Large Medical Group-practice Organizations and Employed Physicians: A Relationship in Transition

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WE ARE WITNESSING THE EARLY STAGES OF A revolution in the way American physicians practice medicine. It is not a revolution of the kind of work they do, but of under what auspices and in what company they do it. Among the precipitating causes are the spiraling costs of medical care and the consequences of strategies designed to contain them; a recent, major increase in the supply of physicians with much greater representation of the young and female; and a continuous parade of new technology with an imperative to use it. Some indirect evidence of a medical practice revolution can be seen in the enrollment gains of health maintenance organizations (HMOs) and the proliferation of various other "managed care" schemes. The best direct evidence is the sudden increase in size of multispecialty group-practice organizations—up from an average of 15 physician staff members in 1980 to 27 in 1984 (Havlicek 1985, 9).

Nostalgic for what they remember as American medicine's "golden age" (Patrick 1987), some of the older generation of physicians have voiced dismay over such unfamiliar features of the medical practice environment as media advertising of medical services, the malpractice insurance crisis, and, particularly, the replete documentation demanded of physicians by "third parties." But when future historians look back on American medical practice in the late twentieth century, none of

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these changes will stand out as the most significant of the 1980s. The revolutionary change, the one likely to introduce a new era of medical practice, is the ascendancy of the organization-employed physician.

Physicians who practice medicine in large organizations perform many different kinds of activities, occupy various formal and informal roles, and maintain several different kinds of relations with each other and with the organizations that employ them. Because these organizations are inherently complex and are undergoing rapid change and growth, they are often difficult to understand using the conventional categories of group practice. In this article, we suggest that the understanding of large group-practice organizations, and especially their relations to the physicians who work in them, can be advanced by reducing such organizations into a manageable number of types. To accomplish this, we offer a new typology of large group practice drawn from the perspective of the physician/organization relationship. This typology, with illustrations of the various organizational types, draws on the historical and contemporary literature, on field observations of a national sample of 40 large medical groups carried out 15 years ago (Madison, Tilson, and Konrad 1977) with subsequent follow-up during 1986 on one-half of that sample, and on our impressions from, as yet, unanalyzed interviews conducted this year (1987) with approximately 300 executives and clinical leaders of the nation's largest medical groups.

We believe that large group-practice organizations can be understood largely according to their values on two continua: the first reflects the organization's basic orientation toward the health care market; the second is a measure of how the organization believes the work of medical practice should be administered. Our principal thesis is that certain environmental and historical factors tend to promote the ascendancy of some of the organizational types delineated by these two measures, and the decline of others. Such ascendancy or decline, however, is not merely the result of the founding or failure of a greater number of organizations of a certain type; it is also caused by the evolution (or metamorphosis) of organizations changing from one type to another. Finally, we believe that the relation between employed physicians and their employer-practice organizations is undergoing fundamental change just when these organizations are rising to new

levels of importance as building blocks of our future health care arrangements.

Most explanations of social phenomena are either tentative or temporary. This analysis is clearly both. It is also incomplete, since it includes only private-sector organizations. That is because most large practice organizations in the public sector respond only indirectly to changes in the health care market; however, some—usually those operated by local government—may respond directly, and to the extent they do, these publicly sponsored organizations can easily fit into the typology. We begin with some notes on the development of large medical-practice organizations in the United States.

The Development of Group Practice: Some Historical Notes

The origins of group practice are not clearly discernible. Physician grouping may have been the natural result of a more elaborate diagnosis and therapy after the emergence of cellular pathology, "safe" surgery, and bacteriology; or perhaps it followed the more definite division of labor that ensued as physicians' skills became differentiated. Whatever the original causes, we know that from about 1910 on physicians were working together in the same practice settings frequently. Many found themselves organized functionally into group practices—on a part-time basis in hospitals and dispensaries (Davis 1914; Pumphrey 1975) and, temporarily, in the military. Yet, working as a part-time volunteer or short-term assignee in a functional group practice is not the same as *belonging* to an organization (in the sense of looking to it when considering one's future career), and few of these physicians viewed their professional interaction in hospitals and dispensaries as a permanent or primary mode of practice. It was not until the appearance of the private medical clinic (as group-practice organizations called themselves) that more than a few physicians could consider a career in organizational employment as an alternative to the more conventional one of independent solo practice.

The first group-practice clinics were formed before World War I. Immediately after the war and in part because of it, several more private clinics opened (Rorem 1931, 15). World War I gave many

physicians their first experience in a highly structured medical program, and the organized arrangements of military medicine, which assured cooperation between specialists, ease of consultation, and efficient care of patients, were something many wartime medical officers were reluctant to give up when they again became civilians. This was especially true of surgeons, whose work benefited most from the kind of team organization found in the army field hospitals. Such was the impetus, for example, for the founding of the Cleveland Clinic; it was, wrote George Crile (1947, 372), "a plan for carrying out the dream that I myself had dreamed overseas in 1915 and which Bunts, Ed and I had discussed so often in our walks through the forests of Rouen; namely that upon our return we would organize an institution of our own on the basis of a standard military hospital unit." Following this postwar surge, the growth of group practice continued at a modest pace until after World War II, when once again many new medical groups were formed. This time the postwar growth continued steadily until the late 1960s, when it began an acceleration—in the number of new groups and the size of older ones—that is still continuing.

The Emergence of "Large" Group-practice Organizations

The meaning of the "large" group-practice organization also changed over the years. The first major national survey of group practice was conducted in 1930 by C. Rufus Rorem for the Committee on the Costs of Medical Care (CCMC). Rorem (1931, 17–18, 115) found only 13 "private group clinics" with more than 15 physicians and only 4 with more than 25 (the largest by far was the Mayo Clinic, which already had a "permanent" staff of 200 physicians; the second largest had 40). The next two surveys, in 1933 and 1940, were carried out by the American Medical Association's (AMA) (1933, 1940) Bureau of Medical Economics. Both reports made the same point, that the advocates of group practice—especially the medical care reformers that had been associated with the CCMC—were confusing the public with "a peculiar type of propaganda" that imagined the existence of a "model type of group which always has a well-balanced, cooperative body of physicians composed of competent specialists who conduct research, education and the general practice of medicine" (American Medical Association 1941). These two surveys set out to correct this presumed misinformation. Relying on the secretaries of county medical

societies to identify groups and to judge their success, the AMA studies concluded that such "model" groups were "nonexistent," and that few new groups were being formed, since some of the stimuli that had prompted the earlier growth of group practice—a general lack of laboratory facilities and specialists in certain parts of the country, and the wishes of physician members of the same family to practice together—seldom applied now; in any case, argued the authors of the 1940 report, there existed doubt regarding the need for such concentrations of specialists and facilities if, as was generally believed, 85 percent of medical problems could be handled by a general practitioner "without any other equipment than the contents of a hand bag" (American Medical Association 1941). The two AMA studies left the impression that group practice was making little headway and would be even less important in the future.

Seven surveys conducted after the war—the first two by the U.S. Public Health Service and the others by the AMA—reveal a different picture. Together, they show a steady postwar trend toward the primacy of larger group-practice organizations. At the end of World War II, when less than a dozen groups in the United States counted more than 25 members, 15 physicians would have been a "large" group practice. By 1970, a "large" group meant at least 20 physicians. At the present time, more than 40 or 50 is "large" and, if the trend continues, this description may soon refer only to practice organizations with 100 or more members. The changed meaning of "large" group practice between 1930 and 1984 is illustrated in table 1.

Accommodation to Individualism

While many private groups were growing larger and more complex, especially after World War II, the relation between the physicians and their organizations changed little. Individualism and autonomy had been the guiding principles for most groups, and remained so even after some of them became quite large. Nor did many of the multispecialty groups fully demonstrate the advantages—actual and potential—that had been claimed for them in the final report of the Committee on the Costs of Medical Care (1932, 44–8, 114–8). In this respect the AMA claim of "propaganda" proved correct; few of these organizations attempted to exemplify or replicate an ideal model of medical care. As Rorem (1931, 13) had reported, "private clinics

TABLE 1
The Changed Meaning of "Large" Group Practice: Number of Groups by Size

Year	More than 15 physicians	More than 25 physicians	50 or more physicians	100 or more physicians
1930*	13	4	1	1
1933**	9	2	1	1
1940***	17	4	2	1
1946	31	8	4	1
1959	128	46	16	7
1965	180	61	24	8
1969	301	147	50	17
1975	614	288	101	35
1980	769	379	146	76
1984	1,182	660	306	158

* Survey based on 55 responding clinics out of 77 invited to participate.
** Excluded "closed staff" hospitals and "groups which furnish medical services to a single industry."
*** Excluded groups as identified in (**) and also "prepayment contract groups . that have been notorious for their exaggerated advertising and solicitation, and whose members have, therefore, been excluded from organized medicine."
Sources: Rorem 1931; American Medical Association 1933, 1940; Hunt 1947; Hunt and Goldstein 1951; U.S. Department of Health, Education, and Welfare 1963; Balfe and McNamara 1968; Todd and McNamara 1971; Goodman, Bennett, and Odem 1976; Henderson, Odem, and Ginsburg 1982; Havlicek 1985.

do not regard group practice as an experiment in social reform." Rather, they existed primarily for the convenience and well-being of the physicians who practiced in them (Rorem 1985, 22), and who owned shares in them—or could anticipate ownership with additional seniority. As owners, the physicians could easily assure the autonomy of their clinics. Their own autonomy as individual practitioners was also preserved by the absence of any strong executive authority within the clinics in favor of various forms of administration by consensus. And if that management style led to organizational inertia, this was not unwelcome, since the status quo was comfortable, and the lack of any serious competition meant that new initiatives would in any case seldom be necessary.

Some of the early group-practice leaders favored stronger administration, but acknowledged that most private clinics preferred "to function with all the staff equal in management." As Dr. E.V. Frederick

explained it in 1922: "The primary difficulty is that no one wishes to admit the leadership of another." The obvious advantage of these multispecialty clinics was their productive potential, but their strong allegiance to individualism limited what they could accomplish. Yet, the two seemed bound together. "The fabric of American group practice is woven from the warp of individualism and the woof of productive organization," observed Richard Weinerman (1968). As long as the traditional group clinic could continue to operate in a sellers' market for physicians' services, the doctor who cherished his professional individuality and at the same time valued the productive advantages—clinical, logistical and financial—of organized group practice, could have both.

There were, of course, exceptions to the usual pattern. Probably the most important of these was the Mayo Clinic, the original large group practice, which attained preeminence during the second decade of this century. Because of its organizational philosophy as much as its size, the Mayo Clinic required and valued central administration (Clapesattle 1941, 530–35). The Mayo example of strong administration was copied by several other large group clinics, although most were still careful to preserve the individual prerogatives of their physician members. Similarly, large groups financed by prepayment gave considerable attention to organizational structure and administration (but less to preserving individualism in their physician staffs) (MacColl 1966, 96–100). Yet, even these exceptional organizations resembled the others as much as they differed. "No one wishing to admit the leadership of another" remained the norm in private group practice—until quite recently.

A Change in the Organizational Environment

In the past few years, as the sellers' market for medical care has been replaced by a more competitive marketplace, the environment of group practice has changed dramatically. Growth in the proportion of physicians affiliated with large organizations is no longer gradual, nor is organizational inertia any longer tolerated. Out of the revolution in medical practice is being forged a new type of group-practice organization—larger and more complex, more tightly administered, more strategically aware. In a highly competitive environment, the "warp of individualism"

is being replaced with threads of a different fiber. These changing organizations are in turn creating a new kind of physician.

Although organization-employed physicians are not yet the prototypical medical practitioner in the United States, they should soon equal, and in time may surpass, the "mainstream" of independent, self-employed physicians. What will be the nature of the organizational work environment of the employed physician? Will it be a modified, updated model of the traditional physician-owned group practice—the archetype of the professionally dominated organization? Or will it come to resemble the large business corporation—a medical variation—thirty years later, of the regulated, conformist habitat of "the organization man" (Whyte 1956)? Or will it emerge as something altogether new and different?

Terms and Labels

A major problem in describing the evolving work environment of the employed physician—and thereby answering the rhetorical questions posed above—is that the conventional labels for various kinds of practice organizations don't serve as well as they once did. For example, one of the most distinctive older terms, "prepaid group practice," has been largely displaced by a newer generic term, "health maintenance organization" (Ellwood 1971). "Closed panel," another formerly distinctive term, is also heard in a different context since "gatekeeper" model individual practice associations (IPAs) and "preferred provider" panels became part of the lexicon. The terms "private medical clinic" and "multispecialty group" evoke less specific images than they once did. Even "group practice" is apt to confuse as often as it clarifies.

When a once traditional, "private" multispecialty group practice gradually expands over the years until it has a medical staff of 300 physicians in 20 locations covering half a state, when it incorporates three hospitals, several postgraduate specialty training programs, an HMO with 50,000 enrollees, a home health care agency, a research foundation, and a health care management company, can it still call itself a "group practice?" Technically, it can, but in terms of the work environment, how much do its staff physicians share in common with physicians in "group practices" at the smaller end of the official AMA definition: "the application of medical services by three or more

physicians formally organized" (Havlicek 1985, 1)? Additionally, what has such a group's expansion done to its distinctively "private" character?

The term "private" applied to group practice was once understood to mean that the group was owned by its practicing physician staff, not by someone else. This distinction is still useful in identifying polar types; but in this example—and in many less elaborate organizations—a classification made on the basis of ownership would be precarious. In the largest group-practice organizations several different corporations—both for-profit and nonprofit entities—are almost always involved. In some circumstances, the physicians own essentially only their "practice," lacking a share of ownership in the equipment and facilities, or even the accounts receivable. Alternatively, ownership and/or control is in some instances essentially vested in a small fraction of the group of practicing physicians, while in still other cases the organization is formally structured as an ensemble of nonprofit organizations with lay majorities on each board, but with overlapping directors from the medical staff to ensure effective physician control while conforming to the letter of the law. Such complex and ambiguous arrangements, legal fictions, and tax-minimizing strategies surrounding the question of ownership may have the effect of making distinctions on the "private"/"nonprivate" criterion where none should be made, or of failing to identify substantially different organizational types because they appear similar "on paper."

There is a tendency also to mix organizational arrangements for payment and organizational arrangements for practice, and use the same terms for both. An example is "staff model," "group model," and "network model," three terms which contribute to a typology of group-practice-based "direct service" health care plans (health maintenance organizations), but refer only approximately to the employed physician's work environment (Wolinsky and Marder 1983; Zelton 1979). As "managed-care" options expand in number and variety and large medical groups do business with more than one, the characterizing of a practice organization with a label that was invented to describe a financing or payment arrangement may be inadequate and even misleading (Wolinsky and Marder 1985, 40–41).

Another term, "the third compartment" (Tarlov 1986), points more specifically to the universe of organization-employed physicians, but doesn't discriminate between different kinds of practice organizations. Labels that purport to describe the practitioner's position vis-a-vis the

organization are similarly elusive. The one we use is "the employed physician." While it brings the disadvantage of having an unfortunate opposite (the *un*employed physician), we note that the AMA now holds an annual conference under the title of the "employed" physician, and the term is, arguably, more evocative than the alternatives. The differences between "employed physician" and similar terms—such as "staff physician," "organizational physician," "salaried physician," and "physician employee"—are, however, at best, subtle. While each of these terms may hint at a slight difference of emphasis in the relation between physicians and organizations, they bespeak ambiguity. All of this suggests that a clearer understanding of the physician/organization relationship is needed.

Toward a Typology of Large Group-practice Organizations

Such understanding requires that one have some familiarity with the organizational culture, at least the part of it that reveals what the organization believes should be the hierarchical rank, status, prerogatives, and obligations of its staff physicians. These beliefs can differ markedly from one organization to the next, and they may change over time in the same organization—as explained by one administrator who recently voiced dismay over such a change:

> Thirty-five years ago bonding between physicians in a group practice was strong. Spouses played an important role. New members were enthusiastically welcomed. But group practice medicine is no longer one-for-all and all-for-one (Hardy 1986).

Although this particular organization strayed from the fraternal ideal expressed in Dumas's motto, exactly why, when, and how the change occurred is unclear. Attempting to understand a changed organizational culture using categories that are static (e.g., then and now, "group-practice medicine" versus some other kind) may lead instead to misunderstanding. What is needed is a more dynamic typology, one that can deal with organizations in transitional phases moving from one type to another.

Organizational culture is many-faceted and too inaccessible for quick analysis. It is, therefore, unlikely to yield a convenient typology of large group-practice organizations from which a clearer understanding

of the employed physician may emerge. Yet, such a typology is the necessary basis for studying the work environment in large group practice. And it is a prerequisite for clarifying the relation between employing organizations and employed physicians.

In this article, we suggest two primary elements in a typology of large medical-practice organizations. One draws on readily accessible management data, the other on certain superficial (nonethnographic) clues to the organizational culture. Together, they contribute to an understanding of the physician/organization relationship. The first element is a measure of organizational response to the new competitive "marketplace" environment for medical care; the second is a measure of the organization's tradition with respect to administration of the professional work. The typology reflects our observation that there exists a close relation between the way large practice organizations elect to respond to their market environments and how they are structured internally (and, therefore, how closely the work of medical practice is administered). But we believe also that the influence of the marketplace on an organization's internal administrative structure is inevitably modified (encouraged or resisted) by the organization's own history.

Market Response Strategy

As recently as two decades ago, the concept of "market" was, at most, peripheral to medical care, if not altogether foreign to it. Now, the medical care marketplace is a major concern of all large group-practice organizations. An important new market force is the preference of many large employers for "managed care" products ("managed care" is a wastebasket term under which are grouped various kinds of prepayment arrangements, negotiated discounts, and agreements for prior authorizations and audits of performance). Virtually all large group-practice organizations have already faced the primary choice of how to respond strategically to this potent market force—whether from an essentially *reactive* or *proactive* position. Group-practice organizations that prefer to operate in the traditional "open" market (unrestricted price setting with fee-for-service payment from an undefined client population) and that resist involvement in "managed care" follow a "reactive" market response strategy. Conversely, groups that

desire greater definition of their service populations and that seek involvement in "managed-care" arrangements follow a "proactive" market response strategy. Which of these differing responses a group practice elects to follow will go a long way in determining its internal administrative structure and the degree of autonomy its physicians are allowed in performing their medical work.

Note that we use these terms narrowly to refer to the way a group responds to "managed care." A "reactive" response doesn't mean that the group need assume a "stand pat" position in the medical care market, nor does a "proactive" response mean that it must engage in "marketing." Indeed, a group that adopts a proactive strategy may be quite traditional in its public relations style, while another group that responds reactively may "market" itself aggressively. We believe, however, that the extent to which a large group-practice organization seeks or avoids participation in "managed care" is the strongest single indicator of its overall market response strategy.

A group-practice organization's market response strategy can be identified in terms of two factors:

1. the portion of the organization's service capacity that is "committed" (already spoken for) under any kind of consumer affiliation arrangement or prepayment contract; and
2. the number of different "clients' agents" that the organization deals with in negotiating the disposition of its service capacity.

"Committed Capacity" and "Clients' Agents"

The idea of "committed capacity" and our use of the term "clients' agents" require explanation. When any medical group-practice organization formally agrees, in advance, to care for a group of people, it must "commit" a certain portion of its medical staff capacity to meet those people's demands for service. The notion of "committed capacity" is probably most familiar in organizations that were founded to serve a particular clientele—for example, a university student health service, or a government program set up to care for, say, military personnel or veterans or native Americans. These organizations, which do not ordinarily compete in the open medical marketplace, know that some particular group of people has first if not exclusive claim on the services they produce. "Committed capacity" applies also,

however, in a competitive market environment; for example, a prepayment contract between an independent group practice and a group of consumers says, implicitly, that some of the service capacity has been "spoken for." The consumers have already purchased the service before it is ever actually produced and used.

Historically, such arrangements were known in the medical profession as "contract practice" and were generally unpopular with American physicians, who, even before the Civil War, feared that the amount of "committed capacity" would be too unpredictable and subject to abuse by those who had already purchased entitlement to the service (Savitt 1978, 190–201). Much later, after the medical profession had organized itself into a powerful guild, it opposed contract *group* practice on the grounds that it restricted "free choice of physician" (Leland 1932; American Medical Association 1934). Organized medicine no longer opposes contracting for "committed capacity."

We use the term "clients' agents" to refer to *all* of the parties that speak for individual clients or groups of clients in negotiations with the group-practice organization. Anyone who purchases services *directly* from the group-practice organization is in a position to negotiate and is, therefore, a potential "clients' agent." Most nonaffiliated patients (and those covered by "indemnity" medical insurance) act as their own agents, with each such person/agent representing, at most, only himself and his dependent family members. On the other hand, organized consumer groups or "managed care" plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), are agents that speak for many clients, possibly even all or a sizable proportion of a group practice's total patients.

"Clients' agents" negotiate with group-practice organizations, first, about the disposition of service capacity. How much an agent negotiates depends on its power, on how many clients it represents. Agents with little power (e.g., individual patients acting on their own behalf) negotiate only minor issues, such as setting an appointment time for a physician visit. The more powerful agents, who may represent from hundreds to many thousands of patients, negotiate progressively larger issues: questions of quality and use of service, the hours a facility will be open, even the physician staffing pattern. Secondly, "clients' agents" are involved in questions of remunerating the practice organization for the use of its service capacity. Again, these questions range from the very minor (e.g., agreeing to pay a single fee for a

single item of service) to the momentous (e.g., deciding on the percent of discount or the amount of per annum capitation payment for the total care required by thousands of people).

Organized medicine also disapproved, historically, of powerful "clients' agents," taking the position that any negotiating over payment of insured medical costs should be done by the insured with the insurance company. That way, physician involvement with "third parties" could be avoided (American Medical Association 1938).

Note here that while "committed capacity" and "clients' agents" can have similar effects on the work of medical practice, they are different concepts and must be considered separately. For example, a large group practice may elect not to contract as the exclusive caretaker of a group of people, yet may still have to deal with powerful external agents. While group-practice-based HMOs generally incorporate "committed capacity," most other "managed care" arrangements—including preferred provider organizations, insurance with preauthorization requirements, and traditional ("nongatekeeper") independent practice associations—do not; all, however, interpose "agents" between groups of patients and practice organizations.

The power wielded by a given "clients' agent" in the affairs of a group-practice organization is generally proportionate to the percentage of the practice's total clientele that the agent represents *plus* the percentage of the practice's service capacity that has been "committed" via prepayment to the clients represented by that agent. Therefore, "clients' agents" that negotiate "committed capacity" arrangements are almost always more powerful than those that do not, even though the latter may represent larger portions of the group's clientele. Any "clients' agent," if it is powerful enough, may force changes in the way a group-practice organization administers the work of medical practice and may, therefore, affect the autonomy of its physicians.

In general, the autonomy of the members of a medical staff will be greatest when their group-practice organization is dealing with many different agents and when a low percentage of the service capacity is obligated in advance. In other words, physicians in large group-practice organizations usually enjoy the most maneuverability when there is a wide choice of clientele and little organized purchasing of care, and they have the least maneuverability when all of the service capacity is preobligated to a group of people represented by a single powerful agent.

To illustrate this dimension we can use two quite opposite practice situations as examples. First, there is the case of the traditional, closed panel, prepaid group-practice plan, i.e., the so-called "staff model" HMO, where a single "clients' agent" (the prepayment plan itself) has reserved the *entire* service capacity of the medical staff. Here, the physicians' maneuverability will be limited by the administrative constraints that are placed, directly and indirectly, by the agent. Clear mechanisms will be in place to insure accountability for how the medical work is accomplished. Usually this means that the agent will have some say about the times and places at which services are delivered, who the medical director will be, and possibly how the medical staff itself is selected and organized. (Even if the group practice owns and operates the prepayment plan, the medical staff still must account for its performance to the "clients' agent"—that other division of the organization.) At the other extreme is the case of the traditional physician-owned medical group that does no "contract practice" and collects fees, at or near the time services are delivered, from an unlimited number of individual payment sources. Here, the accountability to each of these many "clients' agents" is slight, since all of them are weak and exercise no influence over the way the group operates. As a result, few administrative constraints will be imposed on the physicians from outside the medical staff itself.

These two kinds of group-practice organizations represent polar ends of a spectrum. We call the distance between them the "market response continuum."

Strategies for Responding to the Market

Every large medical group-practice organization that operates in an open competitive market, responds in some way to whatever market forces it discerns. The market-response strategy followed by a group practice results from a combination of how it "reads" the market and how it prefers to function irrespective of where it sees the market heading. Obviously, aggressive "third party" purchasers of medical care can be a powerful force in shaping the market, yet, their force is rarely so powerful as to be irresistible to a large group practice that considers the terms offered unacceptable. Market-response strategy, therefore, is an organizational choice; it is seldom an imposition.

We can describe the strategic responses of large group-practice

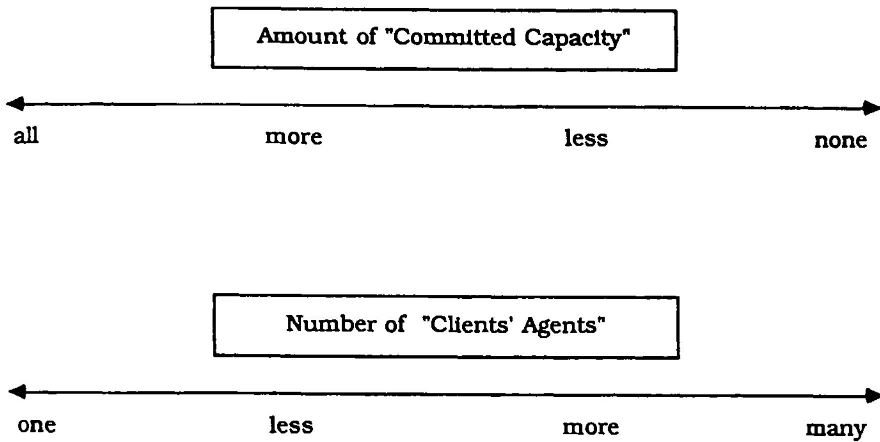

FIG. 1. The market-response continuum

organizations to their market environments along a continuum, representing how an organization limits or expands the number of different "clients' agents" it does business with, and how much of its total service capacity it obligates in advance. Reducing the number of "clients' agents" or increasing the proportion of "committed capacity" (or both) moves a group-practice organization in one direction along the market response continuum, while increasing the number of different "clients' agents" or reducing the proportion of "committed capacity" (or both) moves it in the other direction (figure 1).

On one end of the continuum is the group practice that responds to the managed-care market in a *"reactive"* manner, preferring to sell its services to everyone who comes (while trying to increase the number who do), adjusting both product and price structure according to the immediate demand, absorbing the consequences of any excess service capacity or, should the demand exceed the capacity, limiting the group's services. On the other end is the organization that responds *"proactively,"* selling in advance or negotiating the terms for as much of its service capacity as possible, then making whatever adjustments are necessary, while staying as free as it can of the immediate market by limiting the number of separate purchasers and minimizing the

number of individual product packages (and, therefore, the number of different price negotiations it must enter).

At either end of the continuum defined by these two kinds of strategies one finds a certain "balance" between an organization's market response and the way it deploys its physician staff and regulates their work and reward structure. Where a reactive response has succeeded in preserving the traditional market arrangement (i.e., many "clients' agents," little capacity spoken for), the organization will have no difficulty deploying a medical staff that can fulfill the group's service obligations, since such obligations are few. Similiarly, when a highly proactive market response has been successful (i.e., a single "clients' agent," all capacity committed to a defined population), the correct match between the population's demands for service and the medical staff configuration needed to meet them can be arranged easily, since the group knows the extent of its obligation well in advance. Obviously, these two ends of the spectrum represent very different organizational strategies, and different explanations underlie the "balance" between the type of market response and the internal administrative arrangements for accomplishing the medical work.

Most physician-owned practice organizations that have elected to respond reactively divide the practice's income among the owner-operators, usually by a formula that is heavily weighted toward individual productivity (to each according to his record of "sales"). This highly individualistic method of staff remuneration, along with a tendency toward a high degree of physician work autonomy with limited administrative hierarchy explains why these organizations experience so few problems with staff planning. If there should be a planning "mistake" (not enough or too many physicians in a given specialty), the effect on the *organization* will be slight. (The individual physicians concerned might suffer for a while—either from overwork or from the financial loss associated with the inability to attract enough patients—but the organization would not. At the other pole, in a medical group with a highly proactive response, such a planning "mistake" would bring far greater consequences for the organization. A highly proactive strategy, however, when successful, makes demand so much more predictable that the required service capacity is usually easy to project. Additionally, if these organizations remunerate their staff physicians on fixed salary, administer their work in a hierarchical manner, and

are relatively explicit about production norms, the likelihood of such a "mistake" occurring is further diminished.

The Transitional Strategy

As noted above, the reactive response to the managed-care market is most clearly represented by the traditional physician-owned, fee-for-service group, and the proactive response by the traditional prepaid group practice. There is, however, a large area between these two ends of the market-response continuum. This middle ground is becoming well populated by practice organizations whose strategies reflect a mix of reactive and proactive responses in varying proportions. Indeed, in the current era, when new affiliations between health care consumers and health care delivery organizations are being defined and old ones are shifting, *most* large, traditionally fee-for-service groups already occupy this middle space, or are considering occupying it. These organizations are no longer in a stable state insofar as their market responses are concerned. They are, rather, organizations in transition, reexamining their preferences as they consider new opportunities, adjusting their tactics as they move along the continuum between the two polar strategies.

By far the more prevalent direction of movement is from the old-fashioned, fee-for-service group in a traditional market toward the more highly administered organization with prepaid and other arrangements for "managed care" (from a reactive toward a proactive market-response strategy). Yet, there may be some movement in the opposite direction as well. Prepaid group-practice HMOs now face strong competition from less structured IPAs. Additionally, some of these prepaid group practices are experiencing increased demands for care from their aging enrolled populations and for changes in work rules from their restive staffs. Further, group-practice HMOs are not so favorably treated as they were earlier by federal policy makers. Such developments could influence some of these organizations to adopt more flexible organizational forms (and consider more reactive market responses).

Management Strategies in the Transitional Mode

Management strategies for groups whose responses to the "managed care" market are moving from reactive toward proactive, tend to

operate at three levels. The first is to *simplify the environment* by dealing with fewer and fewer "clients' agents" for larger and larger shares of the organization's product, thereby making the difficult task of responding to a competitive market easier. This tendency toward oligopsony makes the task of negotiating less difficult technically, but if taken far enough it also makes the autonomy of the group more precarious.

The second-level strategy is to *alter the context* of medical work by changing the terms of employment. The market environment of the transitional strategy is an inherently turbulent one, marked by shifting loyalties. In an uncertain market the survival of the organization—not just its growth—may require periodic expansion, involving rapid acquisition of additional medical staff. The deployment of these personnel, however, must remain flexible in order to deal with possible fluctuations in demand for services of various types and in different locations. Thus, a traditional private group practice moving along the market-response continuum in the proactive direction may be more reluctant to extend to its newer physicians either permanent employment commitments or early opportunities to participate in ownership, both of which have been normal expectations in the past (Zirkle and Bengtsson 1987). When a group's market-response strategy is in transition, and the supply of physicians is plentiful, offering early "tenure" to recent arrivals becomes a less attractive policy.

Finally, and most significantly, the transition toward a more proactive market response invites a third strategy, which is to *rationalize the content* of medical work. Productivity must be calculated and ultimately controlled if medical staffing needs are to be accurately predicted and managed. Individualistic incentive mechanisms of physician remuneration may motivate productivity, but they are not useful in calculating it, especially prospectively. Inevitably, then, production norms will become more explicit, if not more effective, in determining how physician work time is allocated. In addition, some of this work rationalization will entail task delegation to physician extenders, and the introduction of fairly explicit clinical protocols.

All three of these management strategies serve to strengthen the hand of the administrators (whether lay or physician) over the practitioners. Narrowing the focus of negotiation enhances the role of administrators as "boundary spanners" who effectively buffer the physicians from the market environment. Restricting access to "tenured" colleagueship creates a less privileged and correspondingly less influential

class of physicians within the group. Introducing formalized expectations of the kind and amount of work to be done leads inevitably to a more centralized governance of the work process, through a clinical administrative hierarchy; new committees and executive roles, such as "medical director," "department chief," and "associate medical director for quality assurance," will appear in groups that previously functioned under minimal clinical supervision. Movement away from a reactive and toward a proactive market response also brings with it a change in the way a large group practice thinks about the service it produces.

Transformation of the Medical Care "Product"

The staff of an established prepaid group practice, that cares for a defined clientele to whom the entire service capacity is committed, will ordinarily share a uniform view of the organization's mission. By contrast, in the transitional group that has recently begun selling various portions of its capacity to large-scale buyers on the open market, the staff's conception of organizational purpose will probably be less clear, certainly less uniform, and could easily emerge as a point of contention within the organization. Medical care "futures" are not yet traded on the commodities market in Chicago, but in the minds of some physicians one way to turn personal services into alienated economic products or commodities is to purchase them before they have been created. Individual staff physicians and the organization's "administration" may have different (even if unarticulated) root conceptions of the ownership of "committed capacity." While the "administration" views medical care as a flow of interchangeable service units that are produced by and are the property of the *organization,* the physician who delivers the medical care, one unit at a time, naturally tends to identify those units as his or her *own* products. In the traditional fee-for-service group, where the administration functions as the coordinating arm of a federation of quasi-independent shopkeepers, and therefore supports the physicians' view for the most part, the tension is minimal. Similarly, in the fully developed prepaid group practice the tension is diminished (but never entirely absent), since both administration and practicing physicians have come to recognize the group's primacy in the ownership of the product and its key role in negotiating with the single agent that represents all of the clients. In the transitional group, however, which yesterday in a less competitive market viewed the sale of its product in one way but today views it

differently, there may be great differences between the administrators—out in front of the organization's market-response strategy, leading it through change—and the practicing physicians whose attitudes were formed in a different market environment and who now are being told to adjust them. The resulting tension may lead to dissatisfaction if not conflict.

Table 2 records some of the characteristics that are typical of large groups at either end and in the transitional area of the market-response continuum.

Organizational Tradition

A group-practice organization's internal structure and administrative behavior cannot be wholly explained by its market-response strategy, no matter how far toward the proactive or reactive end of the market-response continuum the group's strategy places it. Institutional history is an equally important determinant. Medical group-practice organizations have traditions that are as powerful as any market force in determining how their physicians' work is organized and administered, what that work is, how they are remunerated for it, how fully they participate in deciding changes that affect the entire organization, and, especially, what values guide all of these policies. The organizational tradition goes all the way back to the founding of the group and the reasons for it. Who took the initiative, and why? And what values were dominant when it decided on its early policies and modus operandi? Finally, the *strength* of the tradition depends on how carefully the original purpose was preserved or modified as the group practice grew larger and changed, inevitably, into a bureaucracy.

Here, again, there is a spectrum of possibilities, a continuum based on the group's historical purposes, preferences, and goals. This continuum of "organizational tradition" is manifest in how much physician autonomy is encouraged or permitted: (1) at the level of the practice organization—as represented by the medical staff collegium; and (2) at the level of the individual physician member (figure 2).

The Individualistic Autonomous Tradition

At one polar end of the continuum of organizational tradition is the group that values and protects its autonomy not only as a medical

TABLE 2
Characteristics Typical of Large Group Practices with Varying Market-response Strategies

	Proactive	Transitional	Reactive
Specificity of clientele	Highly targeted; well defined; extensively analyzed	Somewhat targeted; described; partly analyzed	Clientele emerged from the practice pattern; estimated; unanalyzed
"Committed capacity"	Virtually all; little or no fluctuation	Between 10 and 60%; considerable fluctuation	None or very little
"Clients' agents"	One dominant agent represents nearly all clients; little fluctuation	A few powerful agents represent between 10 and 60% of clients; considerable fluctuation	Very few or no powerful "clients' agents" (most clients are their own agents); little fluctuation
Physicians' view of clients' affiliation	Physicians identify clients as affiliated with the group-practice organization ("*our* patient")	Physicians identify clients as affiliated with the payment source ("*their* patient") *or* with the group-practice organization ("*our* patient")	Physicians identify clients as affiliated with the individual practitioner ("*my* patient")
Service growth and configuration	Planned, rational growth; specialty and service mix designed to meet requirements of a defined population	Opportunistic, often turbulent growth; specialty and service mix negotiated in response to shifting markets and patient loyalties	Unplanned, natural ("organic") growth; specialty and service mix evolved from consultation and referral requirements of the existing medical staff
Understanding of the medical work	Standardized organizational product lines; production norms are extensive and explicit	Customized and standardized services for different market segments; production norms are ambiguous and shifting	Customized individual service transactions; production norms are undefined

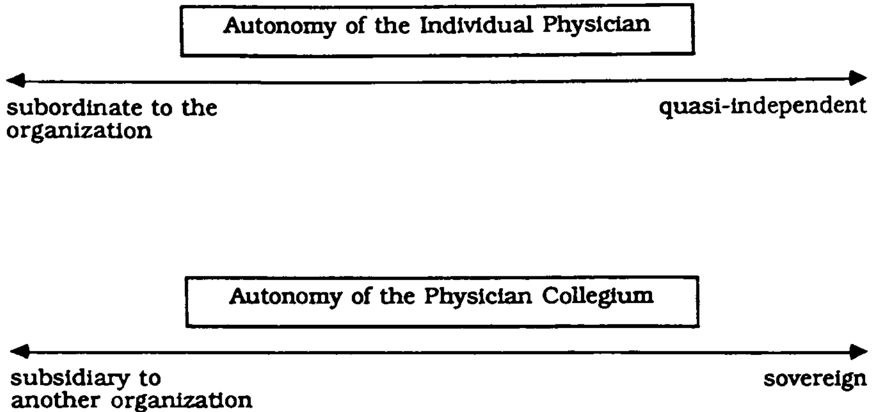

FIG. 2. The organizational tradition continuum

staff, but also the autonomy of each individual member of the staff. Such a group would almost always have been founded by practicing physicians. Its history began with the intent of the founders and early members, who formed or joined the group to gain an advantage in practicing medicine. These physicians agreed that a group practice would benefit them—professionally, logistically, and/or financially—and at the same time conserve much of the individualistic nature of a simpler practice form that they might otherwise have been unwilling to give up or forgo. If, after a few years, the new group practice fulfilled its founders' hopes, and if their entrepreneurial spirit and talents were adequate to the task, the group grew. When new members joined (and were accepted by the older members), it was because they shared the founders' values and agreed with the group's policies, which were based on these values.

At some point in the organization's growth, however, this ethos in which the autonomy of the individual professional is dominant had to be tested against the introduction of an administrative bureaucracy made necessary by the group's increased size. If the proposed administrative solutions passed the test—that is, if the prerogatives retained or given up by the individual physician members were compatible with the original values—the group continued its growth, and, as it grew, a strong organizational tradition developed which reaffirmed and more clearly defined those values and individual prerogatives. On the other hand, if the kind of bureaucratic changes that necessarily

accompany organizational growth beyond a certain size were found to be inconsistent with the group's values, the growth stopped, at least for a while, until the generation of staff who placed the highest value on conserving the original values were replaced by newcomers more willing to compromise. This, of course, suggests that group-practice organizations at the furthest point on the individualistic, physician-proprietary end of the continuum of organizational tradition seldom grow beyond a size needing only the most light-handed of administrative direction, and that they are, therefore probably, unrepresented among the largest groups.

If such an organization ignores its individualistic autonomous tradition and grows too quickly, perhaps moving at the same time toward a proactive market response strategy and making the organizational changes this strategy demands, such a radical departure from tradition could jeopardize the group's stability. A recent report from California (McGinn 1987) illustrates what can happen when rapid change occurs in the face of a strongly opposing organizational tradition. In 1984 a multispecialty group of 30 physicians, which had operated for nearly 40 years in the individualistic autonomous tradition, began making a proactive shift in its market-response strategy. It contracted with an HMO, opened five satellites, brought on a new administrator, and proceeded to strengthen executive control through a change in organizational structure. Some of the physicians objected that these changes were effectively removing them from decisions they had always freely participated in before (e.g., deciding the decor of their individual offices, examining the financial records in the accounting office). When growing dissatisfaction led to attrition, and the shrinking group—now with cash flow problems—began experiencing legal challenges, at first from former members and then from the Internal Revenue Service, it filed for bankruptcy.

It is difficult for a group practice to grow beyond about 25 members without elaborating its hierarchical administrative structure beyond an executive committee of the partners or shareholders and a lay manager. With increased size, an organization's *internal* shape must change disproportionately to the increase in personnel, since the additional functions of communication, coordination, and control must now be provided in an organization that had previously existed essentially without them (Haire 1959). Yet, groups that wish to remain in the individualistic autonomous tradition as they gradually grow larger

may do so if they can minimize the effect of having to accommodate these new bureaucratic functions. They do this by becoming (or remaining) a confederation of quasi-independent solo or single specialty practices. The "group" services (rather than controls) these independent practices—which may even be legally constituted as such. The physician collegium does appoint committees to oversee certain necessary administrative functions, but the hierarchical structure can be kept to a minimum, since little accountability is needed or desired, and since questions of income, fringe benefits, continuing education, and the like are each physician's individual concerns, not the group's. A variation of this method of autonomy preservation is to organize around specialty departments—how each specialty takes care of its affairs is then its own concern. By either of these scenarios, the "group" as it grows larger may continue to maintain a strong individualistic autonomous tradition, yet still represent itself as a unified organization to the outside world.

The Heteronomous Tradition

At the opposite end of the continuum of organizational tradition is the medical group that was founded not by its member physicians, but on the initiative of some other organization—a hospital, a government agency, a labor union, an insurance fund, a consumer cooperative, a medical school, an industrial firm, almost any kind of organization *except* one made up of the physicians themselves. The nature of the initiative could have been any of several possibilities. It could have been the self-interest of a group of persons in satisfying their own demand for medical care—in other words, a *service* initiative. Some examples might be an industrial corporation that opened a medical care program for its employees, a university or prison system that started a health service, a consumer or producer cooperative that organized a medical service for the members' own use. Alternatively, the initiative might have been *financial*—perhaps it came from investors interested in making money by selling medical care or from an insurance company wishing to expand its product line. In contrast to the financial initiative is the *moral* initiative—a church group wished to provide medical services as part of its larger religious purpose. The initiative could have been *political* (e.g., expanded medical services for veterans of World War II), or *organizational* (e.g., a hospital interested in

reversing a declining occupancy or an already organized group practice protecting its flanks from competition, although in the latter case the newly recruited "colonist" physicians in the satellite clinic would probably have been invited to become full "citizens" of the "mother country" group before the new branch grew very large).

All of these are examples of the *heteronomous* tradition, "heteronomous" meaning subject to another (heteros) law (nomos). The term "heteronomous tradition" is derived from the Weberian notion of heteronomy, where "the order governing the organization . . . has been imposed by an outside agency" (Weber [1925] 1968). Others have used "heteronomous" to mean organizations in which the professionals lack autonomy over their own work (Scott 1965; Hall 1967). We use it differently, in reference to the nonsovereignity of a group-practice organization when its *goals* are set (or approved) by someone other than the medical staff collegium or its representatives. Both physicians and administrators of groups that follow the heteronomous tradition have learned to "march to a different drummer," since they must deal with extrinsic as well as intrinsic goals (the purposes of their initiating organizations as well as their own medical care goals). This explains why their administrative styles differ from those of autonomous medical group-practice organizations that pursue only their own, intrinsic goals and the single purpose of producing and selling medical services or, narrower still, "practicing medicine." When a group practice is accountable to a higher level of authority, decision making by consensus or negotiation within the physician staff seldom works as well as executive command by those charged with carrying out the higher authority's purposes.

Goals in Conflict

The multiple extrinsic goals of the initiating organizations are not only different than "medical practice;" they may also in some instances be foreign to the instrumental values that drive any professional medical service organization—quality of care, effectiveness, efficiency, economy, better organization of services, patient satisfaction, and accountability—and which relate to the way in which *medical services* (not something else) are organized, administered, and delivered. These instrumental values may, on occasion, be interpreted by the practicing physicians

as conflicting with the imposed goals, even when they also are "health" goals.

Some goals of some heteronomous group-practice organizations may be so diverse as to be considered alien to the goal of "medical practice." These include one that has been cited often in recent times as being inconsistent with the purposes of medicine: the traditional capitalist, corporate goal of "making a profit for the stockholders" (Relman 1980). There are many other possible alien goals, however, including those that embrace social service ideologies, missionary ideology, social control of the patient population, feminist health concepts, "holistic" health concepts, employing the unemployed or unemployable, empowerment of a minority ghetto community, maintaining the viability and attractiveness to industry of a rural community, or even organizational image enhancement (which in the private sector may be called "marketing" and in the public sector "political responsiveness"). Some of these purposes are as different from each other as each of them is from the primary purpose of doctors getting together to make a living. When physicians become enmeshed in *another* organizational purpose that is not entirely of their own choosing—or, strictly speaking, of *medicine's* choosing (Inglefinger 1976; Seldin 1981; also Light 1986, 14–17)—some of them may voice their disagreement with the organizational goals, thus introducing a potential conflict within the organization.

Strength of the Heteronomous Tradition

Unlike the medical group practice that was founded by practicing physicians, the typical heteronomous group-practice organization began with the appointment of medical and lay administrators who recruited a physician staff to provide patient care and set the style of service consistent with whatever initiative was responsible for the group's existence. This early dominance by administrators—in setting policies and selecting personnel—became the basis of the organization's tradition.

Sometimes, a heteronomous group may divert from its original, narrowly defined purpose. For example, if it should later find itself serving a population well beyond the original clientele, the group might become less dependent on the initiating organization. If so, the instrumental values of medical care would be likely to carry relatively more weight in the group, and the extrinsic goals of the

original sponsor count for less. Such a group over time would probably become less heteronomous in its outlook. Admittedly, this scenario would be unusual, since few large, heteronomous groups have ever become autonomous once they have become large. But even if such a group should evolve away from heteronomy, the influence of that tradition would probably remain strong. The initial lack of ownership by the physicians and their likely high turnover throughout the group's formative period would tend to keep their influence well below that of the administrators and governing board. And although the medical staff might later press for and gain a degree of control, by then it would have attained a size and diversity such that any unanimity of views on changing the organizational mission and style of service would be unlikely. Therefore, much of the policy that governed the group's operation at the beginning would probably remain in effect.

The Administered Autonomous Tradition

There is, finally, another organizational tradition, which contains elements of the first two, and which may represent a later evolutionary stage for some groups that started out either in an "individualistic autonomous" or "heteronomous" tradition. This third tradition places value on accountability and the qualities that tight administrative structure can bring—economy, efficiency, productivity, quality control, prompt response—but it places equal value on the group's autonomy (but *not* the individual physician's autonomy). "Administered autonomous" practice organizations follow a tradition that lies between the other two. This middle area of the organizational tradition continuum, however, does not usually represent a transitional state. Large medical groups that follow the administered autonomous tradition tend to remain tied to it.

Such groups may and often do enter into important affiliations with other organizations, some of which might even wield substantial influence over the group's own policies. Yet, these affiliated organizations do not own or control the group practice: it is not a heteronomous organization; its goals are of its own making, and it may move in whatever direction it wishes to accomplish them. Similarly, the administered autonomous group may make a special effort to involve every individual member of the physician staff in decisions about the

style and content of the medical work and about how and by whom it will be managed. Even though such decisions are arrived at democratically, however, once made they become group policy. The physicians remain under the eye of the appointed administrators, clinical and nonclinical, who are responsible for implementing the policy; individual members are not free to go their own way as they would be in an individualistic autonomous group practice.

In fact, administered autonomous groups more closely resemble heteronomous groups in their regard for clinical supervision. Although the administered autonomous tradition recognizes that the prerogatives of organizational decision making—especially clinically related decision making—should always be reserved to the physician collegium, it also follows Orwell's dictum, acknowledging that in this sphere some physicians "are more equal than others." The structural consequence of this principle is that the physician staff accepts the legitimacy of a clinical hierarchy of physician officers and committees. The tradition holds that the group's welfare is more important than the individual physician's preference, and that such hierarchy is needed to achieve the professional and economic goals of the organization. Applied in the clinical arena, this principle also gives some notion of legitimacy to monitoring—if not explicit supervision—of the work of each individual practitioner.

Some administered autonomous groups may have started out in that tradition, but most probably evolved from more individualistic autonomous or, less frequently, heteronomous origins. Occasionally a large group practice may move in the opposite direction, *away* from an administered autonomous position. When such movement is toward heteronomy, it will likely accompany a major organizational expansion, perhaps capitalized through a "joint venture" with another organization, leading to a reorganization of the medical group itself and, often, a more proactive market-response strategy. When such a shift towards heteronomy occurs, however, the strength of the group's administered autonomous tradition will tend to thwart any new and unwelcome controls imposed by the other organization. Movement of a large group in the opposite direction—away from a tradition of administered autonomy and toward individualistic autonomy—almost never occurs.

Table 3 records some of the characteristics that are typical of large groups from each of the three organizational traditions.

TABLE 3
Characteristics Typical of Large Group Practices from Three Organizational Traditions

	Heteronomous	Administered autonomous	Individualistic autonomous
Founding initiative	Constituency or interest group other than the original group physicians	Either the original group physicians or extra-staff interests	Original group physicians (owner-operators)
Administrative goals	*Extrinsic goals:* keeping services responsive to the constituency	*Instrumental goals of medical care:* quality, efficiency, productivity	*Individual convenience goals:* serving clinical practice, hassle minimization, income maximization
Administrative style	*Centralized directive:* executive command	*Centralized coordinative:* negotiation	*Decentralized facilitative:* consensus
Locus of accountability	External to the professional staff	Executive committee or other idiosyncratic structure of the professional staff	Group physicians (owner-operators)
Clinical policy and leadership	Centralized clinical policy formation and execution; leadership is designated, hierarchical, elaborated	Decentralized clinical policy formation with some centralized execution; leadership is designated, political, often emergent	Notion of clinical policy is lacking or minimal; leadership is informal, constrained, rotating
Physician affiliation	Permanent, nonowner career and noncareer employees; high to moderate turnover expectation	Owner-operators and/or permanent career and noncareer employees; moderate to low turnover expectation	Permanent and aspiring owner-operators; low to very low turnover expectation
Mode of physician remuneration	Fixed salary; ascriptive criteria; much executive discretion	Partly productivity based; mixed criteria; slight executive discretion	Mostly or entirely productivity or "incentive" based; achievement criteria; no executive discretion

Combining the Dimensions

The two dimensions of "market-response strategy" and "organizational tradition" underlie important differences among large medical group-practice organizations in the degree of autonomy that employed physicians are able to exercise over the content and conditions of their work. In addition, these dimensions may help explain varying sources and degrees of physician satisfaction and dissatisfaction with employment in large group practices, differences in group selectivity in physician recruitment, and the extent or character of staff turnover.

Although the two dimensions are defined independently of each other, there is a certain congruence between a group's orientation toward its market environment and its organizational tradition. We believe that attention to this association between the two dimensions can more sharply differentiate between large organizations of various types, help explain why there are more of some types than others, and better understand how some organizations change from one type to another.

A proactive market orientation tends to be characteristic of the heteronomous tradition, where a medical group was founded specifically to care for a defined population or benefit a particular constituency. One finds a structure of accountability, leadership, and rewards, as well as a service configuration and staffing pattern that are designed to support that goal. Physicians working in such settings have a clear understanding that their job is to serve the organization's constituency and are reminded of this by the formal group structure and by informal messages.

On the other hand, groups operating within the individualistic autonomous tradition have generally followed a reactive market-response strategy. Such a group's administrative leadership views its mission as serving the needs of the physician members. The organization's collective understanding of its clientele is that they are the aggregate of the individual practitioners' patients rather than a known population that the group cares for. Indeed, few individualistic autonomous groups have had the unanimity of purpose to move very far in the proactive direction along the market-response continuum, even if they wanted to.

Finally, organizations "in the middle" on one of these dimensions tend to share certain commonalties with those in a similar position

Market-Response Strategy

Organizational Tradition	proactive	transitional	reactive
heteronomous	**MANY**	**SOME**	**VERY FEW**
administered autonomous	**SOME**	**MANY**	**SOME**
individualistic autonomous	**VERY FEW**	**SOME**	**MANY**

FIG. 3. A typology of large group-practice organizations (with expected distributions)

on the other dimension. Most large groups that evolved within the tradition of administered autonomy have by now entered the transitional area of the market-response continuum and are mounting partially proactive strategies. This is especially likely if they are located in communities where prepayment plans sponsored by insurance companies and large employers favoring "managed care" plans are presenting competitive challenges or opportunities for joint action.

Figure 3 represents both of these dimensions as a matrix with nine possible cells. (While the two dimensions would be more accurately represented as continua, for simplicity each is displayed here as having three discrete values.) A hypothetical distribution of group-practice organizations along the two dimensions is also represented in the matrix. We expect that most large medical group practices are located in the cells that lie along the diagonal of this diagram, reflecting the tendency toward symmetry between the tradition-based structure of a medical group-practice organization and the market strategy it adopts. For example, in the upper left-hand cell one would find the older, established prepaid group practices and most of the newer staff model and some group model HMOs. The lower right-hand cell is populated

with numerous multispecialty fee-for-service group practices that have little or no involvement with prepayment contracts or PPOs. Finally, in the center cell of the diagram, one would expect to find larger and older group practices with relatively structured administrative systems which participate significantly in one or more prepayment plans or other managed-care arrangements covering a substantial but not overwhelming proportion of their clientele.

Challenges and Contradictions

It is important to note that the correlation between these two dimensions is imperfect. All cases do not lie along the diagonal. Although there are fewer cases in the off-diagonal cells, they are interesting ones because they usually represent challenging situations where an organization's capacities are strained by shifts in environmental demands. We can say about these off-diagonal cases, first of all, that different regions of the grid portrayed in figure 3 represent different kinds of organizational challenges. Cases below and to the left of the diagonal are those where there is insufficient administrative structure for an effective, unified response to a shifting market environment—the degree of organization is insufficient for the corresponding market response. On the other hand, cases above and to the right of the diagonal are those in which a traditional heirarchical pattern of administration, that may seek direction from organizational centers beyond the medical staff, might slow the initiative needed in a dynamic environment to seek new sources of clients, respond to market fluctuations, or make other innovative organizational changes. Additionally, the "off-diagonal" positions in figure 3 are those in which an organization's current market response strategy is inconsistent with its organizational tradition. Such organizations face the challenge of either changing their structure or altering their current approach to the market environment in a way that better reflects their structure; if they fail to adapt, they are likely to fall into decline and perish. This suggests that most occupants of the off-diagonal positions on the grid are probably there only temporarily.

There is one important exception to the above observations. Some traditionally administered autonomous groups have a combination of reputation and medical staff configuration that has enabled them to

avoid the transitional area of market response almost entirely. The primary example, currently and historically, is the Mayo Clinic, which operates in the administered autonomous tradition while essentially avoiding powerful "clients' agents" and "committed capacity" (though not without aggressive marketing, as illustrated by recent expansions into Florida and Arizona). Groups like the Mayo Clinic are representative of what Weinerman called the "inverted pyramid" or "Noah's Ark" approach to large group practice, since they have inverted the usual broad base of primary care medicine and have instead constructed a base made up of "one or two varieties of every known species of specialist under one roof" (Weinerman 1968). Obviously, so much emphasis on highly specialized diagnosis and treatment requires a very large and diverse clientele to support it, and the prospects for a group attracting such a clientelee in an age of "managed care" and physician oversupply are not favorable—unless the group is the Mayo Clinic. This may explain why all but a few of the most famous large multispecialty clinics have given up their earlier ambitions to operate purely (or primarily) as regional (or national) referral centers, and have added a primary care base and entered the transitional area of the market-response continuum.

Changing Type

The theoretical framework portrayed in figure 3 also helps explain how changes from one organizational form to another can occur or be prevented from occurring. For example, organizations in the individualistic autonomous tradition have difficulty making the transition to a more proactive market orientation since no one is empowered to speak on behalf of the physician collegium in order to sell its services in advance, *en bloc.* On the other hand, such organizations often cannot sustain their tradition in the face of exceptionally rapid growth and/or efforts to harness their market power proactively. Occasionally, as in the California example, they break up from the strain; sometimes they revert back toward a reactive market response while remaining at a fixed size, consistent with a pattern of comfortable, informal interaction; but often they are able to grow and make the transition successfully by evolving in the direction of administered autonomy.

It is not difficult to reconstruct a typical scenario of the transition from an individualistic autonomous group in a reactive response mode

toward a more formalized internal structure with the potential for a more proactive response. As such a group gets larger, traditional incentives remain to make even minor decisions through the democratic "town meeting" mechanism. The economic and professional incentives *not* to hold such conferences, however, increase with growth in staff size. If they are conducted during working hours, such events eat into each physician's productive time, while those conducted in the off-hours vitiate one of the major attractions of group practice—fixed hours and a predictably light call schedule. Finally, there is the not insignificant technical difficulty of achieving consensus in the absence of face-to-face interaction or in meeting rooms the size of an amphitheater.

Under such circumstances some limited decision-making power will be delegated to a smaller group of physicians thought to have the talent and temperament for such activities and who are trusted and respected by their colleagues. Over time, such roles are less likely to be filled by rotation among those willing to serve. Instead, formal positions are established with more authority placed in them and the incumbents are compensated for performing this work. Ultimately such roles become major, often full-time "boundary spanning" positions. Through such changes in its structure, the organization evolves a tradition of administered autonomy where some physicians "speak for" the group and are empowered to negotiate the disposition of some of its productive capacity with "clients' agents."

Often it is the environmental stimulus of "clients' agents" confronting the organization with competitive challenges or offers that persuades the physician-owners to empower certain of the group's physicians or administrators to make decisions rapidly. In such instances the market-response strategy changes first and forces the group, despite its individualistic autonomous tradition, to make a change in structure. Eventually, organizational tradition catches up with the forced changes, and the physician collegium comes to view the administrators' authority as legitimate and necessary. This is how groups move from the lower right-hand cell in figure 3 to the middle cell—via one or the other adjacent cells which represent temporary "way stations."

On the other hand, organizations operating in a heteronomous tradition and a proactive market-response mode often have difficulty adjusting when an underwriting sponsor pulls out, or when market competition for a previously "captive" population intensifies. If there is no tradition of effective administrative leadership contained within

the medical staff itself, the physician members may have difficulty focusing their attention on other potential market strategies or projecting the kind of clinical presence that alternative client groups will find attractive. Because this type of transition occurs less frequently, it is less well understood. The responses of some of the larger coalfield clinics (initiated in the 1950s by the United Mine Workers of America) (UMW) to the cessation in 1977 of the UMW health and retirement funds as a health care financing mechanism, however, provides several examples of unsuccessful as well as successful management of this type of transition (Konrad, Seipp and Boyd 1983). Attempts to introduce productivity incentives and PPO-type options into staff model HMOs (Meyer 1987) and the recent pattern of acquisitions and mergers of such organizations are likely to induce similar transition problems in groups that were established by external sponsors, especially those designed to exploit narrow but vulnerable market segments.

The growth and expansion of the large multispecialty group-practice sector has been fostered by decades of generous indemnity insurance, greater technological and capital requirements to start small independent medical group practices, declining opposition from organized medicine, and ample supplies of medical and surgical subspecialists. Given these factors, it has also been difficult for such groups to fail without exceptionally poor administrative leadership, or overwhelmingly adverse conditions. The emerging dominance of large corporate group practices as a way of organizing physicians and services does not guarantee the survival of any particular organization, however, and in a more competitive environment insulation from failure may be no longer the case. Here again, the typology we propose may be of some help in predicting where changes are most likely to occur. Organizations that fail to grow, that grow too rapidly, that break up under the pressure of competition, or that function poorly due to low staff morale and unexpectedly high turnover are likely to be those that prolong their occupancy of the "off-diagonal" cells, where there is a poor match between strategy and tradition and a failure to reconcile them.

The Physician/Organization Relationship in Transition

The era in which an organization was founded tends to shape its character beyond the length of its founders' careers. Cohorts of or-

ganizations initiated at about the same time can transmit the imprint of those historical eras in medical care into the stream of organizational culture. For example, prepaid group practice plans founded prior to the advent of federal HMO planning grants were generally designed with specific constituencies in mind, if not involved. In addition, the opposition of organized medicine, which for many years forced such organizations to operate outside the mainstream, helped develop among their physicians an internal cohesion and a kind of medical "counter-culture" that is probably not characteristic of the group-practice-based HMOs founded since the mid-1970s. Similarly, the physicians in most private multispecialty group practices that were founded prior to and just after World War II probably have substantial consensus about their organizational goals and the structures that best match them. For both types of older groups, combinations of collective understanding based on a strong organizational tradition, managerial folklore, and concrete knowledge from experience may be proving to be sufficient and effective guides to action in a rapidly changing environment.

In contrast, the newer—and usually initially larger—medical group-practice organizations face a different situation. Developed largely in this decade, such groups have not had enough time to develop strong organizational traditions. Although they probably experienced less ideological conflict than those established earlier, they were subject to more market competition. The physicians in such young organizations, who are mostly young themselves, often have no contact with or leadership from an older generation of organization-employed physicians on which to pattern their future course. They may also lack the feelings of solidarity and the other intangible rewards that many older physicians gained initially from belonging to a small, close-knit organization, defending it from opponents, and participating in its slow but sustained growth. Further, within both older and newer organizations there are different generations of physicians. Newcomers who join the group after it becomes a "going concern" may have different motivations than the founders—especially if the choice of employment came down to what job was available. Whether they are more or less willing to surrender their autonomy to the imperatives of management is an empirical question.

The shift from the small-scale individualistic to the large-scale bureaucratic organization of medical practice is a rapid and irreversible

historic transition. It surely qualifies as a revolution. What is at the other end is not readily apparent, but many observers believe that a real loss of traditional physician autonomy is occurring and that medicine as a profession is moving toward the same corporate context in which other professions, such as law and accounting, now operate (Smigel 1964; Montagna 1973; Lengerman 1974). Because there are so many different varieties of organizational employment for physicians, with different degrees of emphasis on stratification within the profession and on accountability to extra-professional authority, the extent to which this transition actually represents an instance of "proletarianization" is unclear (McKinlay and Arches 1985; Freidson 1985). There can be no doubt, however, that physicians involved in large-scale multispecialty group practices have become both the targets and the agents of corporate activity heretofore unfamiliar to medicine, but characteristic of other economic sectors—mergers, acquisition, and integrated product development (Patricelli 1986). Further, as national HMO chains seek to amalgamate groups of various sizes and structures, representing different epochs and traditions, into unified systems of health care with national (rather than local) marketing strategies, the phenomenon of the "clash of corporate cultures" documented in the discussions of mergers and acquisitions in industry and finance may become endemic in medical practice settings as well.

Also changing is the underlying structure of incentives and controls in medical practice. In 1946, Oswald Hall observed a basic shift in the source of control among some solo practitioners who were becoming less "individualistic" in their practices, who were relying less on their patients' loyalty and more on an "inner fraternity" of colleagues within which referrals of patients were made through an informal network (Hall 1946; 1948). This shift accompanied the emerging majority of specialists in urban communities at the end of World War II. The contrast between *client* and *colleague* control was further conceptualized by Freidson (1963), who also observed a weak form of "colleague" control in a large group practice, a control based not on formal administrative authority within the group, but rather on the collective observance of the same professional norms by its physician staff (Freidson and Rhea 1963; Freidson 1975). This type of normative "colleague" control, we believe, can still be found in the majority of large medical groups—those in the lower right half of the typological continuum

as drawn in figure 3. As the medical practice revolution continues to unfold and practice organizations grow larger and more complex, however, and as powerful "clients' agents" dominate the market, reenforcing the spirit of competition with advertising and imposing or forcing the adoption of preformance standards that are formally set and monitored, another basic shift may be on the horizon—a shift away from "colleague" control toward a new form of *corporate* control.

All of this is transforming the physician/organization relationship into something vastly different than the personal, informal arrangements that prevailed before the revolution began. The response of employed physicians to the shift toward corporate control is particularly interesting. While some employed physicians seek to engage in collective bargaining with their employers using the agency of professional associations as well as more traditional labor unions (Orris 1982; Marcus 1984), others are more interested in formally institutionalizing their emerging rank distinctions by securing recognition for medical administration as a new specialty (Hodge and Nash 1987). The inevitable effect of these movements, taken to their logical conclusions, is the introduction of vertical cleavages into a profession already broken into horizontal segments defined by medical specialization.

What all of these developments suggest is that the end of the practice revolution is nowhere in sight, and that large group-practice organizations and, especially, the physician/organization relationship will undergo more change. As the accountability of group-practice organizations—both to their own standards of professional quality and to the increasingly explicit expectations of "clients' agents"—continues to increase, the individual autonomy of organization-employed physicians is decreasing. How to advance this necessary accountability and at the same time provide the rewards characteristic of more informal settings (satisfactory levels of professional authority and client responsiveness) will be the key challenge facing large group-practice organizations, especially the ones emerging as dominant between now and the end of this century. These organizations, together with their employed physicians, are likely to be either the building blocks of a number of private health care systems—both regional and national—or provide the experiences necessary for the construction of a public one. And not only will their imprint be stamped on our future health care arrangements, it will be transmitted into the professional culture

of the latest and by far the largest generation of American physicians—a generation that, because of its size and age, is at once a cause of the medical practice revolution and its most important product.

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