THE PHYSICIAN EXECUTIVE

AMERICAN COLLEGE OF PHYSICIAN EXECUTIVES—JOURNAL OF MEDICAL MANAGEMENT

MAY•JUNE 2000, VOLUME 26, ISSUE # 3

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Building Effective Health Care Organizational Structures

Associations and Bureaucracies

by Elliott Jaques, MD, PhD

UNDERSTANDING THE nature of associations and bureaucracies—and the crucial differences between them—is essential to develop effective organizations for our hospitals and to provide the conditions for maintaining the private doctor-patient relationship that remains the basis of good medical practice. This understanding lies at the heart of how to establish sound organization of doctors in hospitals as compared with other professional hospital staff, including nurses and diagnostic and therapeutic staff, as well as physician executives.

In order to understand how hospitals can function most effectively, it is necessary to be clear about the distinction between these two very different types of organizations.

1. **Associations are organizations of individuals who join together for a common purpose in pursuit of a common goal.** Examples of associations are partnerships (as, for example, in a *partnership* group practice of six physicians); *shareholders* of companies; *citizens* of a state, city, or the nation; and *members* of a church, trade union, or club.

The essence of a true association is that all members are equal. There are no managers and subordinates. Nor are the *members* considered employees. You become a member of an association by joining it; you do not become a member by being employed by it. The members and the employees of associations are very different things.

The work of associations may be done by its members, as is the case, for example, for partners or for members of a church. Or the members may use their elected board, central executive committee, or a government to act for it. Such elected members cannot, however, tell other members what to do. The only way that one member can instruct another to do something is if they have both *volunteered* to be

KEY CONCEPTS

- **Associations versus Bureaucracies**
- **Doctor-Patient Relationship**
- **Private Practice**
- **The Physician as Employee?**

Hospitals are institutions in which private physicians admit their patients to receive care that could not be provided at home. In order to understand how the organization of such hospitals can function, it is necessary to be clear about the distinction between two types of medical practice. Health care professionals (including doctors, nurses, therapists, etc.) may engage in private practice with patients who choose to be treated by them and with whom they have a private, confidential relationship. Or they may be employed in treatment institutions (mainly hospitals) in which they provide professional services under prescription by a treating physician. In private practice, professionals are free standing. They may join associations to pursue common interests. But as members of associations, they do not work for each other, are not accountable for each others work, and are not in manager and subordinate relationships. If, however, they work for a hospital, then they become employees within a bureaucracy, working for a salary, and subordinate to a manager. The implications for physician executives are discussed, with illustrations of the types of authority that they require to have an effective working relationship with treating physicians.

part of a working group, (or in the case of a church, have been "ordained"), whereby some limited handing out of instructions may be sanctioned.

Members of associations should not be paid "salaries." If they receive any income at all, they should get stipends, honoraria, or fees. Salaries should be recognized as the special type of payment associated only with an employment contract. Thus, for example, members of partnerships do not get salaries, they take out "drawings"—they have an agreement that determines how much each partner takes out of the partnership's total income, say each week or each month.

2. **Bureaucracies are managerial hierarchies with individuals who are salaried employees of the association.** They are employment organizations made up of employees. Employees in bureaucracies are subordinate to managers. Managers, in turn, are subordinates of other managers, until one reaches the top of the executive system and comes to the CEO, who is an employee appointed by the board and is held accountable for the results of the employees' work.

Employees in these organizations are paid salaries. They may get promoted. Managers should be held accountable for the results achieved by their subordinates, because they decide which resources the subordinates should get and no one can predict the conditions and circumstances that will be encountered in carrying out a task. By way of sharp contrast, no member of an association can be held accountable for the work of others.

What is a hospital?

What does all this rigmarole have to do with doctors, hospitals, and patients? First, let's briefly summarize what a hospital is. A hospital (hospice) is an institution in which a doctor can arrange for a patient whom he or she is treating to receive care and treatment that can't be provided at the patient's home. To maintain the private doctor-patient relationship and clinical autonomy, the doctor must remain *outside* the hospital organization, accountable to his or her patient for the treatment prescribed.

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Basics of hospital organization

What is the association in the case of a hospital? In an urban hospital, the association is composed of the citizens of that city, relying upon their elected representatives, the mayor and city counselors, or aldermen, to carry out the board's policies in running the hospital. In a private hospital, it is whomever the shareholders or the "members" of the hospital are, with an elected board. In a teaching hospital, it is whatever the university or medical school association might be—and that may vary widely—represented by the council or the governing body, also organized in many ways.

Whatever the *association*, however, you then come to the hospital staff. If we consider the non-physician staff—the nurses, physiotherapists, laboratory technicians, radiography technicians, dieticians, and other professionals, or the engineers, administrative and clerical staff, porters, cleaners, and others—they are solidly in the bureaucracy. All are *employees* of the hospital, and can and must be

organized into standard managerial hierarchies. And as employees, they experience the common problems of organization, management, and managerial leadership of such systems.

Hospital staff often like to argue that because they are "professionals,"[1,2,3] they should not be "managed." Whether or not they are managed, however, is not a matter of professional status, but of their work situation. Any professionals may engage in private practice, in which case they would not have a manager —because they are not employed on salary by an institution. As employees in a hospital, however, they are not in private practice; they are providing services prescribed by another professional, the treating physician, who is in private practice in relation to the patient.

The treating physician

Now we come to the doctors who are authorized to bring patients into the hospital for treatment. Not only the physicians and the surgeons, but the radiologists, bacteriologists, and pathologists as well. Where should they be? Should they be employees, in the bureaucracy, with managers? That arrangement is possible, as for example in the Veteran's Administration or military hospitals, where the doctors are part of a managerial hierarchy. *But there are no private doctor-patient relationships possible under those conditions.*

The answer to this question is critical for the patient. If the doctor is an employee and in the hospital organizational bureaucracy, then the doctor will be subordinate to a manager. If a doctor has a manager, then his or her patients do not and cannot have a private doctor-patient relationship. *For patients to have their own doctor, that doctor cannot be an employee within a bureaucracy.*

Patients who have doctors that are employees of HMOs do not have a private doctor-patient relationship. The HMO is finally accountable for the treatment given by its employees (the doctors). The fact that HMOs have not solved their managerial issues in terms of being able to articulate clearly where accountability and *authority* lie for determining treatment only makes the situation more confused, thereby making matters worse.

Treating physicians forming associations

The alternative to making doctors employees of the hospital, to be managed by someone else within the bureaucracy, is to leave them as free standing professionals in private practice (including, where they so desire, to combine into small partnerships), wherever their fees might come from. But any hospital where they are authorized to admit patients should require that they form *associations* with the other doctors practicing there, and elect representatives to act for them. They might organize as one single hospital medical association, or in specialty groups, each with its own elected committee.

There is nothing new in this notion of doctors affiliated with a hospital forming an association with an elected committee. It just remains to be clear about what it means—the doctors negotiate, keep under review, and agree with the hospital board the policies under which they shall prescribe for their patients. It is then up to the doctor to determine how much he or she shall participate in the meetings of the association. But regardless of that judgment, each doctor must be bound by

Preserving Clinical Autonomy in England

I had the opportunity to work on organization matters with the National Health Service in England in the early 1970s. One of the major issues was to preserve the clinical autonomy of the medical practitioners. They liked to argue their case in terms of the dignity of the medical profession. That argument was like a red rag to a bull to the nurses, therapists, and technicians who were employees.

The issue was resolved when the doctors' representatives came to see that what was at stake was not the dignity of the doctors, but the rights of patients to have a private and confidential relationship with their doctor. When this crucial point was clarified, the argument subsided, and doctors, both general practitioners and hospital consultants, who worked for the Health Service, were put on special contract of service as individuals, with their own patients.

—Elliott Jaques, MD, PhD

decisions agreed with the hospital board by their committee.

Under these conditions of association membership, the doctor can be a professional free agent, acting with and for the patient, and deciding the diagnosis and treatment. The relationship remains confidential, because, in effect, the doctor is working for his or her patient, and is prescribing diagnostic procedures and treatments to be provided by the hospital, but is not *employed* by this institution.

The hospital bureaucracy then follows the prescribing instructions of the accountable and authorized patient's physician, always within the limits of agreed upon policies. If the physicians are unhappy about the effectiveness of the employees in carrying out their prescribed diagnostic procedures and treatments, these matters are taken up by their professional committee with the hospital board.

The physician executive

Finally, then, what is the role of physician executives? They, of course, have taken the big step of changing from private medical practice with their own patients to being employees of a hospital in the bureaucratic hierarchy. They are, therefore, either directly employed by and subordinate to the hospital board or assigned as a subordinate of a manager who is a hospital employee, perhaps the president. It should be self-evident that physician executives cannot be managers of the practicing physicians. It would be a conflict of interest for them to be members of the professional associations of the doctors practicing in the hospital.

Physician executives should provide appropriate services to the associations of the doctors, and to individual doctors as necessary. They should meet regularly with the elected committees of the professional medical associations to communicate the views of the hospital board, to discuss problems and innovations, and to overcome problems that might arise. They should also have the authority to monitor the doctors to ensure that they are working within the policies established by the hospital board.

For patients to have their own doctor, their doctor cannot be an employee within a bureaucracy.

This last point about monitoring raises all the questions of the physician executive's authority in relation to the practicing physicians. These issues of lateral cross-functional authority are never spelled out in bureaucratic organizations—but they certainly need to be! Physician executives, like their counterparts in management elsewhere, are urged and exhorted: "To be good leaders," "To influence others," "To take on leadership skills," "To build consensus among others," "To develop change management skills," and to carry out all the other so-called intangibles necessary for "getting others to do things," particularly when those others are doctors. It simply will not work!

Allocation of authority

Four types of authority need to be assigned to physician executives to enable them to be successful. The physician executive must work to assist the hospital board to set clear, effective, and comprehensive policies within which the authority can be exercised.

1. **Monitoring.** The authority to keep informed about how doctors and professionals are working to ensure that policies are being adhered to. If the physician executive judges that someone is practicing outside of policy, he or she has the authority to try to persuade the doctor or professional to change. If not satisfied, the physician executive must take the matter up with either the hospital board, president, or the medical committee if a doctor is involved, or with the immediate manager in the case of a professional.
2. **Auditing.** In the case of a possibly dangerous situation, the physician executive can instruct a doctor or professional to stop what he or she is doing or intending to do, and the matter can then be taken to higher level for a decision.
3. **Prescribing.** Where the physician executive judges that a dangerous situation requires that something be done immediately, he or she can instruct a doctor or a professional to take a preventive action, and the doctor or professional must do so. The matter can then be taken to higher level for review.
4. **Coordinating.** When a new policy, practice, or procedure is being implemented, the physician executive can bring together those who are involved to persuade them to collaborate to take certain actions in order to ensure that everything is in sync. If those concerned are not persuaded, then the physician executive must take the matter higher.

These kinds of allocated authority can be used to good advantage in cross-functional role relationships (where managerial authority cannot apply). Their implementation eliminates the need for physician executives to rely upon phony personal so-called leadership skills to do what they need well-articulated authority to do.

Two Types of Organizations

In order to understand how hospitals can function most effectively and to provide the conditions for maintaining the private doctor-patient relationship that remains the basis of good medical practice, it is necessary to be clear about the distinction between two very different types of organizations.

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Conclusion

These organizational processes are meant to be illustrative only. But under such organizational arrangements, patients' rights to a private relationship with their physician can be preserved, and doctors can practice freely, because that freedom is constrained by appropriately negotiated and agreed policies and conditions.

The major concern in these organizational issues does not have to do with the statutes and rights of the clinical physicians. It has to do with the entitlement of the patient to have a private and confidential doctor-patient relationship. It was to provide for such a relationship for patients that the law grants clinical autonomy status to its qualified medical practitioners. The organizational possibilities that enable doctors to maintain such a status are associations of various sorts—partnerships and hospital medical communities—but not employment in a hospital bureaucratic managerial system. ●

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A REACTION...

Please see page 34 for member reactions to this article on the difference between associations and bureaucracies.