. Behavioral scientists don't understand the health world. Their experience is in industry where the goals are very

clear -- making money; where the boss has clear control over his subordinates; where the products are tangible. That is a totally different world from the health world.

7. Behavioral scientists are interested in change for change sake. The process of changing itself seems to be a worthwhile goal for them. Their effort is not related to the reasons for change.

8. Behavioral science interventions might cause a loss of control from our point of view. We cannot afford this in a field which is a life and death profession.

9. Behavioral scientists cannot communicate their knowledge practically. They are too theoretical -- too much jargon.

10. Science values is the mission of the practice of medicine. Social values are a corollary. Our mission is to save lives, to increase technology and to maintain a high quality of care.

11. Medicine is not egalitarian. Behavioral scientists try to influence us toward that condition.

12. Behavioral science insights and practices are "old hat." There is nothing new. As health workers we have been dealing with behavioral matters all of our professional lives.

13. Our lives are filled with interaction with troubled people seeking help. We have developed our coping mechanisms for avoiding getting too involved in the emotional problems of our patients. Behavioral scientists are trying to change our coping mechanisms and reduce our "objectivity."

14. We don't trust behavioral scientists. They have also developed their coping habits and facades and self-protective mechanisms.

Are they practicing what they preach? We doubt it.

15. Psychiatry is for doctors who couldn't make it in surgery and other more scientific professions.

16. Psychiatrists seem outstanding among physicians for their lack of humility and caring. Do all behavioral scientists operate from "Don't do as I do -- do as I tell you"?

B. These are some of the attitudes which produce resistance to collaboration from the health workers. Let's look at some of the stereotypes and attitudes from the point of view of the behavioral science practitioners.

1. We have a technology and skills in the areas of training, team building, individual counseling, etc. This technology can be applied to any setting including the health field. We are primarily technologists and transfers of technology.

2. To be effective consultants, it is not necessary to know all about a particular field. Health organizations are composed of people just like industrial organizations. We don't need a special orientation to the health field.

3. We don't feel competent to work in the health field. It is too high a risk because they are dealing in matters of life and death.

4. There is a lack of social values in much of the medical world. The concept of caring is totally alien to many health workers.

5. We have a number of treatments, but we are not sure whether they fit the problems.

6. It is very difficult to gain access to this system. It is full of resistance to help.
7. We would not know where to begin.
8. Medical people are over-concerned with professionalism. Doctors are more interested in our curriculum vitae than in our competence.
9. The whole health system is controlled by doctors. They have their own goals, which may be science or money or both, but the system is not open to change.
10. Why spend energy in such an autocratic system as a health delivery system?
11. As long as doctors have the social status they do in our society and as long as the Medical Associations have the power they do in our government, we are really not going to change anything in the health field.
12. The health system is a political football. The little bit of help we could give is meaningless in that giant system.

These are just a few of the more widely held stereotypes on each side that produce resistance to collaboration -- and produce the paradox I mentioned earlier.

WHAT'S AVAILABLE?

The difficulties caused by these misperceptions are real, but of less significance, I believe, when compared to the opportunities facing our field today. A core question for our attention is: "What are the major contributions of behavioral science and its practioners to the problems of the health field?"

I think our contributions have two characteristics:

Technology — knowledge, methods, techniques

Support — Personal collaboration in diagnosis, and work on problems.

Technology

I would classify knowledge and skill into five categories:

1. Organization behavior and functioning
2. Individual and group dynamics
3. Management and leadership processes
4. Planning and managing change
5. Community functioning -- power -- political behavior.

I want to look briefly at each of these categories.

1. Organization behavior and functioning

- organization design -- functional program matrix
- systems analysis -- open systems planning, socio-technical systems
- planning -- organizational goal setting, manpower planning
- managerial strategies -- Theory X and Theory Y
- organization of work — job enrichment, etc.
- intergroup relationship — managing inter agency on department relationships, managing goal conflict
- managing professionals -- entrepreneurship, managing scientists
- the organization and its environment — concepts of differentiation, integration, organizational coping cycle

2. Individual and group dynamics and learning

- achievement motivation concepts
- learning theory and practice
- learning styles

- curriculum planning
- curriculum implementation
- performance improvement planning
- management of values
- meetings management
- group effectiveness and group dynamics -- communications, decision making, norms, goals
- team development

3. Management and leadership processes

- management styles
- management processes
  - communications
  - decision making
  - role sets
  - goal setting
  - reward system
  - conflict management

4. Planning and managing change

- organization diagnosis -- models of analysis
- force field analysis
- strategies for planning change
- power and social change
- organization for change -- critical mass, change organization, use of teams, project groups, task forces, etc.

5. Community and larger system organizations and power

- community power structure

- community organization
- community development techniques
- large systems analysis
- political strategy
- public relations
- methods of social intervention

Support

In this category I include the processes of:

Collaborative diagnosis

Joint planning

Information collecting and processing

Providing perspective

Translating theory

I also include personal behavior.

I have seen a number of illustrations of successful and unsuccessful collaborations, where the critical variable was the personal investment of the consultant, expressed behaviorally. A few examples:

The Sloan School of Management at MIT in collaboration with the Association of American Medical Colleges is conducting a one-week management education program for deans of medical schools and academic medical centers. In this program the two coordinators make it a point to attend each session, regardless of which of several faculty members is conducting it. Our role is primarily one of providing linkage between the resource faculty and the participants, whom we have gotten to know. Interpretations, translations, and devil's advocate questions are part of our regular behavior aimed at providing this linkage.

The evaluations of these programs consistently note this behavior with favorable comments. There have been a number of comments that this continued "connection" has made a significant difference to the deans in what they have gotten from the program.

In a follow-up of this program conducted by AAMC, the deans of six to eight different medical schools attend a four-day workshop along with selected members of their staffs or university and hospital colleagues. Their purpose is to work on some institutional or organizational improvement effort. They are assisted by management and behavioral science consultants. Practically all of the successful experiences from these workshops are in schools where the participants specifically commented on the consultants' personal investment in them. Availability outside formal meetings for one-to-one or group discussions; willingness to explore seemingly unrelated issues; personal concern and caring for the individuals and their problems -- these make (as we know), significant differences in the outcomes.

Some colleagues and I have been working for several years at the Martin Luther King, Jr. Health Center in the Bronx, N.Y. The personal interest of the consultants in the individuals and teams of clients, have been seen as an essential condition for effective <u>early</u> progress. There is real and I suspect legitimate dependency in the early stages of an improvement effort for active support—even hand-holding--by the consultant. Trust in the person seems to be equally important to trust in technical competence.

In working with interns and residents in social medicine at Montefiore Hospital in New York, I have found that it is essential for my effectiveness as a teacher or group consultant to have the time, the energy, and the <u>desire</u> to work with the individuals on a variety of their concerns.

The mode of "professional distance" which is common and perhaps appropriate in much counseling and consulting is, I am sure, not always appropriate in working with health workers and managers.

INITIATING ACTION

The facts of the situation, as I see it, require that much initiation of collaborative effort be from behavioral science practitioners.

Locations of possible entry points are numerous. Staffs of community health centers, directors of outpatient clinics, psychiatry departments in hospitals, mental health clinics directors, faculties and administrators of education programs in medical or nursing or dental schools, curriculum planners, administrators in hospitals and health centers, community boards -- these and many others are there, and frequently interested.

The individual practitioner, wishing to become involved can scout his own area for such opportunities.

In addition to looking for clients, there are a number of looks at oneself, that I would recommend. They include:

1. Recognizing the readiness for help that exists among leaders in the health field. There is a growing awareness of the need for technology and application of practice from other settings to the problems of managing both learning and delivery in the health field.
2. Examining one's own stereotypes and attitudes. A lot of potential collaboration is inhibited by lack of information about the real values, priorities and attitudes of many medical health leaders.
3. Trying to understand "empathically" the stereotypes and attitudes of health leaders. Of the several reasons for these stereotypes and attitudes, perhaps the most common is that health workers,

like behavioral consultants, see themselves as primarily in a helping profession. It is a well-known fact that people whose self-image is that of helper, have more difficulty receiving help than do people in more operational roles. Another cause of some of the stereotypes is some bad experiences with behavioral science consultation in the past. A third cause is the transfer of stereotypes from one small part of the behavioral science field to everyone who has a "behavioral science" label attached. It is astounding to realize how many people in the health field, when thinking of behavioral science in medicine, limit their thinking to psychiatry. There is relatively little experience with the kinds of resources that the total range of applied behavioral sciences can bring to their problems.

4. Developing a problem vs. discipline orientation. One cause of a lot of confusion is that health workers have seen behavioral scientists as having a primary need to induce behavioral science concepts and practices into "their" systems. The client feels that the consultant is more concerned with his, the consultant's, expertise than with the client's problem. There is a real need for consultants to take a more client and problem-oriented stance. If we can start from the point of view of the client's problems, which implies understanding a lot more his world than many of us consider necessary, we are much more likely to find receptivity toward collaboration. In medicine itself there is a strong trend toward a non-problem oriented approach to the health worker/patient relationship, but there is a very strong trend toward what is called

problem-oriented patient diagnosis and record keeping. Traditionally most treatment was of specific symptoms, and records were kept around the specific treatment -- in many institutions today there is the introduction of a total record of the person and the relationship of all his current and historic symptoms to each other. This is a dramatic change in the way diagnoses are made and records are kept.

5. Developing an active program for learning about the environemnt. The health field is different from other sectors of society. It is the only sector where people at all levels can and do constantly face life and death issues. The cultural norms that this condition produces are unique. Health workers are affected by the "sickness" and "treatment" mode that is a major theme of most education and delivery institutions. This must be understood and perhaps even experienced, if we are to work with it creatively.

6. Relating empathetically to the strong professionalism of the health field. The great majority of the workers in this field have specialized training and certification. The equating of credentials and competence is very much a part of this world. It is understandable that "health professionals" would apply the same norms to behavioral scientists.

For the "Profession"

There are areas of study that require initiation from behavioral scientists that will not be initiated from health managers. I would like to quote from a paper that Harry Levinson read at the Eastern Psychological Association, entitled, "Relating Psychology to Emerging Health Care Delivery Systems." Levinson says: "It seems to me that psychologists should be involved in and expected to do research on the relationship of feelings to health, including the impact of external forces like social class, occupation, family dissolution and similar factors and their contribution to illness, which in turn could lead to planning with coping for those precipitating problems."[1]

He also says: "Psychologists should be very much involved in changing the attitudes of professionals. I think specifically of the manner in which present medical and ancillary roles are being carried out and the need to break down status hierarchies in present hospital structures."

Another: "We need to think in terms of new professional roles such as the possible role of a professional medical manager. Such a person may or may not be a physician. If he is a physician, he will have to learn to manage; if he is not a physician, he will be a professional manager who will be managing highly technical people..."

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[1]Eastern Psychological Association Annual Meeting, April 28, 1972.

The group working with the Martin Luther King Health Center in the Bronx, New York, has been involved in this particular problem -- helping people learn to be medical managers. The eight delivery teams in the Center are now responsible to unit managers, none of whom is a physician. These managers have had to learn the problems of managing health professionals of a variety of backgrounds. The "professional" members of the delivery teams have had to learn the problems of relating to "professional" managers. We have been working with the medical management staff, developing new concepts and practices around interdisciplinary team delivery of health care. We have worked with the health care teams helping them develop new roles and role perceptions. We have helped the organization redesign its formal structure to support the team delivery system. For example, heads of services such as pediatrics and internal medicine are now in staff positions relative to their counterparts (ex-"subordinates") on the delivery teams. We have worked with the interns in residence pediatrics and internal medicine at Montefiore Hospital who are part of the social medicine house staff and who do their field work in this community health center. The effort here has been to help them become more effective change agents around the delivery of care, both in the community health center and in the hospital ward. We have worked with the same group of students to help them with concepts and practices around the management of their own learning during their internship and residency.

Toward improving the management of health care institutions, there are

a number of activities underway at the moment. The Association of American Medical Colleges has an extensive program in management development, which includes participation by most deans of medical schools in the country and large numbers of department heads, university officials and associated hospital directors. Through educational and planning activities they are becoming aware of behavioral science and management technology; they are planning practical change efforts in their own institutions; they are consciously re-examining their own systems, their own values, their own ways of work. In many cases, they are assisted by behavioral science consultants. It is clear that the demand for resources to help with these activities will increase. Of the 114 medical schools, seventy-five deans have attended the educational phase around management which we conduct at the Sloan School of Management at MIT. Of these seventy-five, well over sixty are committed to follow-up activities with a critical mass from their own institutions toward an organization development effort of some kind. Eighteen schools have already engaged in this activity.

Most faculties of medical, nursing, dental and other health institutions are actively considering major curriculum revisions at this time. These include changes not only in content, but also in faculty/student relationships, methods of teaching, environments for teaching, cross-school collaboration. Organization psychologists and educational psychologists can be of significant help in this area.

The interrelationships of institutions such as hospitals, medical schools, university managements is a core problem for large numbers of institution managers who are working with planning specialists, systems analysts, and organization development specialists. There is a large area

of opportunity for organization development consultants to help organizations plan methodologies and strategies for dealing with the human consequences of large organization changes.

Collaboration around research and action between health care institutions and applied behavioral science departments is growing daily.

SUMMARY

The environment around the health care in our society today is increasingly complex, and is making new demands on education and delivery institution leaders.

There is an increasing awareness among these leaders of the need for help in technology, practices and leadership behavior to cope with the changing demands.

There is a body of knowledge, technology, techniques which could be of significant assistance to leaders of health delivery and education institutions.

There are a number of ready clients in the sense of people who are "hurting" -- aware of the need for help.

There is a paradox in bringing together those who want help and those who might have help to provide. It is caused by the stereotypes, traditions, role generalizations and lack of information that each area of society has about the other.

There is increasing energy on the part of health workers directed at working these problems and seeking professional help.

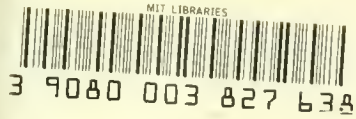
There is a need for behavioral science practitioners to be more aware of this need and to perhaps take a more active stance in trying to find collaborative relationships.

We can pretty well identify the forces in the situation that are pushing toward the application of our technology and skills. We can pretty well identify the historic blocks toward movement.

The challenge and the opportunity now is for those of us in this field who are interested to actively move into this developing market and find ways of entering where we are seen as mutual collaborators rather than soft, fuzzy-headed or over-controlling "psychologists."

It is a challenging time in an important area of society. I suspect that we will see considerable development in it in the next few years.

Date Due



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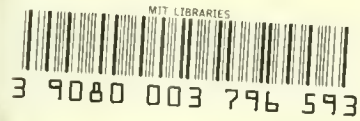

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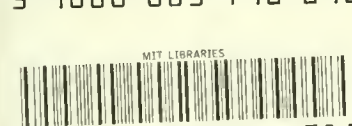

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