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**Betson, Carol Lane**

**MANAGING THE MEDICAL ENTERPRISE: A STUDY OF PHYSICIAN  
MANAGERS**

*University of Colorado at Denver Graduate School of Public Affairs D.P.A. 1984*

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**MANAGING THE MEDICAL ENTERPRISE:  
A STUDY OF PHYSICIAN MANAGERS**

by

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A thesis submitted to the  
Faculty of the Graduate School of Public Affairs of the  
University of Colorado in partial fulfillment  
of the requirements for the degree of  
Doctor of Public Administration,  
Graduate School of Public Affairs  
1984

This thesis for the Doctor of Public Administration

degree by

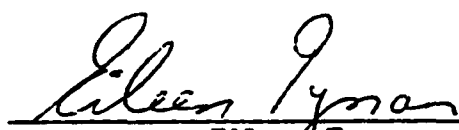
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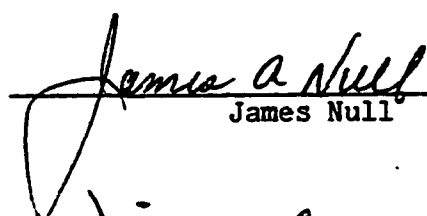
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Managing the Medical Enterprise: A Study of  
Physician Managers

Thesis directed by Assistant Professor Eileen Tynan.

The work that managers do has long been of interest to students of both the public and private sector. This study describes the jobs of physician managers in hospitals, medical group practices, and prepaid health plans. A task inventory consisting of 86 items was developed to analyze these jobs. Organizational and personal characteristics are identified which influence the jobs (or responsibilities) that physicians managers have.

The empirical portion of this study is based on a self-administered survey mailed to the 893 members of the American Academy of Medical Directors (AAMD). The task inventory was developed in accordance with the form and language of job analysis techniques. The tasks are grouped according to management functions developed in a previous study: policy management, program management, and resource management. The survey also contains questions about organization affiliations, work arrangements, experience, and education. There was a response rate of 56 percent.

Key findings indicate that physician managers are primarily responsible for policy management tasks. The majority of these tasks involve issues specific to physician relations. In addition, the tasks for which most physician managers are responsible deal with coordinating, managing conflict, and organization decision making. All of these processes are known to be associated with improvements in the effectiveness and efficiency of health care organizations.

Another important finding is that organizational characteristics are associated with task responsibility more often than the personal characteristics of physician managers. For example, a line as opposed to a staff position is significantly associated with responsibility for certain tasks more often than experience or education. However, of the personal characteristics, experience is associated with physician manager responsibility more often than education.

One conclusion of this study is that physician managers are responsible for tasks that contribute to efficiency and effectiveness in health care organizations. It is likely that increasing numbers of physician will become part of management teams in these organizations. Therefore, it seems reasonable to

expect that health care institutions will strive to structure jobs that use the skills of physician managers to further the goals of the organization.

The form and content of this abstract are approved.

I recommend its publication.

Signed *Eileen Lyman*  
Faculty Member in Charge of Thesis

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The subject of the study is the job of physician managers, and it would not have been possible without the support of Roger Schenke, the executive director of the American Academy of Medical Directors. I hope he will find this work a good return on his investment.



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me on track and convinced that this was a viable project.

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## CHAPTER I

### INTRODUCTION

#### Purpose of the Study

A disturbing paradox exists in the health care delivery system. On the one hand, the practice of medicine with its technological advances is often described as being the best available in the world. On the other hand, it is riddled with controversy regarding escalating costs, inappropriate care, and poor management. Obviously, there is a distinction between the individual practice of medicine and the general delivery of medical care.

One approach to this dilemma is an effort to improve the management of health care organizations by increasing physician involvement. Physicians, skilled in the technologies of medicine, who in addition develop management skills, are in the unique position to integrate the two and help to improve the health care system. A physician manager has been defined as:

any physician with full or part time managerial roles, i.e., medical directors, department chairs, chiefs of service, presidents of medical staffs, clinical directors, directors of medical affairs, etc. (Schenke, 1980, p. xiii)

Although there is general agreement on a theoretical level about the potential benefits of physicians in management, this group of professionals has undergone little systematic study.<sup>1</sup> This is unfortunate, as knowledge about physician managers could aid greatly in the formulation of a thoughtful approach toward the role of physicians as managers in the health care system. It is to this end that this study was undertaken.

In short, the purpose of this study is to describe the job of physicians who are in management positions, and where possible, identify organizational and personal characteristics that might influence the performance of their jobs. The study also provides a vehicle for looking at the skills physician managers need if they are to be more effective. Finally, the study highlights the need for additional research on physician managers, their jobs and their potential for a meaningful management role in the health care system.

The study is undertaken with the recognition that a complex set of issues underlies any study of physician managers. One of them is the nature of the health care delivery system. This section, therefore, provides an overview of the environment in which physician managers operate. Chapter II discusses some of

the more specific issues relating to physician managers.

### The Health Care Delivery System

The health care delivery system in the United States is both large and complex. The numerous problems of the system, such as escalating costs, are well publicized. To better understand the problems involved, a brief historical review of the American health care system is presented. Then, the current system is described. Finally, two urgent problems that face health professionals, policy makers, and the public, (1) escalating costs, and (2) quality of care, will be discussed.

### Historical Developments

While there are varied approaches to examining the historical evolution of the American health care system, Torrens (1980) presents a clear, concise framework. He divides this evolution into four periods: (1) institutionalization of health care, (2) introduction of the scientific method into medicine, (3) a growing interest in the social and organized structure of health care, and (4) the current period of limited resources, restriction of growth, and reorganization of methods of financing and delivering care.



Torrens suggests that the first period, institutionalization of health care, began around the middle of the 19th century and was symbolized by the establishment of large hospitals such as Bellevue Hospital in New York City and Massachusetts General Hospital in Boston. These hospitals provided "visible institutions around which health care services could be organized." (Torrens, 1980, p. 4).

Before the establishment of these institutions, almshouses (poorhouses) existed to provide food and shelter for the homeless poor. They incidentally housed the chronically and mentally ill as well as others too old or disabled to care for themselves (Dowling, 1980). Pesthouses were also common at this time and served as isolation or quarantine facilities for people contaminated with diseases such as smallpox or typhus. Medical care was strictly a secondary function of these institutions, with the protection of the community as the primary goal. Most commonly, anyone able remained home and was cared for by family or friends (Garrison, 1929).

Community and voluntary hospitals began to be established during the late 1700s and early 1800s (Dowling, 1980). These facilities were built because physicians and surgeons needed a place to practice their craft, and medical students needed a place for

their preceptorships. These hospitals accepted both charity and paying patients as long as they did not have a contagious disease. Despite the improved accommodations, most people who became ill continued to remain at home. It was not until the late 1800's or early 1900's that hospitals began to be accepted as a place to receive medical care, and this was a result of scientific advances.

Torrens suggests that the second important period in the historic development of the health care system was marked by the introduction of the scientific method into medicine. Prior to this time, medicine was viewed as ". . . a rather informal collection of unproved generalities and good intentions." (Torrens, 1980, p. 4). Although Torrens dates this period as occurring around the turn of the century, it probably began in 1860 with the critical discovery that a bacillus caused a disease called anthrax (Garrison, 1929).

Subsequently, the notion that diseases were caused by specific organisms became firmly established. Major discoveries by Pasteur, Koch, and others followed, resulting in cures for diseases that had previously plagued mankind. These discoveries, together with dramatic surgical successes made possible by the developments of anesthesia and asepsis,

lead to a qualitative break with the past and the beginning of the scientific era of medicine (Freidson 1970; Starr, 1982).

During this period the Johns Hopkins medical school, which opened in 1893, became an important influence in defining medicine and medical care. This school is credited with making the most radical change from the old ways to the new scientific orientation (Torrens, 1984). John Hopkins was the first school to establish a four year program of medical study with the unprecedented requirement that all students have college degrees. In addition, this institution believed medical education should be rooted in the basic sciences and in hospital medicine. Therefore, scientific research and clinical instruction were hand in hand, and a hospital was built in connection with the school. This approach to medicine soon dominated medical education in the United States and abroad. Graduates of Hopkins became esteemed practitioners, professors at other schools, and scientists, and played a major role in shaping the character of medicine in the 20th century (Starr, 1982).

The third historical phase in the development of the health care delivery system is characterized by Torrens as a period of growing interest in the social and organizational structure of health care.

Beginning with World War II and continuing to the early 1980s, major scientific and clinical advances continued to occur. However, at the same time, there was a prevailing concern about financing health care and the government's role in the delivery of health care. These concerns resulted in the proliferation of health insurance plans, including government programs such as Medicare and Medicaid.

It is important to emphasize that the tremendous growth of third party payors, e.g., private or government sponsored health insurance plans, that occurred during this third phase, inexorably altered the way in which medical care was delivered. For example, individuals covered by health insurance no longer had to be concerned about the cost of care. This resulted in an increased demand for medical services. In addition, third party payors provided funds that made the tremendous expansion of health care facilities possible.

The current period is said to have begun in the early 1980s. It is described by Torrens as: ". . . an era of limited resources, restriction of growth, and reorganization of the methods of financing and delivering care" (Torrens, 1980, p. 4). These issues translate into several major problems now facing the health care delivery system, including cost

and quality. These will be discussed further in a later section of this chapter.

### The current system

In order to describe America's health care delivery system, the major components of the system need to be identified. These are: (1) the people for whom the system provides care, (2) the providers of care, (3) the institutions and organizations within which they work, (4) the financing mechanisms, and (5) the government under which the system functions.

People. In 1981 the United States had a population of 226,504,825. Numerous ethnic and national groups are represented, and there is a wide range of social classes and incomes. The infant mortality rate in 1981, often used as a general measure of the health of a population, was 43 per 1000 live births<sup>2</sup> (Statistical Abstract of the U.S., 1982-1983). In 1982, the major cause of death in the United States was heart disease, accounting for about one-third of all deaths in that year. Life expectancy in 1982, at 74.5 years, was at its highest point ever. Women (78.2 years) continued to live longer than men (70.8 years) (Department of Health and Human Services 1984).

Providers. The health care delivery system, as discussed later in this chapter, is one of the country's major employers. The largest categories consist of nurses, clerical staff, hospital manual workers, physicians, dentists, pharmacists, and technicians. Physicians are the dominant group and are generally acknowledged as having the most power and control over the system (Berger, 1983).

Institutions and Organizations. The principal mode of physician organization is still private, solo practice, although the proportion of physicians practicing in groups and/or salaried by hospitals is increasing steadily (Starr, 1982). Ambulatory care is the most frequently used type of care. Typically, it is provided in doctors' offices, ambulatory care centers, or neighborhood health centers (Jonas, 1977).

There are two major types of institutions that provide beds for inpatients. These are hospitals and nursing homes. Hospitals are the most numerous. In 1980, there were 7,051 hospitals in the United States with more than 1,365,000 beds (Statistical Abstract of the United States, 1982-1983). Hospitals are usually categorized either by ownership, size, function, or average length of stay. The principal types of ownership and the number of hospitals represented in

each category in 1980 are as follows: government (federal, state, or local) 2,562, private, not-for-profit (voluntary or community) 3,547, and private, for-profit (proprietary) 942 (U.S. Bureau of Census, 1982-1983).

According to the American Hospital Association, hospital size is classified according to the number of beds, as follows: 6-24 beds; 25-49 beds; 50-99 beds; 100-199 beds; 200-299 beds; 300-399 beds; 400-499 beds; and over 500 beds (American Hospital Association, 1983). Hospital function is generally categorized as: general, tuberculosis, psychiatric, and other special. There are only two length of stay categories: long (average length of stay 30 days or more), or short (average length of stay less than 30 days) (U.S. Bureau of Census, 1982-1983).

Financing. Between 1970 and 1981, the percentage of the Gross National Product (GNP) devoted to health and medical care increased from 7.6 percent to 9.8 percent (Statistical Abstract of the United States, 1982-1983). In 1982, it rose to over 10 percent, translating to a total of \$322 billion, or \$1,354 per person (Department of Health and Human Services, 1984). These amounts included monies spent for hospital care, physician and dentist services,

pharmaceuticals, research, hospital construction and administrative costs.

Table 1.1 illustrates the distribution of these expenditures by type of care. The largest single category of expenditure is for hospital care (42%), followed by physician services (19.2%). The remaining expenditures are distributed among dental services (6.0%), drugs (6.9%), nursing home care (8.5%), other personal health care (6.3%) and other health spending (11.1%).

Government. The United States government does not operate the health care delivery system. Actually, the government is less involved in health care than the governments of most other countries (Jonas, 1977). However, the role government does play is enormous and expanding rapidly. For example, the government collects and disseminates information; trains personnel; operates institutions; provides services, finances services; supports and carries out research; plans; evaluates; and regulates.

#### Problems Facing the Health Care System

Almost all Americans are aware of at least some of the problems that plague the health care delivery system today. Unfortunately, neither the problems nor concern about them is new; they have just



TABLE 1.1

NATIONAL HEALTH EXPENDITURES BY TYPE OF CARE  
UNITED STATES, FISCAL YEAR 1982

TYPE OF CARE	PERCENTAGE
Hospital care	42.0
Physician services	19.2
Dentist services	6.0
Drugs and drug sundries	6.9
Nursing home care	8.5
Other personal health care	6.3
Other health spending	11.1
Total	100.0

Source: R. M. Gibson, D.R. Waldo, and K.R. Levit. "National Health Expenditures." Health Care Financing Review. 4, no. 5, 1983.

gradually increased in magnitude. To illustrate, the following is a summary of a study on health care delivery service released in 1932:

The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency and social waste. Furthermore, these conditions are, as the following pages will show, largely unnecessary. The United States has the economic resources, the organizing ability, and the technical expertise to solve this problem. (Committee on the Costs of Medical Care, 1932, p.2)

This statement was made by a committee appointed in 1928 by President Hoover to investigate the problems of health care delivery. It is disturbingly relevant today.

In actuality, the problems of the health care system are so interrelated that an attempt to deal with one without regard for the others would be futile. However, for the purposes of this discussion, a review of two of the major problems facing the health care system, cost and quality, will be presented. These are selected because they are relevant to issues of physician managers. Subsequently, the issue of regulation is described. Regulation is recognized to be a response to cost, quality and other problems;

however, it is also a problem in itself and is discussed here because of the influence it has had on physicians in management.

### Costs

Constantly rising expenditures have characterized the health care system since 1929, when data were first collected (McCarthy, 1977). The most commonly cited reasons for these rising costs are as follows.

Structure of health care financing. The cost-based third-party payment system of health care financing is a primary cause of high health care cost (Summers, 1981). The involvement of third party payors (government and private insurance), means little or no out-of-pocket costs to consumers. This system insulates consumers and to some extent providers from the true cost of treatment decisions.

Further, reimbursement by third-party payors has up until now been on a fee-for-service basis. This means the more service provided, the more money collected. Medicare and Medicaid followed this model, making large amounts of money available for services. These programs were originally designed to address another problem of the health care system, that of access. It was intended that through this program the elderly and poor would be able to receive needed care.

As a result of the payment system, there has been a sharp increase in requests for service, skyrocketing costs, and little or no incentive to weigh costs against benefits (Fuchs, 1974; Summers, 1981; Starr, 1982).

High provider fees. The problem of high provider fees is related to the structure of health care financing. Medicare/Medicaid and other insurance plans typically pay physicians according to their "customary" or "reasonable" fees. This has built-in bias toward high cost. In addition, reimbursement systems have paid most for hospital-based care, further encouraging physicians to provide care in a more costly environment (Starr, 1982).

Physician control. Physicians make the decisions that determine the type and amount of services provided. For example, physicians determine whether a patient needs to be admitted to a hospital, the length of stay once admitted, etc. However, research has shown that many physicians have not been aware of costs such as diagnostic procedures, laboratory tests, or the cost of a hospital room (Moore, 1983; Berger, 1983; Weisbord and Stoelwilder, 1979).

Physician training. Physicians are trained to practice medicine at the highest level of their

technical ability without regard to costs (Friedson, 1970). In addition, there are no limits placed on the number or variety of medical specialists trained in this country. Specialists do more complicated procedures, use the hospital more often, and charge higher fees.

Advances in medical technology. New procedures, equipment, and techniques flourished after World War II and continue to do so today. It has been said that the health care industry has been "captured" by technological developments<sup>3</sup> (Torrens, 1980, p.8). Although these technical advances have been credited with making a substantial improvement in the quality of medical care, they usually involve complex and costly equipment, procedures, and/or facilities. Recent examples of these developments include computerized axialtomography (CAT) scanners, lasers, ultrasonography, coronary artery bypass surgery, microsurgery, artificial organs, intensive care units, neonatal units, advanced pharmacies, etc.

Higher demands and expectations. The increase in demand for services is associated with at least three factors: (1) belief that health care is now a "right", (2) the growth of health care insurance plans including Medicaid/Medicare, and (3) advances in

technology (Fuchs, 1974; Summers, 1981; Starr, 1982). The increase in expectations means simply that consumers want the best medical services available. When confronted with situations involving personal or family illnesses, people want to disregard cost and get all the care they need and/or desire (Mechanic, 1978).

Labor intensity of the health industry.

There has been a dramatic growth in the number and type of personnel employed in the health care industry. It is now one of the largest employers in the country and, in 1980, employed over 7 million persons (United States Department of Health and Human Services, PHS., 1981).

Recently new categories of health care personnel have appeared. These include physicians' assistants, nurse practitioners, dental hygienists, specialized laboratory and radiology technicians, home health aids, nutritionists, etc. These personnel, some of whom received many years of professional training, demand salaries commensurate with their level of skill.

Increased litigation. As the number of malpractice suits brought against physicians has increased, so have malpractice insurance premiums. These higher rates add to the overall cost of medical

care in at least two ways. First, physicians pass most of these costs on to patients; and second, in trying to avoid any possible suits physicians practice "defensive" medicine. This means that in order to document their diagnosis or a specific treatment, physicians order more tests or perform more procedures than they would otherwise. This documentation has proved to be a powerful weapon in defending against malpractice suits (Eisenberg, 1978; Summers, 1981).

It has been said that the "crisis" in America's health care system is a crisis of money (Starr, 1982, p. 381). In other words, if costs (limited resources) were not an issue there would be no crisis. While the problems facing today's health care system involve more than just costs, it is clear that the nation probably cannot afford to pay for the quantity and quality of care desired. This brief and undoubtedly incomplete list of factors which contribute to health care costs is intended to provide some insight into the magnitude of the problem.

### Quality

Concurrent with concern over escalating health care costs are concerns about the quality of health care. Although there is no universally accepted definition of "quality", it can be thought of simply as

"the degree of excellence or confirmation to standards" (LoGerfo and Brook, 1980, p.403). Concern about quality of care is not new. As early as 1918 the American College of Surgeons stated that:

. . . the medical staff [should] review and analyze at regular intervals their clinical experience in the various departments of the hospital such as medicine, surgery, obstetrics, and other specialties. The medical records of patients, free and pay, to be the basis for such review and analysis.  
(American College of Surgeons, 1918, p.1)

Assessments of the quality of care are undertaken for a variety of reasons. For example, there may be a substantive concern about existing problems in quality of care, or an assessment may be made to satisfy the requirements of a regulatory agency. The focus of quality studies is generally specific providers, e.g., physicians; specific conditions, e.g., review of patients with acute myocardial infarctions; or care received by selected groups of patients, e.g., on a particular unit of a hospital (LoGerfo and Brook, 1980).

The type of quality review originally suggested by the American College of Surgeons became institutionalized as the Morbidity and Mortality Conference (M & M's). This has occurred at most hospitals with training programs for over 50 years and continues today. In addition, the medical staff in most



hospitals have made efforts to ensure quality through activities such as, credentialling, medical record review, tissue review, utilization review, etc.

(Vanagunas, Egelston, Hopkins and Walczak, 1981).

More recently a legal impetus for quality assurance and quality assurance programs has come from Title XIX of the Amended Social Security Act (Medicaid), which linked reimbursement to specific standards of care. As a result, formal quality assurance programs have become part of several accrediting organizations, including the Joint Commission on Accreditation of Hospitals (JCAH). In 1976, JCAH added a quality of professional service section, part of which states:

There shall be evidence of a well-defined, organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the correction of identified problems. (JCAH, 1981. pp. 151-54)

To ensure meeting accreditation requirements, hospitals have been required to have formalized assurance programs. These programs involve, among other activities, conducting medical audits. These in turn are to be conducted in accordance with an audit methodology developed by JCAH for this purpose. Other quality assurance activities often involve the traditional M&M conferences, credentialling, medical records,

tissue review, and utilization review, but in addition are being directed at infection control, antibiotic usage, drug utilization, etc. (Vanugdunas, et. al., 1981).

Quality assurance activities have been studied and criticized as having "little documented impact in terms of improving patient health or reducing care costs" (Williamson, 1978, p.631). Williamson (1978) attributes this to the lack of an appropriate decision process for selecting priority areas where target outcomes will most likely be achieved. Nonetheless, there are no signs that the plethora of quality assurance programs and activities are decreasing, which may be due to demands of regulatory agencies. Nor does it appear that a more accurate selection process is being employed.

### Regulation

As previously mentioned, increased regulation in the health care industry has been in response to other problems. However, regulation in and of itself has become an issue that affects the job of physician managers. In the broadest sense, regulation encompasses:

. . . the entire panoply of laws, rules and ethical precepts, public and private, which govern the conduct of the health

industry and health professionals. (Levin, 1980, p. 1)

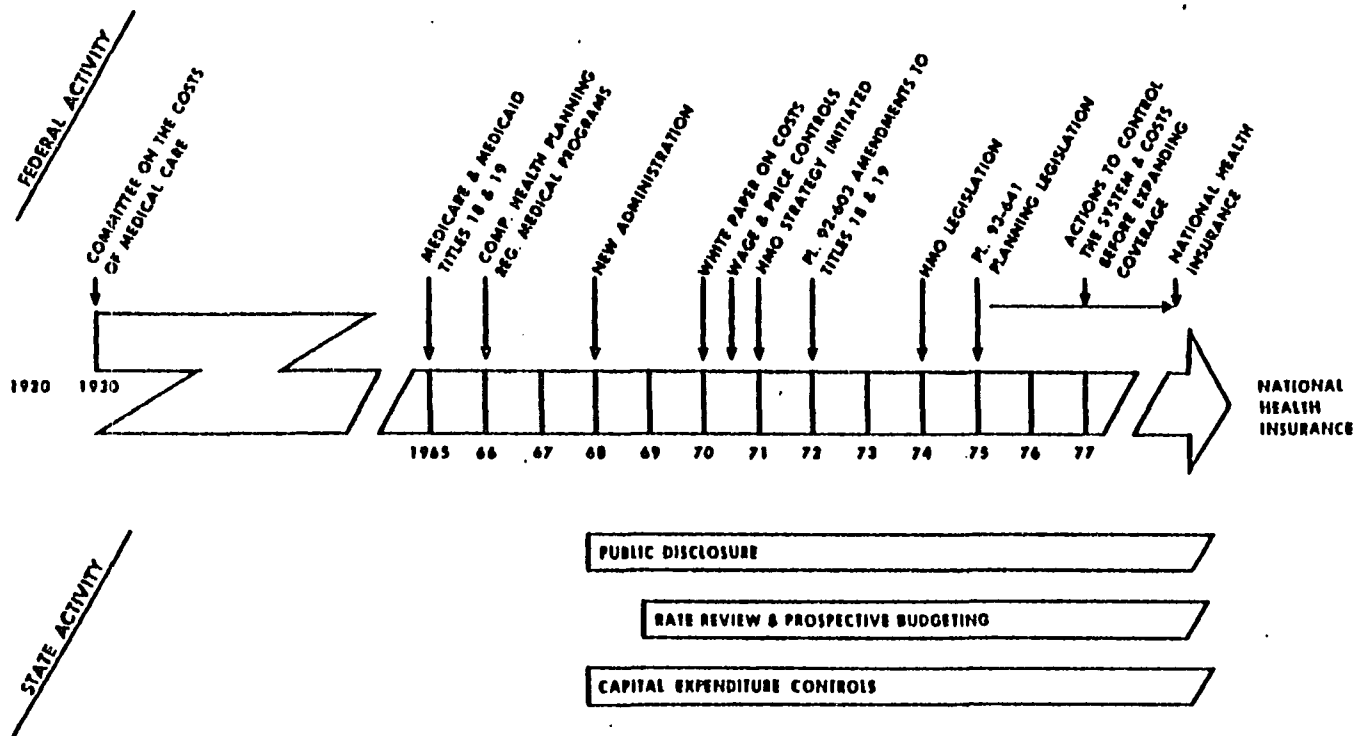
Virtually every aspect of the health care industry is subject to some type of regulation. The training and education of health professionals, the construction of health facilities, the introduction of new medical treatment, and the financing and operation of health care institutions. All this results in the health care industry being called "the most heavily regulated industry in the United States." (Levin, 1980, p.1).

Whatever the specific regulation, laws enacted in the area of health care have two things in common. First, they are intended to remedy or alleviate perceived social problems, e.g., the uneven quality of health care or containing escalating health care costs. Second, laws require detailed and often extensive administrative regulations in order to be implemented (Morgan, 1980).

Figure 1.1, prepared by Wolper and Hopkins (1977), illustrates the major health care regulations on both federal and state levels from 1930 to 1977. Although this table is several years old, it dramatically depicts the changes in regulatory activity since 1965. In addition, it shows that the majority of federal regulations have revolved around controlling

FIGURE 1.1

HEALTH CARE INDUSTRY REGULATION



Source: Lawrence F. Wolper, and Wallard G. Hopkins. "Prospering in a Regulated Environment." Hospital Progress 58, no. 9 (1977).

rising health care costs by either planning, stimulating growth of alternative delivery systems (HMOs), or utilization review. On a state level, attempts have been made at prospective budgeting and reimbursement systems and rate review since the late sixties.

Wolper and Hopkins categorize health care regulations into four areas:

1. Planning. States are required to have state health plans, and institutional providers are required to consider the service demands of the community.

2. Development and distribution of services. Some regulations are intended to control demand by limiting supply. Such regulations focus on new and expensive services.

3. Utilization controls. Cloaked in the language of quality care, utilization controls focus primarily on controlling "misuse" (overuse) of patient care services.

4. Financial controls. Aimed directly at controlling health care expenditures made by purchasers such as the federal government, financial control regulations lean towards being punitive as well as incentive oriented.

Bice (1984) categorizes the types of regulatory instruments in the health industry.

Figure 1.2 shows that these are either (1) subsidies, (2) entry controls, (3) rate or price settings, or (4) quality controls. Subsidies are considered the most traditional and widely used means of regulating the supply and demand for health services. Entry controls such as licensure and certification are used to ensure that persons offering goods or services are at least minimally qualified to do so. Rate or price setting is usually assumed by governments for a number of reasons, but most often in health services to protect the public from high costs of needed services. Quality controls include a wide variety of regulatory mechanisms aimed at reducing risks and generally apply to all designated suppliers.

Despite the enormous number of regulations within which the health care industry currently functions, additional efforts to control cost are likely to result in even more. For example, because of huge deficits in the Medicare program, regulations that base government reimbursement on a Diagnosis Related Group (DRG) are becoming a reality.

The DRG is a culmination of a number of efforts which have as their ultimate goal a precise description of various kinds of health care products (Studnicki, 1983). Using this concept, Congress has

**FIGURE 1.2**

**A TYPOLOGY OF REGULATORY INSTRUMENTS AND  
EXAMPLES FROM THE HEALTH SERVICES INDUSTRY**

		<i>Objects of Regulation</i>	
		Individuals	Institutions
Regulatory Instruments	Subsidies	<b>Supply</b> Training grants  <b>Demand</b> Medicare / Medicaid Tax exemptions	<b>Supply</b> Construction grants, loans, loan guarantees Tax exemptions  <b>Demand</b> Tax exemptions to employers
	Entry Restrictions	Personnel licensure	Facilities licensure Capital expenditures controls
	Rate Controls	Fee schedules under Medicaid & the Economic Stabilization Program	Rate setting commissions Medicare and Medicaid reimbursement limits
	Quality Controls	Professional Standards Review Organization	Certification for Medicare and Medicaid

Source: Thomas W. Bice. "Health Services Planning and Regulation." In Introduction to Health Services. 2nd ed. Eds. Stephen J. Williams and Paul R. Torrens. New York: John Wiley & Sons, 1984, p. 390.

approved a single fee system, with specific fees for 268 different groups of illnesses requiring hospital care. To date, this system includes only costs billed directly by the hospital to Medicare. The Department of Health and Human Services is studying how this system could be extended to cover bills from physicians for hospitalized Medicare patients. It is too early to document positive or negative results of reimbursement based on DRGs. However, concern over regulatory devices using DRGs seems focused on the potential "for providing financial incentives for distorting the legitimate practice of medical art and science" (Studnicki, 1983, p. 110).

### Summary

This chapter highlighted some of the complex issues facing the health care delivery system today. A brief historical review and a description of the current system were presented, because the importance of environment to organizations, and therefore managers, is well recognized. The issues of cost, quality, and regulation have been discussed, because clearly they have implications for health care managers. These will be described more fully in Chapter II.

The dissertation is organized in five



chapters. Chapter II presents the rationale for the study, and a review of the relevant literature on physician managers. Chapter III contains the methodology. Chapter IV presents the findings of the study, and Chapter V discusses the implications and a general summary.

## NOTES - CHAPTER I

1. The literature relevant to physicians' involvement in the management of health care organizations is reviewed in Chapter II.

2. Infant mortality and life expectancy are widely used indicators of general health status. Infant mortality, the rate of infant deaths per live births can be compared with that of other industrialized countries. For example, in 1978 the infant mortality in Sweden was 7.7 per thousand live births, compared with 43 per thousand live births in the United States in 1981. Further, in 1979 the life expectancy for men in Sweden was 72.5 and 78.7 for women (World Almanac, 1983).

3. This argument is similar to one made about public administration by Sayre (1948), when he observed that personnel specialists had become obsessed with techniques at the expense of purpose. Sayre urged fundamental examination of both ends and means in the system of personnel administration.

## CHAPTER II

### RATIONALE FOR STUDY OF PHYSICIAN MANAGERS

As mentioned previously, the primary purpose of this study is to describe the job of physician managers, and to identify personal or organizational characteristics that might influence the performance of this job. In order to better understand the work of physician managers, this chapter reviews some previous studies of managerial work. Next, aspects of the health care delivery system that may substantially affect managerial work are discussed. Finally, the relevant literature on physician managers is presented.

#### The Nature of Managerial Work

The work that managers do has long been of interest to students of both the private and public sector. Fayol (1949) and Gulich (1937) defined management activity in terms of a number of functions for which managers were responsible. Fayol, credited with developing the first comprehensive theory of management, identified 14 different principles of management. These include: division of work, authority,

discipline, unity of command, centralization, and scalar chain (line of authority). Gulick, (1937) also viewed management in terms of functions for which managers were responsible. He proposed seven major management functions: planning, organizing, staffing, directing, coordinating, reporting and budgeting. Known collectively as POSDORB, this approach to management has influenced management theory for forty years.

Barnard (1938) emphasized what managers should be doing for the organization to survive. He argued that the most important managerial functions should parallel the organization's needs. These include having a common goal toward which members of the organization could work, members who are willing to contribute, and members who have basic communication skills.

More recently, Mahoney, Jerdee, and Carroll (1965) obtained estimates from managers on the amount of time they spent on several management functions: planning, investigating, coordinating, evaluating, supervising, staffing, negotiating, and representing. Mintzberg (1973) distinguished eight major schools of thought on the managerial job. These are: classical, great man, entrepreneurship, decision theory, leader

effectiveness, leader power, leader behavior, and work activity. Mintzberg's own work belonged to the last category, which seeks to find out what managers actually do.

Mintzberg (1975) sought to determine how managers spend their time and how they perform their jobs. From his research and the research of others who have studied managers with the same focus, Mintzberg concluded that managers fill ten roles. He grouped these roles into three major categories. These are:

A. Interpersonal roles.

1. The figurehead role (performing ceremonial and social duties as the organization's representative).

2. The leader role.

3. The liaison role (particularly with outsiders).

B. Informational roles.

4. The recipient role (receiving information about the operation of an enterprise).

5. The disseminator role (passing information to subordinates).

6. The spokesperson role (transmitting information outside the organization).

C. Decision roles.

7. The entrepreneurial role.
8. The disturbance-handler role.
9. The resource allocation role.
10. The negotiator role.

Additionally, one of Mintzberg's major findings is that rather than being systematic, reflective planners, managers simply respond to the pressures of their jobs. He suggests that managerial work is characterized by "...brevity, variety and discontinuity." (Mintzberg, 1975, p. 50).

Mintzberg's work has been criticized on several counts, e.g., insufficient sample size, and failure to include non-managerial work performed by all managers (Koontz, O'Donnell, and Weihrich, 1982). However, McCall and Segrist (1980) tested Mintzberg's framework using a questionnaire based on the roles. They asked managers to rate the importance of the role to their own supervisory performance. They concluded that the construct validity of six of the roles was supported. In addition, they stated:

Managers' perceptions of relative role importance across levels and functions were sufficiently similar to support Mintzberg's contention that managerial jobs are essentially alike. (McCall and Segrist, 1980, p. 47)

That management is generic is a widely held assumption (Drucker, 1973; Sheldon, 1975; Caplow, 1976). According to this viewpoint, organizations

resemble each other to such a great extent that much of what is learned by managing one organization can be applied to managing any other organization. According to Sheldon (1975), despite minor differences of degree in organizations "there is not that much difference between a manager in the health field, whether he be a physician or not, and a manager in industry."

(Sheldon, 1975, p.1). Drucker (1973) discussing essential management functions, suggests that management faces the same problems everywhere:

. . . it has to organize work for productivity and achievement. It is responsible for the social impact of its enterprise. Above all, it is responsible for producing the results, -- whether economic performance, student training or patient care -- for the sake of which each institution exists. (Drucker, 1973, p. 17)

While it is not the intent of this study to argue whether or not management is generic, it is relevant to examine the research that addresses some characteristics of the health care delivery system which affect the work of health care managers.

#### Distinguishing Aspects of the Health Care System

The health care delivery system is considered by many to be different from other systems. Austin (1974) identifies five characteristics that he suggests make the health care industry "unique". He emphasizes that other industries may share one or more

of these characteristics but in no other field do all of these factors converge as they do in health care:

1. Delivery of individualized services. Whether in a large, complex setting or a small, intimate one, the health care industry delivers a service that must be individualized to a greater extent than those of any other service industry. Personal health or medical care cannot be mass produced, and even services delivered to groups must be tailored to the needs of the individuals.

2. Professionalism. The health care delivery is ". . . the most highly professionalized industry in our society" (Austin, 1974, p. 308). Members of numerous different professions work both as providers of service and as directors of institutions, agencies, and programs. However, all those involved in direct patient care are responsive and responsible to the physician.

3. Extreme complexity. Complexity has been a generally accepted fact about the health care system because the system's three major components (users, providers, and mechanisms for bringing users and providers together) interact in extremely complex ways. Factors contributing to this complexity include: the pluralistic nature of the mechanism involved; the interface of public service objectives; private



interests and obligations within the industry; the financing structure, which depends largely on third party sources; and the complicated internal and external relationships, which must be developed and maintained.

4. The wide range of delivery facilities.

Service delivery settings range from large academic health centers providing comprehensive care, to small, single service units. Between these two extremes, a wide variety of organizations exists that are frequently fragmented and uncoordinated. Such variety requires ". . . a diversity of administrative approaches unequalled in other specialty fields" (Austin, 1974, p. 310).

5. Financial reimbursement arrangements. The

variety of payment sources and the proportion of third party payors involvement upsets classical supply and demand market conditions and creates layers between provision of service and payment.

Austin argues that all these factors result in ". . . a complexity of professional and administrative relationships unrivaled by most other industries" and therefore, the need for an exceptionally high degree of coordination between units of the system (Austin, 1974, p. 310).

The differences between hospitals and other

organizations in our society have been the subject of extensive study. Considerably less attention has been paid to physician organizations, (e.g., group practices or pre-paid health plans) at least in a comparative sense. Burling, Lentz, and Wilson (1956), and Georgopolous and Mann (1962), were among the first to describe the structure and functions of a hospital. Burling's work, a case study approach to six community general hospitals, was conducted from 1949 to 1954 and served to "map" the territory.

Burling's study was probably the first to recognize what has become a recurrent theme in the literature: that unlike most other organizations, three separate power bases exist within the hospital. The Board of Trustees considers policy; the administration oversees the daily operations of the organization; and the physicians manage and control the clinical services. Burling observed that no one person or group has complete authority to dictate change. Each of these forces has its own separate interests, and its behavior serves to protect these interests (Burling, Lentz and Wilson, 1956).

Georgopolous and Mann (1962) in their study of twelve Michigan hospitals, examined the concept of three power bases or lines of authority within the hospital in more detail. <sup>1</sup> These authors identified the

physicians as the major power group and noted that they are socialized as professionals, assume a cosmopolitan role, are autonomous and independent, and may or may not be committed to the goals of the organization. In addition, physicians may play several roles in the hospital, which results in role conflict (Georgopolous and Mann, 1962).

These authors argued that because of the three power groups, coordination becomes a crucial management issue. Georgopolous and Mann concluded that: (1) good coordination is essential to the effectiveness of community general hospitals, and (2) that an increase in the quality of nursing care and total patient care accompanies increased coordination.

These observations have been confirmed. The professional model in which physicians are socialized places a high value on autonomy. This in turn results in managerial problems for hospitals (Hage, 1974; and Rubin and Beckhard, 1978). Perrow (1965), after acknowledging the unique position of physicians in the hospital, suggested that role conflict occurs because, depending on the situation, doctors are staff, line managers, or guests in the organization.

Freidson, (1970) and Nadler (1978) noted that while physicians were crucial to the survival and functioning of the hospital, they may not be committed

to organizational goals and objectives. This situation is in contrast to that existing in most other organizations, where role conflict is rarely tolerated. The primary power base is fully committed to the goals of the organization and interdependence between members is expected and acknowledged.

Additional differences among hospitals and other types of organizations have been identified. The most important distinguishing factor of the hospital is the character of the product. Health or medical care is largely immeasurable and unquantifiable. This results in vague and ambiguous goals that make effective management difficult. The service is variable, diverse, and subject to little standardization. At the same time, quality of the hospital product is considered more important than in an industrial setting (Georgopolous and Mann, 1962; Drucker, 1973; and Bennett, 1978).

Other characteristics thought to contribute to the uniqueness of hospitals are as follows: Hospitals are considered vitally important to society and likely to remain so, while other organizations may or may not be considered important. Hospitals are extremely complex, highly differentiated, quasi-bureaucratic organizations while other organizations may be simple or complex. The hospital is dependent upon and

responsive to the surrounding community, and its work is more integrated with the needs and demands of its customers. The hospital has less control over its environment and services than other businesses (Georgopolous and Mann, 1962; Bennett, 1978).

Medical centers are even more complex than hospitals. Weisbord (1978), who has worked with several academic medical care centers, with the American Association of Medical Colleges, and other medical care groups, collaborated with Lawrence and Lorsch to conceptualize a model analyzing how parts of a medical center fit together. Instead of being one organization, Weisbord said, an academic medical center is actually (1) a medical school and one or more teaching hospitals, (2) other professional schools, and (3) a university with different departments. This structure requires professionals to play more than one role or "wear more than one hat" at a time, which leads to role conflict and organizational problems.

Although individual differences among hospitals exist due to geographical location, local environment, size, mission, and goals, one overriding similarity has been established: they all differ in significant ways from other complex organizations and social systems. The hospital is heavily dependent upon human energy and knowledge and sophisticated

technical facilities, as well as effective coordination of both elements (Georgopolous, 1972; Rakich, Longert, and O'Donovan, 1977).

More recently Shortell and Kaluzny (1983) summarized and listed nine ways that hospitals may be considered different from industrial organizations:

1. Defining and measuring output are difficult.
2. The work involved is more highly variable and complex than in other organizations.
3. More of the work is of an emergency and non-deferrable nature.
4. The work permits little tolerance for ambiguity or error.
5. The work activities are highly interdependent, requiring a high degree of coordination among diverse professional groups.
6. The work involves an extremely high degree of specialization.
7. Organizational participants are highly professionalized, and their primary loyalty belongs to the profession, rather than to the organization.
8. There exists little effective organizational or managerial control over the group most responsible for generating work and expenditures: physicians.
9. In many health care organizations, particularly hospitals, there exists dual lines of

authority, which creates problems of coordination and accountability and confusion of roles (Shortell and Kaluzny, 1983, pp. 13-14).

While these authors acknowledged that the "uniqueness" of health care organizations can be overstated, they seem to agree with those that say "the field [of health services management] is different as a whole and not by its parts" (Brown, 1973). It is "the confluence of professional, technical and task attributes that make the management of health care organizations particularly challenging" (Shortell and Kaluzny, 1983, p. 14).

#### Management in Health Care Organizations

It is clear that the health care system is complex, and it is evident that a significant body of literature argues in favor of the health care industry being substantially different from other industries. From the studies on the work of managers, much is known about the general functions managers perform and the various roles managers fill. The question now becomes, how do all these factors affect the work of managers in health care settings?

There appears to be a paucity of research addressing this question, either directly or in any breadth. However, there are fragmented strains of

research that address subsets of the question. A number of studies have been done on the role of health service managers. These provide information about how non-physician health care managers spend their time, the forms of communication they use, and what activities they undertake and consider important (Munson and Zuckerman, 1983).

Other studies, conducted for the most part in hospitals, focus on the cost and quality problems of the health care field and stress implications for managers. Although related to cost and quality problems, regulation is often discussed as a separate issue and cited as a reason for the increase in physician managers. Therefore, a brief review of regulation is also presented.

#### Role Studies of Health Care Managers

The available literature on the role of health care managers has focused on the following dimensions: (1) time spent on various activities, (2) forms of communication, and (3) activities. Allison (1975) studied the role of 24 health administrators in four different types of organizations: hospitals, long-term care facilities, multi-specialty group practice clinics, and health maintenance organizations. He developed 46 items that described specific management functions and asked respondents to indicate level of



involvement, time spent, and degree of importance of each.

Kuhl (1977) used Allison's work to develop her questionnaire, which was mailed to a national sample of chief executives in hospitals and prepaid group practice health plans. The content of executive work was the dependent variable, measured in two ways. First, executives were asked to indicate in their own words four aspects of their work that were most important. Second, executives were asked to indicate the nature of their involvement in 114 distinct activities, the time devoted to activities in which they were involved, and the importance attached to those activities.

In order to analyze the data, Kuhl used content analysis, which produced 23 groupings. These were then placed in four broad areas that represented components of the executive role. These areas were (1) internal management (all activities that relate to the general purpose of managing the internal operations of the organization), (2) organizational development (activity oriented toward changing or developing the organization), (3) external relations (activities relevant to maintaining contact with people or organizations pertinent to the organization's present or future operations), and (4) environmental surveillance (monitoring or surveying the environment for the

purpose of interpreting how changes in the environment may affect the organization).

Kuhl found that the majority of activities fell into the internal management area, which was in turn subdivided into organizational design, personnel management, financial management, logistical management, service delivery, and legal work. She concluded that the role of these executives closely conformed to the traditional administrative model in that these executives are primarily concerned with maintaining the ongoing operations of the organization. Their major responsibilities include assuring conformity with organizational objectives, allocating organizational resources, promoting efficiency, and providing for organizational growth.

Munson and Zuckerman (1983) reviewed several other role studies of health care administrators and concluded that the general findings support the universalist model of the manager's role. In other words, most of the studies reviewed by these authors, including the two presented here, document that management activities such as planning, organizing, etc., and organization-building human relations activities comprise most of the work of health care managers.

### Studies of Cost and Quality

As discussed earlier, Georgopolous and Mann (1962) concluded that because of the three power groups that existed simultaneously in hospitals, coordination was the pivotal element in ensuring both organizational effectiveness and quality of care. For example, management practices such as asking subordinates for their ideas about various work related problems were associated with increased coordination. In addition, Georgopolous and Mann found quality of care to be associated with situations where there was less tension between doctors and nurses and greater understanding of each other's roles.

More than ten years later, Shortell, Becker, and Neuhauser (1976) examined 42 Massachusetts hospitals and came to similar conclusions. In this study, quality of care was measured by the rate of post operative complications and the medical-surgical mortality rate (controlling for case mix and severity). These authors found that the number of regularly scheduled meetings between radiology, laboratory and nursing service to facilitate coordination was associated with lower costs and higher quality of care. The extent to which physicians perceived they influenced decisions involving the purchase of hospital equipment was also associated with lower costs.

Most important was the conclusion that these and other managerial practices explained more of the variance in cost than differences in case mix or the quality of care provided.

It is becoming increasingly evident that health managers can improve organizational performance through their influence on the composition of the medical staff and medical staff organization. Roemer and Friedman (1971) studied the relationship between hospital performance, physicians on contract, and medical staff organization. They found positive relationships between a high proportion of contractual physicians and several measures of hospital performance.<sup>2</sup> They also found a positive association between organizational performance and hospitals with a tightly structured medical staff.

Sloan and Becker (1981) examined the relationship between costs and characteristics of the medical staff organization in 228 hospitals. They found several management factors to be associated with lower costs per admission: the percentage of hospital-based physicians on contract, incentive contracts for physicians who were not hospital based, and the presence of physicians on the executive committee of the governing board.

In a study involving 15 short term general

hospitals, Flood and Scott (1978) examined the effect of several selected structural characteristics on medical outcome. Specifically, these characteristics included the distribution of power among professional role groups, and the power exercised by the surgical staff over its own members. They found the extent of control exercised by the surgical staff over individual surgeons to be associated with the quality of care. However, they also found that when the hospital administrator had more power, it was the factor most strongly associated with quality of surgical care. (Flood and Scott, 1978)

Shortell and LoGerfo (1981) examined the relationship of hospitals, physicians, and medical staff characteristics to quality of care for two conditions, acute myocardial infarction (AMI) and appendicitis. For the conditions and hospitals studied, they found that structural characteristics of the hospital (e.g., bed size, degree of teaching involvement) and individual physician characteristics (e.g., specialty composition) were not strongly related to better performance. Instead, medical staff characteristics such as degree of physician participation in hospital decision-making, frequency of committee meetings, concentration of activity in one hospital, and percentage of physicians on contract were strongly associated with

superior performance. The authors concluded that a key factor in improving the quality of hospital care may be activities aimed at changing medical staff organization and ensuring its involvement with the overall hospital organization.

In summary, it is clear from these representative studies that the problems of cost and quality (referred to as efficiency and effectiveness in several studies) can be significantly affected by management practices.<sup>3</sup> For example, all managers can influence the number of regularly scheduled meetings that facilitate coordination, a key variable in insuring effectiveness. Managers can also influence the composition and organization of the medical staff and provide physicians with a variety of opportunities to have input on organizational decisions.

The complexity of the system and differences cited earlier certainly do not make it easy for health managers to have a positive influence in their organization. One of the most obvious difficulties and recurring themes is the lack of control managers have on physicians and their behavior (Austin, 1974; Friedson, 1975; Summers, 1982). Building on Mintzberg's conceptualization of management roles reviewed earlier in this chapter, Scott and Shortell suggested that health care managers are able to exert

a positive influence on the efficiency and effectiveness of their organizations by working through three major roles. These are (1) the interpersonal role (direct attempts to influence others), (2) the information gathering role (monitoring of environment and organizational activities), and (3) the decision-making role (entrepreneurial activities determining allocation of resources).

However, these authors also warned that "in executing these roles, health care managers, perhaps more than their counterparts in industry, are called upon to make use of their expert and referent power rather than their legitimate or coercive power" (Scott and Shortell, 1983, p. 443). Scott and Shortell suggested a number of specific actions managers can take to affect their organizations. Some of these are as follows:

1. Emphasizing structural and process control, rather than outcome control. This translates into carefully selecting employees and professional staff members and developing good interpersonal relationships and making procedural suggestions to professional staff.

2. Creating substitutes for formal leadership by developing cohesive work groups, organizational development, and training programs.

3. Helping to enact reality for people by articulating shared concerns, attitudes, values, and capabilities of staff members and by directing the flow of information. Examples include deciding what issues to place on agendas and whom to appoint to various committees.

### Regulation

It was noted earlier that regulation in the health care delivery system is directed most often at either controlling costs or ensuring quality. In essence, the number of regulations in the health care field have been an outgrowth of the cost and quality issues. While much of this regulation is reported to have had little or no effect on health care costs, there is some evidence to suggest that they may have prevented some hospitals from acquiring certain equipment or providing expensive services, thus controlling "misuse" and increasing quality of care (Bice, 1980; Sloan and Steinwald, 1980; Goldsmith, 1980).

Whether or not any given regulation is or is not effective, it is generally agreed that regulatory policies have significantly complicated the work of health care managers. Goldsmith (1980) outlines four types of regulations thought to have the most profound effect on managers:



1. Certificate of need. This law requires health facilities of all types to obtain approval from state health departments prior to proceeding with building programs, and in some cases with purchasing equipment. In addition, there are often target occupancy rates which, if not met, would be cause for facilities to be denied permission to renovate or even replace equipment. These restrictions have created incentives for managers to compete with other health care facilities for patients, services, etc.

2. Health manpower policy. Based on the belief that there is now an over-supply of health professionals, the health profession's Educational Association Act of 1976 restricts entry of foreign-trained physicians. The eventual reduction in the total number of new physicians will create problems for health care managers in areas that even now have low ratios of physicians to population.

3. Federal Trade Commission (FTC). Believing that there may be a cost benefit to price competition among physicians, the FTC has acted to lift the medical society ban on advertising for physicians. Evidently this has also occurred for institutional providers.

4. Cost containment. There are numerous new regulatory approaches to cost containment, especially

for hospitals. This has caused health care managers to focus on increasing or maintaining levels of use and on expanding their market share. It is predicted that the 1980s will see the use of the corporate enterprise in health services, which is already having a profound impact on the politics of medical care, its institutions, and its managers (Starr, 1982).

### Physicians as Managers

An increasing number of physicians are assuming management positions within their organizations (Schenke, 1980). This trend is occurring despite the presumption that physicians view management as a less prestigious kind of work and may not be enthusiastic supporters of formal organizational methods (Thompson, 1979). In fact, tension between physicians and health care managers, specifically hospital administrators, is a frequently cited problem in the literature. Therefore, a discussion of this issue will be presented. This is followed by a review of studies focusing on physicians as managers in hospitals and physician organizations.

### Tension between Physicians and Managers

Tension between professionals or clinicians and managers or administrators is not limited to the

health care field. Simon (1945) described tensions between practitioner-oriented faculty and discipline-oriented faculty in a university setting. Whether in a business school, engineering school, or school of education, Simon warned that efforts must be made to lower barriers that impede communication between these two factions. Without communication, he said, deleterious developments occur, such as the members of each discipline in the professional school demanding increased autonomy so that they can pursue the goals defined by their discipline without regard to the "irrelevant professional school goals" (Simon, 1945, p. 250).

Perrow (1972) asked why conflict always seems to exist between groups such as faculty and administration in colleges, doctors and nurses and administrators in hospitals, and social workers and psychiatrists. He suggests that the answer lies in the never-ending struggle for values dear to the participants (e.g., security, power, autonomy, and a host of rewards):

Because organizations do not consist of people sharing the same goals, since the members bring with them all sorts of needs and interests, and because control is far from complete, people will struggle for these kinds of values. (Perrow, 1972, p. 154)

Before discussing the conflict between physicians and health care managers further, it must be

emphasized that this seems to be a more prevalent issue in hospitals than in physician organizations. This may be explained by the small size of the group vs. the larger, more bureaucratic hospital and the need for physicians in a group to take quick corrective action (Shortell and Kaluzny, 1983).

Simon (1945) and Perrow (1972) argued that the issues of diverse goals and needs associated with power and autonomy are at the root of tension or conflict between groups. While there may be additional factors involved, the literature reviewed supports this view of conflict as it pertains to physicians and health care managers. Freidson, (1970); Austin, (1974); Starr, (1982), and others have recognized that physicians tend to identify more closely with professional goals than with those of the organization. Their relative autonomy stems from their control over clinical matters and allows them to pursue goals defined by their professional training (e.g., patient care) without regard for the major problems of the health care system or their organization (e.g., cost control).

Fry (1980) argued that a major obstacle of innovative growth and development in the health delivery system is the inability of physicians and their professional and administrative counterparts to

agree on problem definitions and priorities for change, and to coordinate with each other to implement a collective strategy. The result of these difficulties is conflict between physicians and managers.

An alternate view on the reasons for tension between physicians and managers is the difference in risk-taking behavior. Stone (1976) found hospital administrators to be risk avoiders, especially with regard to investment decisions. This is different from physicians, who are risk takers. The ability of physicians to take risks was attributed to their training and need to evaluate risks but not avoid them. In the situation described by Stone, the risk-taking doctors would recommend solutions that the risk-avoiding administrators would be unwilling to implement, resulting in conflict.

Although the reasons may vary, tension between physicians and health care managers occurs frequently. At the same time, studies reviewed earlier in this chapter show that increased physician participation in organizational decision-making and policy decisions results in a higher quality of care and a greater ability to control costs. The question now becomes how can tension or conflict be managed while organization effectiveness is maximized?

One theme repeatedly stressed in the

literature is the need for integration of administrative and clinical-decision making. This is viewed as an attempt to merge the power possessed by the physicians by virtue of his clinical expertise with a legitimately defined organization role (Shortell, 1974). Practically, this can result in arrangements such as interdisciplinary management teams, physicians being appointed to governing boards, and physicians assuming a variety of full-time managerial positions (e.g., medical director, vice president of medical affairs, etc.).

#### Physicians in Management Positions

The literature discussed thus far suggests that the increasing involvement of physicians in the management process is both inevitable and highly desirable. However, there is a dearth of empirical research on the physician in management. After describing what little research is available, the literature that discusses issues relevant to physician managers in general will be reviewed.

#### Research on Physician Managers. Slater

(1980c) conducted a study that explored the roles of physician managers. Using a task list previously developed by Kuhl (1977) he surveyed the membership of the American Academy of Medical Directors (AAMD).

Basic and expanded roles were identified. A basic role was defined "by identifying those task items for which 70 percent or more of the respondents claimed involvement" (Slater, 1980c, p. 61). Slater identified eight basic role tasks, six of which related to what was termed internal management, one to external relations, and one to quality assurance.

Expanded role tasks were defined as, "those tasks accounting for the differences among physician managers" (Slater, 1980c, p. 65). These were analyzed and grouped to identify common sets of tasks, such as physician personnel administration, service delivery, external organization and maintenance, external relations, interorganizational arrangements, environmental surveillance, and quality assurance. According to Slater, these expanded role tasks moved the physician toward a managerial role in which physicians are involved in the planning, organizing, staffing, directing and controlling, but not the budgeting activities related to the delivery of medical care in their organizations.

In another study of physician-managers, Kurtz (1980) used three different self-assessment feedback instruments: (1) Firo B, (2) Styles of Leadership Survey, and (3) Lifo to examine patterns of behavior of physician managers who attended an AAMD-sponsored

physician-in-management seminar. Further, he assessed the effects of these behavior patterns on the role of organization-leader and physician-manager. His findings revealed the following:

1. That these individuals were very selective in the groups they joined and, in general, had low inclusion needs. This, Kurtz reasoned, is fine for solo practitioners but potentially difficult for physicians assuming managerial positions.

2. There was a high need to take control among these individuals, which might also be inconsistent with a managerial role.

3. This group of individuals had low affection needs, typical of physicians socialized to suppress emotional involvement.

Lloyd and Shalowitz (1980) surveyed large non-government, not-for-profit hospitals in order to find out what type of hospitals were most likely to have physician managers with the title of "medical director" and what, in general, medical directors did in these hospitals. They constructed a profile of hospitals employing medical directors, and a profile of the individuals serving in those capacities. Their survey revealed that one third of the total number of hospitals responding, (109/323), had medical directors, and these were in the larger hospitals (average



bed size of 498). These hospitals were also three times as likely to be teaching hospitals. Most of the demographic information on the medical directors was consistent with Slater's findings.

Lloyd and Shalowitz described the functions most often associated with the position of medical director. Their survey revealed the numerous committee meetings attended by medical directors, as well as the percentage of respondents engaged in other areas such as medical staff, nursing service, medical education, Joint Commission on the Accreditation of Hospitals (JCAH), Professional Standards Review Organization (PSRO), pharmacy, physician recruitment, laboratory, x-ray, research, marketing, risk management, and program development.

Issues Relevant to Physician Managers. Physicians have the potential for becoming managers. They have intelligence, discipline, motivation to organize, and altruism (Torrens, 1980). Based on their clinical background, they are able to communicate well with their peers. This, combined with their understanding of the field, helps them articulate needs within their organization and within the health care delivery service (Slater, 1980b). They also have a demonstrated ability in didactic learning and broad exposure to analytic thinking (Hejna and Gutmann, 1983).

Despite these attributes, physicians do not receive training or even exposure to management skills while in medical school <sup>4</sup> (Yanda, 1977; Herzlinger, 1978; Long, 1980; Phillips, 1981). Therefore, as physicians have increasingly been assuming managerial roles, the majority of the literature has been normative describing the management skills physicians need to develop.

Kralewski (1980) emphasized the leadership role of physician managers in the development of public policies affecting health services. Therefore, he argues, a policy perspective and the accompanying policy analysis skills are important for physician managers to develop. Further, Kralewski argues that it is especially important for physician managers to learn to subordinate their professional self-interests to public needs and resources. The degree to which physician managers are able to accomplish this will quite likely determine the future nature of the health care delivery system.

Rubin (1980c) proposed that the singular and unique responsibility of physician managers is, "to make a difference in the lives of the people who report to you" (Rubin, 1980c, p. 45). Rubin argued that since this is done through the conscious and active exercise of power and influence, physician

managers must be aware of the style of power and influence and the need for style flexibility, and must develop a broad range of power and experience skills.

Delbecq (1980b) agreed with Rubin and maintains that in order to make a difference in an organization, the physician manager needs to be skilled at making strategic decisions. He summarized strategic decisions considered important for the physician manager to actuate. These include decisions regarding domain, decisions regarding environmental challenge, decisions regarding organizational strengths and weaknesses, and decisions to test and implement innovations.

The need for physician managers to obtain skills in the area of financial management is well documented. Long (1980), discussing the need for improved financial management in the health care industry, suggested that the need is particularly acute among the smaller physician dominated health and medical care organizations. Herzlinger (1978) and others argued it is most acute in hospitals where physicians skilled in aspects of financial management could help make difficult choices (Stoelwilder, 1979; Berger, 1983).

According to Kurtz (1980b) one explicit need of the physician manager is an awareness and understanding of the psycho-sociology of organizations and the people

who work in them. In other words, physician managers need to be familiar with the field of organizational behavior. Kurtz argued that the application of organizational concepts may make the difference between success or failure for the physician manager. Delberq (1980a) in a more specific discussion, emphasized the need for physicians to develop skills in dealing with deviant behavior. He suggested the use of a protocol where, in the absence of a personal relationship, the potential for dysfunctional consequences are minimized.

Kaiser, stressing the importance of the interface role, suggested the greatest problem faced by physician managers is that of maintaining joint accountability, i.e., to management and the practicing physician (Kaiser, 1980). The issue of a dual role, that of clinician and manager, is one that is well-addressed in the literature. Slater (1980a), epitomized the position that physician managers should continue to practice. He stated that "the continued respect of his colleagues depends on his continuing to be an effective clinician" (Slater, 1980a, p. 75).

Royer, while acknowledging that physician managers have many reasons for continuing to practice, including credibility, discussed some problems faced by those choosing to maintain a practice. These include maintaining continuity of patient care and

limited clinical exposure. Royer stressed that credibility accrues from the quality of decisions made by the manager. His position is that physicians in management positions do not have to maintain a medical practice. Rubin (1980a), addressing the issue of dual roles and role conflict, agreed with Royer that maintaining a clinical practice may not be the best approach. His view was that trying to be in two camps simultaneously (clinician and manager) results in never being fully in either camp. Physician managers, Rubin suggested, need to develop a new reference group.

Physician Managers in Hospitals. The literature on physician managers in hospitals seems devoted to elaborations on the need for physician managers. There are also numerous references to tasks and roles that should be performed. These are basically the same as those previously discussed for physician managers in general, but the references to specific organizational issues will be discussed.

Reasons behind the need for physician managers, some of which have been covered previously, include problems with the medical staff, problems with patients, regulatory and judicial calls for monitoring physician performance, increased urgency for professional coordination of contract and salaried

physicians, cost containment efforts, the need for integrating clinical and managerial goals, developing medical technology, and unrealistic time requirements of voluntary positions (Harvey, 1970; Ashley, 1972; Cohn, 1975; Fifer, 1979; Johnson, 1979; Rogatz, 1979; and Blanton, 1980).

Mastrangelo (1980) reported on a case in which a segment of the hospital administration decided that the organization needed a medical director but could not muster the necessary support. The recommendation originated from the past-president of the medical staff and was studied by an ad hoc committee of the medical executive committee, which acted as the joint conference committee (JCC). This committee assembled the available literature and information regarding the role and function of a hospital medical director.

On site visits to hospitals that had medical directors were also conducted. In addition, medical directors from other institutions were invited to talk with the committee. Despite the recommendations of the ad hoc committee that the hospital hire a medical director, the JCC voted against creating this position for two reasons, the hospital ad hoc committee did not fully explain the reasons for supporting the position of medical director, and the physicians objected to the proposed job description on the grounds that the

medical director would have too much power.

There are other references to physicians feeling threatened or resistant to physician managers. Harvey (1970) suggested that many doctors and administrators feel a full time physician manager would pose a threat to their clinical freedom. Blanton (1980) suggested that in many hospitals, the case for the full-time physician manager is being seriously considered, despite the usual resistance of the medical staff. Rogatz (1979) explained resistance to the establishment of the position by the medical staff as forcing recognition of the fact that the staff is not as autonomous as it would like to be, and perceiving the physician manager as a threat to the balance of power among the governing board.

Finally, the question of where a physician manager fits in the organizational hierarchy is addressed. The consensus seems to be that a line position is best.<sup>5</sup> Cohn (1975) argued that the medical director should report in direct line to the hospital administrator but also should be assured direct input to the board of trustees. Marcarelli (1976) quite clearly stated, "In my opinion, a medical director must function in a line or managerial position capacity if he is to properly discharge his responsibilities" (Marcarelli, 1976, p. 5). While Snyder (1977)

presented the pros and cons of each arrangement, he seemed predisposed to the line position. Fifer (1979) suggested that the physician manager report to either the CEO or board of trustees, but serve in a line capacity.

#### Physician Managers in Physician Organizations.

For purposes of this study, physician organizations have been defined to include group practices, pre-paid health plans, and individual practice associations. Therefore, the literature on physician managers in both types of organizations are reviewed together. In addition, physician managers in Health Maintenance Organizations (HMOs) and group practices most often have the title of medical director, and in this section the terms will be used interchangeably.

Studies of HMOs have focused primarily on organizational performance, rather than on the physician manager. However, because medical directors have historically been a part of HMOs, the literature does occasionally address the role. For example, Phillips and Dorsey (1980) studied some aspects of structure and function in a survey of 40 prepaid group practice HMOs, including issues related to the role and status of the medical director and the relationship between the medical and executive directors.



Analysis of the data seemed to indicate that in "staff" model plans, medical directors are selected by and report to health plan managers rather than their professional peer group.<sup>6</sup> In the "group" model plans, medical directors more often are selected by and report to members of the physician group. The authors concluded that with regard to HMOs, medical directors seem to have more delegated authority in the group model than their staff model counterparts. A more general conclusion was that there is a trend toward more physician involvement in medical services administration.

There are more similarities than differences between the literature on physician managers in hospitals and physician organizations, especially with regard to the need for medical directors. This need is again suggested to be a result of cost containment efforts, the need for coordination between departments and people, quality control, complicated staffing requirements, and patient relations (Rodenbaugh, 1973; Gray, 1975; Pollard, 1976; and Waterhouse, 1981). This list is almost identical to that reported for hospitals.

One difference between physician managers in physician organizations and in hospitals is that medical directors of physician organizations are expected

to participate in personnel functions, such as physician recruitment and physician evaluation, more often as part of their primary responsibilities (Pollard, 1976; and Waterhouse, 1981). Another difference between physician managers in the two groups is that in the literature on physician organizations, there is little attention paid to resistance or tension between the medical director and other physicians or to issues such as whether the position is line or staff.

### Summary

This chapter reviewed literature relevant to the study of physician managers. First, literature suggesting that managerial principles can be applied in a generic way was presented. Next there was a discussion of various aspects of health care organizations that differentiate them from other types of organizations. Studies of management in health care settings were then described. These were primarily role studies or studies dealing with specific problems such as cost and quality.

The studies on the role of health care managers concluded that this role closely conforms to that of the traditional, generic manager. For example, the activities performed reflected the primary concern to be maintaining the ongoing operations of

the organization. Other studies of health care managers focused on issues of cost and quality. It is clear from this work that managers in health care settings can improve the efficiency and effectiveness of their organization in a variety of ways. The most important ways are facilitating coordination, influencing the composition and organization of the medical staff, and ensuring physician participation in organizational decision-making.

Finally, this chapter reviewed the literature on physicians as managers. Included here was a description of the tension between physicians and managers. Regardless of the specific reasons for the tension, the need for integration of administrative and clinical decision-making is well recognized. With few exceptions, the literature dealing with physician managers focused on documenting the need for physician managers, the skills required by physician managers, and the problems faced by physician managers. Little is known about the work of physicians who hold management positions.

## NOTES - CHAPTER II

1. The phenomenon of multiple decision-makers in hospitals remains an important theme in the literature. Two general models of physician/hospital relationships, the dual authority model and the shared authority model are currently being examined in the light of pressures towards cost containment and concerns about quality. According to Shortell (1983), the more traditional dual authority model suggests that physicians determine the nature of hospital operations and the hospital administration (management) provides the equipment, supplies, and facilities for the physicians. The shared authority model has evolved as a result of legal, economic, and social forces and emphasizes shared decision-making on most organizational issues. Evidence regarding the association of more shared decision-making between administrators and physicians and increased integration of clinical and administrative information suggests that this results in both lower costs and higher quality of care (Shortell, 1983).

2. Historically, physicians and their trade organizations have opposed "contract practices," e.g., pay on a capitation basis rather than by visit, or physician practicing within a corporate structure as opposed to solo practice. However, the profession no longer seems as opposed to either arrangement, and an increasing number of physicians accept a variety of contractual arrangements with prepaid hospital plans, hospitals, and other corporations. Currently, about 26 percent of physicians have contractual relationships with hospitals on salary (Starr, 1982). These physicians are then employees of the organization, and their presence has obvious implications for managers.

3. Effectiveness is the degree to which goals and objectives are successfully met. Efficiency refers to the ratio of outputs to inputs: the number of products and/or services provided by a given supply of resources (Scott and Shortell, 1983, 420-421).

4. Of the 125 medical schools in 1981, three offered formal practice management courses and 11 offered courses in cost containment (AAMC Curriculum Directory, 1980-1981).

5. A line position is managerial with delegated authority to make certain organizational decisions. A staff position is defined as advisory, not

usually requiring final decision-making activity (Snyder, 1977; Cohn, 1975).

#### 6. Definition of Staff and Group Model HMOs, and IPA's.

##### Group Model

There are two kinds of group model HMOs:

a. The first type of group model is one in which medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HMO. A Kaiser Permanente Medical Group is the best example of this model. The group is paid a negotiated monthly capitation by the HMO (Kaiser Foundation Health Plan), and the physicians in turn are salaried and generally prohibited from carrying on any fee-for-service practice. For the purposes of the monograph, this type of group model is called a PPD-only group model HMO.

b. In the second type of group model, the HMO contracts with an existing, independent group of physicians to deliver medical care. Usually, an existing multispecialty group practice adds a prepaid component to its fee-for-service mode, becomes an FFS/PPD medical group, and affiliates with or forms an HMO. Both fee-for-service and prepaid medical services are delivered at the group's clinic facilities. The group may contract with more than one HMO. This type of group model is referred to in the monograph as FFS/PPD group model HMO.

The group is paid a monthly capitation by the HMO(s), based on a negotiated rate for each HMO enrollee. The group in turn will distribute the capitation income to physicians according to an established procedure. Any one of a number of procedures can be used for such distribution: regular fee-for-service equivalent for HMO patients actually served; fee-for-service, less a discount; equal shares of the HMO capitation revenue to all physicians, regardless of how many prepaid patients they individually served

during the month; or a combination of the above methods.

A hybrid of this form of group model HMO is one in which several independent group practices with a prepaid component "network" together as the physician supply. HMO Colorado, sponsored by Blue Cross, is an example of a model. Five independent FFS/PPD medical groups, located in different parts of the Denver metropolitan area, are affiliated with the HMO.

The two kinds of group models are also known as prepaid or capitated group practice models.

### **Staff Model**

The staff model consists of a group of physicians who are either:

- a. salaried employees of a specially formed professional group practice that is an integral part of the HMO plan (Genesee Valley Group Health Association, Rochester, New York, is an example of this model), or
- b. salaried employees of the HMO. An example of this model is Group Health Plan of Puget Sound, Seattle, Washington.

Medical services in staff models are delivered at HMO-owned health centers and only to HMO plan enrollees. The physicians in either form of staff model are usually limited in carrying on any fee-for-service activities.

### **Individual Practice Association (IPA) Model**

The IPA model HMO has a central administrative core that contracts directly with individual physicians who continue to practice in solo settings in their own offices serving both FFS and PPD patients. They usually are reimbursed on a discounted fee-for-service basis, and ancillary services are usually performed at local hospitals. Some IPAs include a separate, specially formed corporation that represents the solo practitioners. A hybrid of the IPA model is formed when one or more FFS/PPD

group practices are included with participating solo practitioners. The Comprecare HMO in Denver which contracts with solo and group physicians through the Columbine Medical Group is a good illustration of this type of hybrid. (Neal, 1983).

## CHAPTER III

### THE STUDY APPROACH AND METHODOLOGY

This chapter first reviews the purpose of this study and the conceptual framework used to address the study objectives. Next, a review of the methods used to study jobs is presented. This is followed by a discussion of the specific method selected for use in this study and a description of the dependent and independent variables. Then, issues involving the study sample and data collection techniques are addressed. The chapter closes with a description of the approaches used to analyze the data.

#### Study Purpose

As discussed earlier, the purpose of this study is twofold: first, to describe the job of physician managers, and second, to identify organizational and personal characteristics that might influence the performance of this job. Two questions are addressed:

1. Does the job of the physician manager vary among organizational types?
2. What are the organizational and/or personal



characteristics associated with the performance of specific tasks by physician managers?

### Conceptual Framework

The conceptual framework used for this study was adapted from earlier work that identified and categorized managerial functions. Burgess' (1975) categorization dividing management functions into three areas: Policy Management, Program Management, and Resource Management was used to group tasks for analysis. According to Burgess, policy management is a process involving the strategic functions of guidance and leadership. Specifically, it refers to the capacity to perform the needs assessment, goal setting, and evaluation functions; the ability to establish priorities and mobilize and allocate resources; and the ability to guide relations with the community.

Program management encompasses administrative functions and tactical requirements of executing policy. Planning and overseeing programs and services, identifying opportunities for improving efficiency, and developing cost-effectiveness measures and other evaluation criteria are examples of program management. Finally, resource management refers to the capacity to carry out and manage the administrative and organizational support functions. These

activities constitute an organization's basic capabilities and bottom-line assets. Like policy management, resource management cross-cuts functional departments. It includes personnel administration (e.g., recruitment, labor relations, etc.), property management, information management, and financial management.

### Review of Job Analysis Techniques

Although the question of what people do in their jobs can be studied in a variety of ways, there are two phases common to all approaches. First, there is a need to collect and record the information about the job under study. Second, the data must be analyzed in order to discover aspects of the job that are important to the purpose of the analysis (Livy, 1975). The specific methods used to collect and analyze this information vary according to the purpose of the analysis and the preference of the analyst.

### Time Studies

Various efforts at gathering information on the general nature of work, specific jobs, worker qualification, and the interaction between them date back to the late 1800's. Frederick Taylor, the father of the scientific management movement, is generally acknowledged as the originator of work time studies in

1881 at the Midvale Steel Company (Larkin, 1969). Taylor used an observer to determine the amount of time a job took under various conditions, and then used this information to establish time standards, or the amount of time a job should take (Taylor, 1912).

Taylor believed that there was "one best way" of accomplishing any given task. His mission was to discover the fastest, most efficient, and least fatiguing way to do a job which, he reasoned, would result in an increased output for the organization. Therefore, one of the basic tenets of Taylor's scientific management movement was to scientifically investigate all aspects of the job. Based on this information, fundamental rules, laws, and formulas governing the best working methods could be developed. In addition, compensation for a fair day's work could be established.

#### Motion Studies

At about the same time Taylor was developing time studies, Frank B. and Lillian Gilbreth were working on motion studies. The Gilbreths, concerned with eliminating wastefulness resulting from ill-directed and inefficient motions, focused on the physiological and psychological capabilities of the individual worker (Larkin, 1969). They took a "systems" approach and examined the job within the context of the

work-place (Barnes, 1937). The Gilbreths investigated several fields of work, including health care. They filmed and then analyzed the activities of a team of doctors in the operating room. This resulted in a decision by the surgeons to decrease by fifteen percent the amount of time patients were given anesthesia (Smalley and Freeman, 1966).

Thus, motion and time studies represent the marriage of Taylor and Gilbreths' works. Used since the early 1900s, they still exist as an accepted methodological approach to job analysis. Barnes offers one of the most precise definitions of motion and time studies:

Motion and time study is the systematic study of work systems with the purpose of 1) Developing a preferred system and method, i.e., at the lowest cost, 2) Standardizing systems and methods of work, 3) Determining the time required by good individuals working at a normal pace to do the task at hand, and 4) Assisting in training workers in appropriate methods. (Barnes, 1937, p. 1)

#### Ratio Delay and Work Sampling

Through the 1920s and 1930s, motion and time studies, considered part of scientific management, represented the accepted method for studying work in the United States. However, in England, L.H.C. Trippett was using a new technique called ratio delay to study the jobs of workers in the textile industry (Barnes, 1937).

Ratio delay, and what is now called work sampling, are similar in that they are both based on the laws of probability, inferential statistics, random and instantaneous observation, and the use of the binomial distribution to establish sample size and confidence levels (Torgersen, 1956). However, ratio delay is traditionally used when the concern is with the down time of machines, while work sampling focuses on human activity. Although introduced into the United States during the 1940s, neither technique was widely accepted until the 1950s (Connor, 1961).

In contrast to the continuous observation required for motion/time studies, work sampling consists of making observations of workers or machines at random intervals, and noting whether the worker is active or idle. The focus is on investigating the proportion of total time devoted to the numerous activities that comprise a job. Statistically, the number of times an activity is observed to be performed has been found to be closely correlated to the total length of time spent on its performance (Barnes and Trinca, 1978). Introduction of the work sampling technique represented a significant advance for job analysis because it was found to provide accurate information at a lower cost and with less time than continuous observation required of motion/time studies (Torgersen, 1956;

Connor, 1961; Cercone, 1978).

### Critical Incident

Another important contribution to job analysis techniques occurred in 1949 with the introduction of the critical incident method. Flannagan (1949) developed this approach because he was concerned that most attempts to analyze jobs were too general to be useful for either evaluation or training. He proposed that observing incidents of extreme behavior, either good or bad, and evaluating, classifying, and recording these incidents, could result in establishing the critical requirements for a job.

Critical incident studies have been used to describe an important job-related event where decisions have to be made promptly and correctly. They usually examine interpersonal relations or judgment. Recordings of critical incidents can be made by supervisors, job incumbents, observers as the behavior occurs, or by recall. Critical incidents records typically include: (1) what led up to the incident; (2) exactly what the employee did that was so effective or ineffective; (3) perceived consequences of the behavior; and (4) whether the consequences were within the control of the employee (McCormic, 1979).

The critical incident technique has come to be

used increasingly for performance appraisal. However, aggregated data on incidents about a given job from multiple incumbents can still be a useful job analysis technique.

### Functional Job Analysis

Functional job analysis (FJA) represents yet another important method for obtaining information about jobs. The fundamental concepts of FJA were developed during the early 1950s, when the United States Employment Service was producing the 1965 edition of the Dictionary of Occupational Titles and a new job classification system (McCormic, 1979). Although Fine (1971), who was involved in the development of FJA, originally proposed its use as an approach to manpower planning, this technique has been used extensively for job analysis (Fine and Wiley, 1971).

FJA has been characterized by Fine and Wiley as both a conceptual system for defining the dimensions of worker activity and a useful way of measuring this activity. Some of the primary premises of the FJA system are paraphrased as follows:

1. A fundamental distinction must be made between what gets done and what workers do to get things done.

2. All jobs involve the worker to some extent with either data, people, or things.

3. Workers function in unique ways in any one of these three areas. For example, when a worker's task is involved with equipment (things), certain physical resources are required. When the task involves the use of ideas (data), mental resources are required. When the task involves customers and co-workers (people), interpersonal resources are required.

4. Although there may be an infinite number of ways of describing the tasks performed, there are only a few patterns of behavior (functions) which describe how workers use themselves in relation to information, people, and things. Those functions have been defined by Fine in worker-function scales. These make up the primary tools of FJA, providing a standardized, controlled language to describe worker activity over a range of varying conditions and difficulty. For example, in relation to information, a worker functions to compare, compile, compute, or analyze.

5. The functions appropriate to each area (information, people, and things) are hierarchical and ordinal, moving from simple to complex.

In summary, Fine argued that in order to design jobs, a base of accurate and comparable information



describing the job is essential. In order to develop this information, he proposes the use of two fundamental techniques:

1. Defining the fundamental unit of work and jobs using task statements written according to a specific form and structure in order to express what workers do and what is accomplished.

2. Describing worker functions using hierarchies (simple to complex) related to data, people, and things (Fine and Wiley, 1971).

### Task Inventories

Task inventories have been used over a period of many years, but the United States Air Force is credited with developing and refining this method specifically for use as a job analysis approach. The armed services have a long history of being interested in job analysis. Their stated objective has been to clearly identify tasks performed for various jobs in order to plan adequate training (Ammerman, 1965). Prior to the 1960s, a variety of methods for examining jobs had been tried. However, most had significant limitations, such as reliance on an expert job analyst, high cost, incompleteness, non-quantifiability of data, and small sample size.

The Air Force viewed task inventories as

promising because they could be administered to a large number of people, were relatively inexpensive, and were quantifiable. Research that included rigorous reliability and validity testing was sponsored. Subsequently, this approach to job analysis has been used extensively and enjoys widespread acceptance in the military as well as in many other organizations (Nelson, Jacobs, and Breer, 1975).

Typically, a task inventory appears in the form of a questionnaire that job incumbents, supervisors, or analysts use to provide information about the incumbent's involvement with each task. Two features characterize a task inventory: (1) a list of tasks for the occupational field under study, and (2) some type of response scale. Usually the scale elicits an indication of the respondent's involvement in the task, but may also request an opinion about the task (McCormic, 1979).

The list of tasks that comprise the task inventory should include as many of the tasks performed by the incumbent as possible. Statements describing the tasks are usually grouped into broad categories but focus on what is done, not on how or why it is done. McCormic presents the following steps for construction and use of task inventories:

1. Define scope or breadth of the occupational

area to be covered.

2. Locate written sources of activity statements. This usually means reviewing any available literature that may describe the occupational area.

3. Develop preliminary inventory. There are two approaches to developing a preliminary inventory. One involves the analyst developing the preliminary inventory based on the source material. This can be done by developing the task statements and then categorizing them into duty groupings or by beginning with a duty outline and then developing task statements within this framework. The second approach is for the job analyst to ask a sample of job incumbents or experts to list the activities performed in the occupational area. The analyst then consolidates and edits the statements.

4. Review preliminary inventory. The preliminary inventory should be reviewed by several technical advisors.

5. Prepare revised draft of inventory. This inventory should be redrafted by several technical advisors.

6. Select scales to be used.

7. Administer pilot test of inventory.

8. Print inventory

9. Administer inventory. Some task

inventories are mailed and others are administered within an organization. Sample selection must be carefully considered. Once task inventory data are obtained, any number of statistical analyses can be carried out, depending on purpose and projected uses.

### Summary

Numerous methods are used to perform job analyses. However, a national survey conducted in 1968 by the Bureau of Business Research to determine the current uses, methods, and practices of job analysis showed continuous observations, questionnaires, interviews, task inventories, and written narratives to be the methods most commonly used (Jones and DeCotris, 1969). This survey, which consisted of 1805 mailed questionnaires, distinguished between job analyses done for workers paid hourly and those paid a salary. When designed for salaried workers the analysis tended to focus on functional relationships between the worker and data, individuals, social skills, company policies, and the relationship to other jobs in the organization. When designed for workers paid by the hour, the analysis focused on the environment and physical working conditions.

Method Selected for Studying the Job of  
Physician Managers

The method selected for this study was a self-administered, mailed questionnaire containing a task inventory. Tasks were presented in accordance with the form and language suggested by Fine for use with the functional job analysis technique. Eighty-six tasks were included in this survey. Questions about personal and organizational characteristics were asked in order to explore factors that might influence the tasks for which physician managers were responsible and which they performed. This approach reflected considerations of economy and time while permitting the standardization necessary in research.

However, this method also has limitations. Continuous observation and work sampling have been shown to be more effective methods of job analysis than the mailed survey (Nelson, 1975). Nonetheless, with the population of interest, physician managers, spread across the nation, and with limited resources, a compromise in the methodology of choice was necessary.

An additional limitation involves the recognition that a list of tasks simply can not capture all the cognitive, judgmental, and unobservable processes which are components of the job (Goddard, 1953; Melia,

1979). In developing this instrument, an attempt was made to capture both job content and specific operating conditions or constraints in the organization which result in differences in the physician manager's job. However, certain important variables may have been omitted. Unfortunately, this will most likely go unnoticed, and it is therefore assumed a priori that complete accuracy will not be achieved.

### Dependent Variables

The primary dependent variables in this study are the eighty-six tasks comprising the task list section of the questionnaire. According to the United States Training and Employment Service, a task is defined as follows:

It is a distinct activity that constitutes a logical and necessary step in the performance of work by the worker. A task is created whenever individual effort, physical or mental, is exerted to accomplish a specific purpose. (United States Training and Employment Service, p. 1)

Fine stipulates a task be defined in terms of a controlled language, a controlled method of formulation and in relation to a systems context (Fine, 1974). According to Fine, the definition of a task is as follows:

A Task is an action or action sequence grouped through time designed to contribute a specified end result to the accomplishment of

an objective and for which functional levels and orientation can be reliably assigned. The task action or action sequence may be primarily physical, such as operating an electric typewriter, or primarily mental, such as analyzing data, and/or primarily interpersonal, such as consulting with another person (Fine, 1974, p. 4).

The tasks for this study were composed to reflect Fine's concern about the proper way in which to articulate the work. Each task statement begins with the action the physician is expected to perform and includes the result expected of the action.

For example, task nine is: writing new or modifying existing criteria for the responsibilities of physicians. "Writing" is the word in the task statement that describes the action or activity to be performed. "Criteria for the responsibility of physicians" is the phrase in the task statement that describes the expected outcome or what gets done as a result of the action.

The list of tasks was developed in the following manner: First, a review of the literature on physician managers provided some descriptions of what the job of physician managers should be (Phillips, 1979; Rogatz, 1979; Mastrangelo, 1980). These descriptions were subjected to content analysis, expressed as tasks, and placed in the policy, program, and resource management function categories discussed earlier.

Second, the activities enumerated in Slater's survey of physician managers discussed earlier were reviewed and incorporated into the task list as appropriate. (Slater, 1980c). Third, personal interviews with physicians in managerial positions served both to expand the task list and confirm the accuracy of tasks already listed. (See Bibliography for identities of physicians interviewed).

### Independent Variables

Although the major area of concern in this study is discovering what physician managers do, it is also important to identify the personal or organizational characteristics which may affect job performance. As shown in Table 3.1, the independent variables are grouped under two headings: organizational characteristics and personal characteristics.

#### Organizational Characteristics

The organizational characteristics selected for this study include two categories: The first relates to the organization and are as follows: (1) type of organization (e.g., hospital or physician organization), (2) ownership of the organization, and (3) size of the organization. The second category relates to the position (of physician manager) within



TABLE 3.1  
INDEPENDENT VARIABLES

Organizational Characteristics	Personal Characteristics
<p><b>A. Variables Relating to Organization</b></p> <p>1. Type</p> <p style="padding-left: 20px;">a. Hospital</p> <p style="padding-left: 20px;">b. Physician Organization</p> <p>2. Ownership</p> <p style="padding-left: 20px;">a. For Profit</p> <p style="padding-left: 20px;">b. Non Profit - Non govt.</p> <p style="padding-left: 20px;">c. Government</p> <p style="padding-left: 20px;">d. Other</p> <p>3. Size</p> <p style="padding-left: 20px;">a. Number of beds</p> <p style="padding-left: 20px;">b. Number of physician full time employees</p> <p><b>B. Variables relating to position</b></p> <p>1. Title</p> <p>2. Job Description</p> <p>3. Line/Staff</p> <p>4. Full/part time</p> <p>5. Number of people preceding in position</p>	<p><b>A. Education</b></p> <p>1. Training in Management</p> <p>2. Masters Degree</p> <p>3. Graduate Courses</p> <p>4. Continuing Ed. courses</p> <p><b>B. Experience</b></p> <p>1. Years in practice</p> <p>2. Years in paid management position</p> <p>3. Years in other paid job</p> <p>4. Years in armed services</p> <p>5. Years in voluntary management experience</p> <p>6. Years in current job</p> <p>7. Work in organization before current job</p>

the organization. These include (1) title, (2) whether or not there is a job description, (3) whether the position is line or staff, (4) whether the position is full or part time, and (5) the number of people who preceded the incumbent in the position.

Type of Organization. The American Hospital Association (AHA) defines a hospital as:

a health care institution with an organized medical and professional staff, and with permanent facilities that include inpatient beds, medical, nursing and other health related services to patients. (AHA, 1984, p. 17)

Although all hospitals have in common certain unique qualities that differentiate them from other organizations, there are individual differences among hospitals. These differences include ownership, geographical location, local environment, overall mission, and specific goals (Rohrer, 1962). These differences are reflected in some of the items on the questionnaire and in the independent variables selected. For example, whether the hospital is established as a non-profit, proprietary, or federally owned institution.

The term "physician organization" covers a wide variety of meanings in regard to organizational arrangement. However, in this study, the term is used specifically to mean any group medical practice or

pre-paid health plan. The American Medical Association (AMA) Council on medical service defines a group practice as follows:

Group medical practice is the application of medical services by three or more physicians, formally organized to provide medical care, consultation, diagnosis and/or treatment through the joint use of equipment and personnel, and with income from medical practice distributed in accordance with methods previously determined by members of the group. (Goodman, Bennett, and Odem, 1976, p. 2)

A prepaid health plan is defined as:

A legal entity which provides directly, or arranges for the provision of comprehensive health care services to an enrolled population; the services to be delivered through a multi-specialty medical group or groups; the enrolled population comes substantially from employer groups. (Kuhl, 1977, p. 5)

Size. Size is often considered the single most important factor influencing and explaining the characteristics of organizational structure (Pugh, Hickson and Hinings, 1969). For example, large organizations are usually more formalized and tend to distinguish between specialized groups which then require systematic coordination (Mintzberg, 1979). In addition, employees of a large organization often view the organization as offering more potential and being more efficient than a smaller organization, but also more authoritarian (Handy, 1976).

Alpander emphasized the importance of size as

a variable that influences the internal complexity of hospitals (Alpander, 1982). He believes that a positive association exists between larger hospitals and complexity. Kuhl included size as an independent variable when exploring the roles of health administrators. She found size to be "positively related to a policy-making role in most areas of responsibility, and negatively related to executives personally performing activities in most areas of responsibility" (Kuhl, 1977, p. 57). Scott, Flood, and Ewy (1979), focusing on the structural features of organizations, addressed size as a stratification variable, and Shortell and Getzen (1979) incorporated size in a discussion of the resource capability of hospitals. In this study hospital size is measured by the number of beds, while the size of physician organizations is measured by the number of full-time physician employees.

Title. Titles create expectations and implies rank and responsibility (Drucker, 1973). Physicians assuming managerial roles are known to have a wide variety of titles, such as Medical Director, Chief Executive Officer (CEO), Department Chair, Vice President of Medical Affairs, etc. (Schenke, 1980). Because of this variety, it is appropriate to examine

the influence of Title on the physician manager's responsibility for the tasks.

Job Description, the People Preceding in the Position, and Full-or Part-Time Position. Job descriptions serve to specify the responsibility and obligations of a position (Shafritz, 1980). The number of people preceding an individual in a job may influence the behavioral expectations of the job. Thus, these aspects of a job can be seen as related to characteristics of an organization, specifically, organizational structure (Shortell and Getzen, 1979). Whether or not a position is full or part time may affect several aspects of the job. For example, the individual's ability to participate in decision making, the degree of commitment to the organization, and the degree of control/communication possible. Therefore, this characteristic is included as an independent variable.

Line or Staff Position. The distinction between line and staff positions has long been accepted as a fundamental tenet of organizational theory. Line positions are generally considered to be those with the formal authority to make decisions, while those in staff positions advise (Mintzberg, 1979). This distinction may be oversimplified, may not consider the

various types of staff work, and may not be relevant to all types of organizations (Sherman, 1966; Handy, 1976; Mintzberg, 1979). Nonetheless, it is included as an independent variable in this study because of its widespread acceptance as a way to differentiate between types of positions within organizations.

#### Personal Characteristics

Organizations are often discussed as if they operate independently of the people who work in them. However, people constitute the essential ingredient in organizations (Sherman, 1966). In an attempt to capture the impact of certain personal characteristics on the tasks for which physician managers are responsible educational preparation and experience have been included as independent variables in this study.

Education. Education, especially for professionals, is often linked to age and is typically considered a demographic characteristic. However, it is important to emphasize that in addition, education plays a powerful role in determining performance (Freidson, 1975). In this study, all respondents had a basic medical education. What is of more specific interest is what effect additional education in the field of management may have on the tasks for which physicians managers assume responsibility.

Experience. Experience is included as an independent variable in this study for at least two reasons. First, it has been suggested that the work environment is even more important than education in explaining some important elements of professional performance (Friedson, 1975). Second, physicians generally have experienced the traditional techniques for acquiring knowledge, such as lectures, seminars, etc. However, management is a complex activity, requiring more communication, coordination, and cooperation than physicians may be used to. Further, the methods of learning required to create and support behavior and attitude changes necessary to become a manager are dramatically different from those required for knowledge acquisition (Rubin, 1980b). Therefore, experiences, the actual performance of managerial tasks, may be the most powerful factor influencing physician manager responsibility for task performance.

### Data Collection

#### Choice of Population

As previously mentioned, physician managers have a variety of titles, ranging from Medical Director to CEO. In addition, they are employed or associated with a potpourri of organizations, such as hospitals, nursing homes, pharmaceutical companies, and

group practices. Despite the decision to limit the focus of this study to physician managers in hospitals and physician organizations, the random selection of organizations was impractical. Instead, the entire population of an organization, The American Academy of Medical Directors (AAMD), whose membership consists largely of physicians in management positions, was surveyed.

The membership of AAMD was selected as the appropriate population for two reasons. First, AAMD is a well recognized organization, established in 1975 and accredited by the American Medical Association (AMA) in 1976. Second, its members are physicians who are either in management positions or have an interest in management. The membership is self-selected and open to "any licensed physician with an interest or with full or part-time administrative or management responsibilities" (AAMD Bulletin, 1983). Further, AAMD states its purpose as "the national professional and educational association of physicians with leadership, management, or administration responsibilities in hospitals, specialty practices, HMOs, industry, nursing homes and government" (AAMD Bulletin, 1983).

However, the decision to focus on only members of AAMD who are affiliated with a hospital or physician organization is also a limitation of the study.



First, the generalizability of the findings is limited to physician managers within AAMD. Second, little is learned about physician managers in health care organizations other than hospitals and physician organizations.

#### Development of Survey Instrument

A review of the literature and search for an already developed instrument revealed only two previous surveys of physician managers. One, conducted by Lloyd and Shalowitz (1980), concentrated on physician managers with the title of Medical Director working in large non-government, non-profit hospitals. The aim of this survey was to construct a profile of hospitals employing medical directors, and a description of the individuals serving in those capacities. Their instrument was clearly different from the one required for this study, since it did not focus on tasks and limited the study to physician managers with the title of Medical Director.

The second survey, conducted by Slater (1980a), studied AAMD members and was reviewed carefully as a possible model for this study. Slater incorporated a task list previously used in a study of non-physician health care administrators in hospitals and HMOs. The study focused on the roles of physician

managers.

Despite the apparent similarities, there are at least three intrinsic characteristics of the instrument used in Slater's survey that made it unsuitable for use in this study. First, although there was a list of tasks in the instrument, other dimensions of interest, such as responsibility for the task and frequency of performance, were not addressed. These dimensions will be discussed in more depth in a subsequent section of this chapter. Second, Slater used the terms role and role tasks and this study is about the job of physician managers. This is not a semantic issue. The two terms have quite different meanings.

There are numerous definitions of role.

Linton's classical distinction between position and role is as follows:

A status, as distinct from the individual who may occupy it, is simply a collection of rights and duties . . . A role represents the dynamic aspect of a status. The individual is socially assigned to a status and occupies it with relation to other statuses. When he puts the rights and duties which constitute the status into effect, he is performing a role . . . There are no roles without statuses or statuses without roles.

Just as in the case of status, the term role is used with a double significance. Every individual has a series of roles deriving from the various patterns in which he participates and at the same time a role, general, which represents the sum total of these roles and determines what he does for his society and

what he can expect from it. (Linton, 1936, 113-114)

More recently, Katz and Kahn, who emphasized the importance of roles in their theory of organizations state that a role is "a set of expected activities associated with the occupancy of a given position" (Katz and Kahn, 1978, p. 200). Further, Katz and Kahn define role behavior as "the recurring action of an individual, appropriately interrelated with the repetitive activities of others so as to yield a predictable outcome" (Katz and Kahn, 1978, p. 189).

In contrast to a role, a job is a relatively simple concept. A job is viewed as:

a group of positions which are identical with respect to their major or significant tasks and sufficiently alike to justify their being covered by a single analysis. One or more people can have the same job. (United States Department of Labor, 1972, p. 1)

Clearly, it can be seen that the terms role and job have different meanings. Job is position, and role is the expected behavior associated with that position. Therefore, it is inappropriate to use an instrument using the term role for a study which focused on the job.

The third characteristic of Slater's survey that posed problems for this study was the use of a task list developed for non-physician health care administrators. This, it seems, does not acknowledge

the uniqueness of physician managers.<sup>1</sup> Slater's finding that none of the tasks in the physician manager's basic role overlapped those of the health care administrator emphasizes this concern.

In summary, it appeared that there was no existing instrument suitable for use in this study. Therefore, despite the difficulties of developing a new survey instrument, it was both necessary and appropriate. The issue of validity and reliability will be discussed next.

Validity and Reliability. Concern with reliability and validity stems from the necessity for research to be believable. To be useful, the data collected, analyzed, and ultimately reported during a research effort must be both relevant to the research questions and correct. Validity and reliability are two crucial aspects of correctness. Ideally, research instruments should be reliable, valid, relevant, and sensitive. However, in the social sciences, few researchers are able to meet all of these criteria (Selltiz, Wrightman, and Cook, 1976).

Synonyms for reliability include consistency, dependability, stability, and predictability (Kerlinger, 1964; Henerson, Morris, and Fitz-Gibbon, 1978). Basically, an instrument (or procedure) is

reliable if it repeatedly yields similar results. Several factors often classified as either constant or random errors are known to influence reliability (Selltiz, Wrightsman, and Cook, 1976). According to Selltiz, a constant error is "one introduced into the measurement by some factor that systematically affects the characteristic being measured or the process or measurement". (Selltiz et. al., 1976, p. 168). For example, in this study, the well known "social desirability" influence, which is the tendency to present a favorable picture of oneself, might result in physicians indicating responsibility for an exaggerated number of tasks.

A random error is one resulting from a transient aspect of the person's views, situation, or procedures (Selltiz, 1976). These are likely to vary from one act of measurement to another, despite stability of the characteristic of interest. Feeling ill, excessively stressed, or angry are examples of situations that result in a random error.

Specifically, this survey attempted to establish reliability in the following manner. The questions were written as unambiguously as possible. All respondents received the instrument the same way (via mail), and the same detailed instructions approved on all surveys. The survey asks questions dealing with

either personal factual information or information about the work place. According to the literature, this type of information is highly reliable (Blalock, 1972; Selltiz et. al., 1976; Henerson et. al., 1978).

The validity of an instrument is a more complex concept than reliability. It is defined as "the extent to which differences in scores on it [the instrument] reflect true differences among individuals on the characteristics that we seek to measure, rather than constant or random errors." (Selltiz et. al, 1976, p. 169). The concept is epitomized by asking: are we measuring what we think we are measuring? (Kerlinger, 1964). In this study, the question is: are we measuring physician managers' responsibility for specific tasks?

There are numerous classifications of validity, but traditionally three are discussed: content, criterion-related, and construct. Content validity addresses whether or not the the instrument provides an adequate representation of the kind of behavior with which it is concerned (Kerlinger, 1964; Isaac, 1978). It requires "careful consideration of exactly what the behavior is that one wishes to measure and of the variety of ways in which it might be measured" (Selltiz, 1976, p. 179).

It seems generally accepted that judgment

plays a key role in establishing content validity. That is, each item on a test instrument must be judged by competent judges for its presumed relevance to the property being measured (Kerlinger, 1964).

Criterion-related validity focuses on the issue of predictability. Interest is not on what the test measures but how well the instrument compares with external variables that are considered to be direct measures of the characteristic or behavior in question (Isaac, 1978). Therefore, it follows that to achieve criterion-related validity, it would be necessary to compare test scores with one or more criteria known to measure the attribute of interest. One example of the importance of establishing criterion-related validity is the use of tests as predictors of some specific behavior, such as the likelihood of applicants to succeed in certain jobs. Since physician managers are not generally subjected to testing prior to being offered their jobs, criterion-related validity is not of concern in this study.

Construct validity addresses the question "to what extent do certain exploratory concepts or qualities account for performance on a test. . ." (Isaac, 1978, p. 82). Construct validity is needed when the investigator is interested in using the test performance as, "a basis for inferring the degree to which

the individual possesses some characteristic or trait. . . . presumed to be reflected in the test performance". (Selltiz, 1976, p. 173). These traits are abstractions or constructs, such as intelligence or attitude toward war, not specific behavior. The method used for validating this kind of instrument involves setting up hypotheses regarding the behavior of persons with high or low test scores and then testing the hypothesis in another research situation (Isaac, 1978).

Although all research efforts require that reliability and validity be addressed, it is generally agreed that the intended use of a test should determine what kind of evidence is required. It is this distinction, between intended use and the nature of a test, that is pivotal for this study. The intention here is not to predict future behavior, to classify persons according to personality traits, or to account for test results. Instead; the focus is on finding out more about the nature of the job held by a group of physician managers. Therefore, establishing content validity seems to be the most reasonable demand on the study.

To ensure content validity, a panel of experts who are physician managers and members of AAMD reviewed each item on the survey. These experts



determined that no important questions were omitted and that the survey reflected a balanced picture of the physician manager's job. Further, the survey provided the respondents with an opportunity to add any work done that was not included in the task list.

In addition, validity was considered in the manner in which the data were analyzed and reported. Inferences or descriptions of associations are made only about the physician managers in the surveyed population. No predictions about individuals are made. In short, measures considered to be appropriate for this study were taken in order to minimize error and maximize both reliability and validity.

In general, survey research may have unique advantages with respect to reliability and validity. First, it has been shown that the reliability of test items dealing with personal factual information is high (Henerson, et. al, 1978). Second, although the reliability of attitudes is more difficult to determine, the reliability of average responses is higher than that of individual responses. Third, the use of survey research can permit the researcher to check the validity of the survey data with repeated interviews of the respondents and/or with outside criteria (Kerlinger, 1964; Isaac, 1978; Henerson et. al., 1978).

For example, it would be possible to ask a physician manager if he/she is responsible for a specific task, such as reviewing the budget for the organization. Others in the organization could then be asked if the physician manager is responsible for that task. Finally, during the process of constructing the survey instrument, questions can be examined by any number of experts or judges to ensure content validity.

Steps in Developing the Survey. In order to describe the job of physician managers, it was necessary to have a survey instrument which would 1) present the appropriate choice of tasks for physician managers, 2) assess the respondent's responsibility for the task, 3) measure the frequency with which the task was performed, and 4) measure the respondent's perception of the tasks important to the organization.

Having responsibility for a task is different from performing that task. Therefore, for each task, responsibility and frequency of task performance were treated as separate dimensions. Asking about the perception of the task's importance to the organization was suggested by work on organizational effectiveness. Goodman and Rennings (1979) proposed that to maximize effectiveness, organizations need to specify

tasks performed and then decide, among other things, the relative importance of those tasks to the overall objectives of the organization.

The specific steps in the development of the survey instrument included:

1. The development of the task list and other questions on organizational and personal characteristics.

2. Consultation with experts.

3. Pre-test of initial instrument.

4. Revisions as a result of the pre-test.

The development of the task list (dependent variables) and other questions on organization and personal characteristics (independent variables) have already been described.

After drafting the survey instrument, a meeting was held with the executive directors of AAMD. These physicians, all of whom are managers, first completed the instrument and subsequently reviewed and discussed each question. A second draft of the survey was then prepared and pre-tested among sixty-five members of AAMD. The pre-test was administered personally by the executive director of AAMD during a physician-in-management seminar. Of those who received it, 42 (64%) completed and returned the survey.

Based on the responses and suggestions

received from the pre-test, several minor changes were made. For example, the average amount of time required for completion of each section was included in the directions presented before each section. Other modifications included enlarging the print and attaching a cover letter to each survey.

Mechanics of Administering the Survey. The final survey instrument accompanied by a cover letter from the executive director was mailed to the entire 893 membership of AAMD during May, 1983. (See Appendix A for the complete survey instrument). In June, with a response rate of 46 percent, a follow-up letter from the executive director was mailed. By July, 1983, when the data collection deadline was reached, a total of 502 surveys had been received, representing a response rate of 56 percent.

#### Description of Survey

The final survey instrument contains four sections, each with a distinct focus. Table 3.2 illustrates the major issues addressed. Part One asked questions about personal background and training, including the following: (1) area of clinical specialty, (2) status on the medical staff, (3) education in management, (4) general experience, (5) helpfulness

TABLE 3.2  
MAJOR ISSUES ADDRESSED IN EACH  
SECTION OF SURVEY INSTRUMENT

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SECTION ONE - PERSONAL CHARACTERISTICS

1. General demographic information (age, sex).
2. Area of clinical specialty
3. Status on medical staff (e.g., active, inactive, courtesy, etc.)
4. Education in Management
5. General Experience
6. Helpfulness of education and/or experience
7. Current position (years in, method of selection, full/part time, etc.)
8. Arrangement between physician and organization with regard to contract, job description and evaluation.
9. Professional commitments (e.g., private practice).
10. Job satisfaction

SECTION TWO: ORGANIZATIONAL VARIABLES

1. Title
2. Type of Organization
3. Formal and informal reporting/communication arrangements
4. Line/Staff
5. Authority/influence
6. Organizational size

SECTION THREE: COMPENSATION

1. Time devoted to management
2. Salary
3. Bonuses and benefits
4. Time off
5. Total compensation

Table 3.2 (continued)

MAJOR ISSUES ADDRESSED IN EACH  
SECTION OF SURVEY INSTRUMENT

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SECTION FOUR: TASK LIST

For each task the respondent was asked three questions:

1. Whether or not he/she had responsibility for the task as part of the job.
2. How often he/she performed the task.
3. How important he/she perceived the task to be to the overall effectiveness of the organization.

The tasks were grouped under the following categories:

- a. Policy management tasks inside organization
  - b. Policy management tasks outside organization
  - c. Program management tasks
    - (1) Quality assurance
    - (2) Education
    - (3) Risk management
  - d. Resource management tasks
    - (1) Data management
    - (2) Financial management
    - (3) General management
    - (4) Resource management
-

of education and experience, (6) years in current position, (7) method of selection, (8) full or part time, (9) arrangements between physicians and organizations with regard to contracts, (10) job descriptions and evaluations, (11) professional commitments, and finally, (12) job satisfaction.

Part Two asked questions about the organization, such as: (1) title, (2) type of organization, (3) formal and informal reporting/communication arrangements, (4) line/staff designation, (5) amount of authority/influence, and (6) organization size.

Section Three focuses on compensation and asks the physician about (1) the amount of time devoted to management, (2) salary, (3) bonuses, (4) benefits, (5) time off, and (6) total compensation.<sup>2</sup>

Section Four contains 86 tasks grouped under the following categories: (1) policy management tasks inside the organization, (2) policy management tasks outside the organization, (3) program management tasks, and (4) resource management tasks.

As previously mentioned, three dimensions were investigated for each task listed:

1. Responsibility: Respondents were asked if they had responsibility for the task in their organization. The response choices were Yes, No, or Not Applicable (N/A). Instructions on the survey

indicated N/A was the appropriate answer if the task did not apply to the respondent's work situation. If the respondent shared responsibility for the task, he/she was instructed to mark Yes.

2. Frequency of occurrence: This was separated from responsibility because managers may in fact perform tasks for which they are not formally responsible or vice-versa. Response choices for frequency were: Rarely, Occasionally, Frequently, and Very Frequently.

3. Importance to the organization: This last dimension was developed to gain insight into how physician managers perceived the importance of the various tasks for which they were responsible. Choices were: not very important, somewhat important, very important.

#### Data Analysis

In non-experimental research, such as this study, there are a number of approaches to analyzing the data. A positivist approach was selected, which suggests that when data are qualitative, they can be refined and quantified and/or categorized (Selltiz, 1976). This approach implies the use of a variety of techniques and statistical methods, which order and summarize findings to perform statistical analysis.



As the questionnaires were received, several steps were taken: (1) they were examined for completeness, (2) any additional comments by respondents were recorded, (3) responses were subjected to preliminary editing, and (4) they were coded for keypunching. Inspection of the raw data was instructive.

For example, early in the study, the issue of importance was considered. However, for a variety of reasons, this was rejected and further analysis was limited to responsibility and frequency. In addition, on several questions the respondents were instructed to select only one answer or answer only one group of questions which related to the type of organization in which they worked. Despite these instructions, approximately 17 percent of the physicians answered more than one group of questions. This fact required subjective judgements and influenced the way in which questions were coded.

Finally, the comments and additional tasks that were added to the Task List were of interest from a phenomenological perspective. For example, notes of encouragement with positive feedback were common, as were requests for copies of the summarized results and detailed explanations of various answers.

Once the initial editing was completed, data from the entire population were examined. As

mentioned earlier, AAMD members are affiliated with a wide variety of organizations. A general profile of the repondents' affiliations was developed.

Next, three organizational categories were defined: hospital, physician organization, and "other". Respondents who indicated that their primary affiliation was in one of the following settings were included: general hospitals (university-based), general hospitals (non-university-based), specialty hospitals (university-based), specialty hospitals (non-university-based). Only respondents from long-term care hospitals (.8 %) were excluded from analysis.

The physician organization group was obtained in the same manner. Respondents who indicated their primary affiliation was in any of the following were included: single-specialty group practice, single-specialty group practice with over 50 percent associated with a health plan, multi-specialty group practice, multi-specialty group practice with over 50 percent associated with a health plan, multi-specialty with less than 50 percent associated with a health plan, staff (or group) model prepaid health plan (PPHP), or independent practice association (IPA).

Respondents from any other type of organization were grouped in a third or "other" category, consisting of such organizations as: long-term care

hospitals, nursing homes, industrial organizations, pharmaceutical companies, government agencies, military services, and community health centers.

#### Analysis of Physician Manager Responsibility

This study employs univariate analyses to examine the tasks for which physician managers are responsible. Within each type of organization physician manager responsibility for the tasks was analyzed in the following ways: First, the percentage of physicians within hospitals and physician organizations who are responsible for each of the 86 tasks was calculated. Second, the tasks were ranked according to this percentage of responsibility. Third, the ranked tasks were examined within the management function categories, Policy Management, Program Management and Resource Management. Fourth, comparisons were then made between the hospitals and physician organizations. Fifth, in order to examine how responsibility for the tasks differed, a Spearman's rank correlation coefficient was computed. This measured the degree of relationship between the two sets of ranked items for task responsibility.

Analysis using chi-square was then performed in order to assess the extent of association between the independent and dependent variables. Core tasks

were selected from among all of the 86 tasks as being most representative of the tasks for which physician managers are responsible. A factor analysis was used to select this subset of ten tasks.<sup>3</sup> Crosstabulations were then done on the ten tasks by each of the independent variables.

#### Analysis of Frequency of Task Performance

Prior to analyzing the frequency dimension, the responses Frequently and Very Frequently were collapsed into one category. This was done in order to provide a more general sense of how often physician managers performed the tasks. This new category is termed Often in the following discussion.

The responses of physicians answering either "Yes" or "No" for responsibility were included in the frequency analyses, since responsibility and performance are separate variables. Physicians responding "No" to the responsibility question were included, because there were some tasks where some physicians answered that they performed the task "often" despite their "No" response. People responding "N/A" on the responsibility variable were not included in the analysis.

Within each type of organization, frequency of performance was analyzed in a manner similar to

responsibility. The proportion of physicians performing each task often was calculated. Tasks were then ranked within the management function categories. A Spearman's rank correlation coefficient was then computed to measure the degree of relationship, within each type of organization, between responsibility and frequency.

## NOTES - CHAPTER III

1. Physicians are generally recognized as occupying positions of cultural authority, economic power, and political influence. No group has ever held a more dominant position in our society. Unlike the other classical professions, law and the clergy, the medical profession maintains close bonds with modern science, which also enjoys privileged status. In addition to the association with scientific knowledge, physicians come into direct and intimate contact with people, are present at critical transitional moments of life, and serve as intermediaries between the world of science and private experience (Starr, 1982).

2. This study did not address the compensation aspect of the job of physician manager. The questionnaire included it at the request of AAMD.

3. A Q-type factor analysis was used to select a core group of representative tasks. An orthogonal solution was obtained, and the ten tasks with the highest loadings were selected. Categorized by management function these are as follows:

#### Policy Management Tasks

#5, Deciding which programs and medical services the organization, department/service, or agency offers.

#6, Deciding the size of programs and medical services.

#13, Monitoring and reporting on issues of interest of administration to medical staff.

#33, Promoting the organization, department/service, or agency.

#### Program Management Tasks

#40, Ensuring that a system for review and evaluation of medical staff competency operates effectively.

#60, Designing new or modifying existing risk management functions and/or programs.

### Resource Management Tasks

#51, Monitoring and reporting on data from systems designed to obtain information about medical care.

#55, Designing ways to improve efficiency of professional departments within the organization or agency.

#68, Designing contracts for physicians.

#82, Advising and/or counseling physicians on career or professional issues.

## CHAPTER IV

### FINDINGS

This chapter presents the findings of the study, beginning with a description of the 502 physician respondents.<sup>1</sup> Next, results of the analysis pertaining to physicians in hospitals, physicians in physician organizations, and comparisons between the two groups are presented. Finally, findings from the chi-square analysis are discussed.

#### Characteristics of Physician Manager Members of AAMD

Characteristics of a typical member of the American Academy of Medical Directors (AAMD) are illustrated in Table 4.1. The most typical physician manager is a 53-year-old, Board-certified, male internist.<sup>2</sup> He has been in practice over 16 years, and in his current full-time managerial position for over five years. Before being selected for this position, more than half of the respondents were already employed by the organization. After assuming his current position, he is not likely to maintain a private medical practice. On the average, fewer than two



TABLE 4.1  
CHARACTERISTICS OF SURVEY RESPONDENTS (N=502)

	n
Sex: Male n=479 (96%) Female n=20 (4%)	499
Age: Average = 53 years (Range: 31-76 years)	487
Clinical Specialties:	502
Internal Medicine 29.1% Physical Med. & Rehab. 2.6%	
Family Practice 14.3% Anesthesiology 1.8%	
Pediatrics 12.0% Radiology 1.8%	
Other <sup>1</sup> 10.8% Emergency Medicine 1.6%	
General Surgery 7.0% Orthopedics 1.4%	
Ob/gyn 5.6% Pathology 1.2%	
Psychiatry 5.2% Otolaryngology 1.0%	
Preventive Medicine 3.4% Urology 1.0%	
Board certification in area of specialization: 79.4%	502
Number of years in medical practice: average 16.7 years (Range 0-42 years)	485
Number of years in current position: average 5.4 years (Range 0-35 years)	489
53.5% were working for the organization before assuming current position.	502
70% consider jobs full time. 30% consider job part time.	502
43.6% maintain a private medical practice.	493
86% are either somewhat satisfied or very satisfied with their job.	494

Note: Respondents include physicians in all types of organizations.

<sup>1</sup>

For list of "others" see Appendix C, p.272

persons preceded him in the job. The vast majority of respondents (86%) reported being satisfied with their jobs.

#### Experiences Found Helpful

As can be seen in Table 4.2, almost all respondents (99%) had both an internship and residency. In addition, the vast majority (95%) had experience in a medical practice, and most felt this experience was helpful in preparing them for their current positions. Although about 83 percent of the physicians had some management education, only about 61 percent of them felt this had been helpful in preparing them for their positions. The majority of the physicians served in the armed forces, (65%), but only 40 percent found this experience to be helpful.

Focusing on the respondents with formal managerial training, 78 percent participated in continuing education programs.<sup>3</sup> These seminars, courses, or workshops, were sponsored by a variety of groups and organizations, including AAHD, the military, and the American Hospital Association (AHA). Other types of managerial training included the following: graduate courses in a university-based management or business program, Master's in Public Health, Master's in Business Administration, Master's in Health Administration,

TABLE 4.2  
EXPERIENCES FOUND HELPFUL IN PREPARATION  
FOR CURRENT POSITION (N=502)

EXPERIENCE	PERCENT WITH EXPERIENCE	PERCENT WITH EXPERIENCE WHO FOUND IT HELPFUL <sup>1</sup>
Clinical experience of internship and residency	99.4	62.4
Organizational or supervisory experience of internship/residency	99.4	59.8
Clinical aspects of medical practice	95.4	82.6
Managerial aspects of medical practice	95.4	81.1
Formal management education <sup>2</sup>	82.8	60.7
Voluntary management experience	81.8	75.5
On-job training	81.3	75.5
Armed services	65.2	39.6
Paid management experiences (other than practice)	63.0	55.2
Business experience	35.2	38.2
Other paid organization work	19.4	22.9

<sup>1</sup> For this Table, the responses "Helpful" and "Very Helpful" were combined.

<sup>2</sup> Formal management education included the following:

Undergraduate degrees in management or administration  
Masters in Public Health  
Masters in Business Administration

Masters in Health Admin.  
Graduate courses in university based mgmt.  
Continuing ed. in mgmt.  
Other

and undergraduate degree in management or administration.

### Work Arrangements

An examination of the various managerial arrangements between this group of physicians and their organizations reveal that about 64 percent have written contracts or memoranda of understanding with the organization. <sup>4</sup> Approximately 77 percent have a written job description, which the majority (56%) wrote themselves. The chief executive officer wrote 41 percent, and the board of trustees wrote 20 percent. Formal evaluations of job performance occur for more than half of the survey respondents, and the majority (87%) of these are annual.

The type of organization within which AAMD members most frequently work is the non-university-based general hospital. As can be see in Table 4.3, this type of hospital accounted for almost 38 percent of the affiliations reported. Other types of hospitals, specialized hospitals, and long-term care hospitals, accounted for over 16 percent of the respondents' affiliations. Over 54 percent of the respondents reported some type of hospital to be their primary organizational affiliation.

TABLE 4.3  
 ORGANIZATIONAL AFFILIATION OF  
 SURVEY RESPONDENTS (n=498)

TYPE OF ORGANIZATION	PERCENT
HOSPITALS (n=270)	
General hospital (non-university based)	37.8
General hospital (university based)	6.8
Specialty hospital (non-university based)	6.6
Specialty hospital (university based)	2.2
Long-term care hospital	0.8
PHYSICIAN ORGANIZATIONS (n=122)	
Multi-specialty group practice	7.0
Staff (or group) model pre-paid health plan	6.4
Multi-specialty group practice with less than 50% associated with a health plan	5.0
Multi-specialty group practice with over 50% associated with a health plan	2.8
Single specialty group practice	2.2
Independent practice association	0.8
Single specialty group practice with over 50% associated with a health plan	0.2
OTHER (n=106)	
<sup>1</sup> Other	8.6
Government agency	4.0
Military	3.8
Industrial organization	2.2
Pharmaceutical company	1.0
Nursing home	0.8
Community health center	0.8

<sup>1</sup> For List of "others" See Appendix C, p. 278

Less than half (41%) of the hospitals within which physicians worked had a national or regional affiliation. Of those who did report an affiliation, 74 percent were affiliated with Catholic hospitals and 24 percent with the military, thus accounting for 98 percent of the affiliations.

The average number of physicians on the medical staff of hospitals was reported to be 332.<sup>5</sup> The average number of full-time physicians employed by the organization was 40, and the average number of full-time physicians on contract was 13.<sup>6</sup> The average number of licensed beds was 424 and the average number of ICU beds was 31.

Physician organizations accounted for about 26 percent of respondents' affiliations. These include multi-specialty group practices with or without a prepaid health plan association, representing almost 15 percent of the total response; staff or group model prepaid health plan accounted for 6 percent; single-specialty group practices, representing less than 2.5 percent; and Individual Practice Associations (IPAs) accounting for less than 1 percent of affiliations. No respondents reported being affiliated with a single-specialty group practice with less than 50 percent association with a prepaid health plan. The average number of full-time physicians in group practice was

56, with 10 as the average number of part-time physi-  
<sup>7,8</sup>  
 cians in the group. The average number of full  
 time non-physician employees in the group was reported  
<sup>9</sup>  
 as 325.

Of the organizations with any type of prepaid  
 health plan, 57 percent had no national or regional  
 affiliation. Of the 43 percent that did claim an  
 affiliation, there was no large grouping in categories  
<sup>10</sup>  
 as there was for hospitals.

Those organizations with a staff model prepaid  
 health plan had an average of 33 full-time physicians,  
 67 part-time physicians, and 202 non-physician full-  
 time employees. Of the 0.8 percent of the total AAMD  
 respondents reporting their primary organization asso-  
 ciation to be an IPA, the average number of participa-  
 ting physicians was 102.

Other types of health care organizations in-  
 clude nursing homes, industrial organizations, pharma-  
 ceutical companies, government agencies, military  
 community, health centers, and miscellaneous types.  
 Here the average number of full-time physicians was  
<sup>11</sup>  
 82. The average number of part-time physicians was  
<sup>12</sup>  
 25 and the average number of non-physician full-time  
<sup>13</sup>  
 employees was 532.

It is important to emphasize that despite a  
 choice of nineteen different types of health care

organizations, a relatively large percentage of respondents (8.6%) felt the organization in which they worked did not fit into any of the established categories. In actual count, this represents 32 "other" types of organizations.<sup>14</sup>

The job titles held by AAMD members who responded to the survey are presented in Table 4.4. Medical directors of organizations represented over 34 percent of the respondents and were the largest single group reported. The remaining titles ranged from vice president of medical affairs, at 13 percent, to assistant medical director, at 2 percent. The "other" category for title, while smaller than for organization type, was still considerable, at over 5 percent. (See Appendix C, p. 277).

Whether a physician manager holds a line or staff position is an organizational issue addressed in the survey. When "line" and "mostly line" categories are combined, over 70 percent of the survey respondents held line positions within their organizations. Further, almost 80 percent felt their positions should be line. This issue will be discussed further in Chapter V.

When responses to the questions on authority and influence are compared, it is clear that these physicians perceive themselves to have much more



TABLE 4.4

## JOB TITLES REPORTED BY SURVEY RESPONDENTS (n=499)

TITLE	PERCENT OF RESPONDENTS	n
Medical director of an organization	34.5	172
Vice president of medical or professional affairs	12.8	64
Chief executive officer	12.0	60
Medical director of a service, department or program	10.0	50
Director of medical affairs	8.2	11
Chairman or chief of department or service	7.2	36
Chief of staff	3.4	17
Clinical director of department, service, or program	2.2	11
Director of medical education	2.2	11
Assistant medical director	2.0	10
<sup>1</sup> Other	5.4	27

<sup>1</sup>  
For list of "others" see Appendix C, p. 277

influence than authority.<sup>15</sup> While 57 percent of them said they felt they had a great deal of formal authority, 72 percent said they felt they had a great deal of influence.<sup>16</sup> Further, while 2 percent claimed to have almost no formal authority, only 0.2 percent claimed to have almost no influence. Other data from the survey support these findings. Less than 30 percent of the respondents reported having a vote on the governing board. Slightly more (37%) were board members, while a much higher number (73%) attended Board meetings but had no vote. Therefore, it may be that the presence and presumed participation at board meetings of respondents resulted in their influence being greater than their authority. This issue is discussed further in Chapter V.

Although compensation and benefits for physician managers is not a major focus of this study, information regarding these issues was obtained at the request of the sponsoring organization. Table 4.5 presents a summary of the financial profile for AAID members who responded to the survey. The average salary for 1982 was \$80,561.<sup>17</sup> The average bonus from the organization was \$5,628. The average share of profits or dividends was \$2,540, and the average annual pension and retirement was \$8,742. The sum of

Table 4.5

1

SUMMARY FINANCIAL PROFILE OF SURVEY RESPONDENTS

TYPE OF COMPENSATION	n	Average amount
Annual salary	482	\$80,561
Amount received in bonuses from organization	465	\$ 5,628
Total share of profits or dividends	448	\$ 2,540
Annual amount of pension and retirement pay con- tributed by organization	448	\$ 8,742
Average total compensation	383	\$97,471

<sup>1</sup>All responses are based on 1982 figures.

these figures result in an average total compensation of \$97, 471.

In addition, respondent's organizations paid for the following extra benefits: malpractice insurance, health insurance, life insurance and disability insurance. Other benefits reported included an average of three and one-half weeks of paid vacation, and nine days of paid educational leave per year. The average number of hours per week devoted to management activities was about 35 hours.

### Tasks

The task list, as presented to respondents, appeared to be relatively complete. Respondents were given the opportunity to add any tasks they performed that they perceived to be omitted from the list. Relatively few tasks were added (n=27), and those that were seemed to be uniquely associated with the organization and/or position held by the physician. For example, one respondent was required to fly four hours<sup>18</sup> per month.

The frequencies with which respondents are responsible for each task are presented in Appendix B. There were no tasks unchecked, suggesting that all the tasks are relevant to the job of some physician managers. The range of response was from 94 percent

(preparing new or modifying existing policies or procedures) to 8 percent (negotiating with unions).

The 10 tasks for which the highest percentage of physicians are responsible is shown on Table 4.6. For purposes of comparison, the 10 tasks for which the fewest percentage of physicians are responsible is presented in the same table. Nine of the 10 tasks for which the highest percentage of physicians are responsible are considered policy management functions. One task is considered a resource management function. There is more variation among the tasks reported with low frequency. Three are policy management, three are program management, and four are resource management tasks.

#### Physician Managers in Hospitals and Physician Organizations

After the initial analysis of responses for all physicians who returned the survey, data from physicians in "other" types of organizations were excluded. This left data from physician managers in hospitals and physician organizations for further analysis. As discussed in Chapter III, the hospital group included: general university-based and non-university-based hospitals. The physician organization group included: single specialty group practices alone, with, and without a 50 percent association with

TABLE 4.6

TASKS FOR WHICH SURVEY RESPONDENTS ARE  
MOST AND LEAST RESPONSIBLE (n=502)

MOST		LEAST	
TASK	PERCENT	TASK	PERCENT
POLICY MANAGEMENT		POLICY MANAGEMENT	
Preparing policies or procedures	93.6	Representing org. to third-party payors	31.2
Designing or reviewing new programs	91.4	Lobbying regulatory agencies	26.5
Communicating info. to med. staff and governing body of the organization	88.3	Chairing board comm.	18.1
POLICY MANAGEMENT		PROGRAM MANAGEMENT	
Preparing goals and objectives for the org.	87.7	Teaching CE pgms. to non-physicians	30.7
Monitoring and reporting to administration issues of interest to med. staff	87.6	Designing CE pgms. for non-physicians	27.1
Monitoring and reporting to med. staff issues of interest to administration	84.3	Designing general educational pgms.	15.3
POLICY MANAGEMENT		RESOURCE MANAGEMENT	
Attending medical staff committees	83.7	Supervising construction projects	25.2
Attending administration committees	80.9	Designing contracts for non-physicians	18.3
Deciding on programs and med. services	80.5	Designing wage/benefit schedules for non-physicians	12.9
RESOURCE MANAGEMENT		RESOURCE MANAGEMENT	
Mediating conflict among physicians	78.6	Negotiating with unions	8.0

a health plan; multi-specialty group practices alone, with, and without a 50% percent association with a health plan; staff (or group) model prepaid health plan; and IPAs.

The findings for physicians in hospitals and physician organizations are presented separately. First, descriptive findings for each of the two groups with regard to personal characteristics are discussed. Next, analysis of task responsibility and frequency of performance is described. Finally, comparisons between the two groups are presented.

#### Physician Managers in Hospitals

As shown in Table 4.7, physician managers in hospitals are more likely to be male (95%) than female (5%). This finding corresponds to that for all physician respondents, 96 percent of whom were male, and 4 percent of whom were female. The average age for these physicians is 54 years.

The percentage of physicians in the various specialties is similar to those shown for all survey respondents. Internal medicine is the predominant specialty (28%). This may be compared to the national proportion of 15 percent of all practicing physicians listed as as specialists in internal medicine in 1980 (Bureau of Census, 1980). The reasons why internal

TABLE 4.7

## CHARACTERISTICS OF SURVEY RESPONDENTS IN HOSPITALS

	n
Sex: Male n=255 (95.1%)      Female n=13 (4.9%)	268
Age: Average = 54 years      (Range: 34-74 years)	261
Clinical specialties:	265
Internal medicine 27.9%      Anesthesiology 3.0%	
Family practice 15.8%      Emergency medicine 2.6%	
Pediatrics 10.9%      Orthopedics 2.3%	
Other 8.7%      Pathology 1.9%	
General surgery 6.4%      Radiology 1.9%	
Psychiatry 6.4%      Urology 1.1%	
Ob/gyn 5.7%      Preventive med. 0.4%	
Physical medicine 4.9%	
Board certification in area of specialization: 81%	268
Number of years in medical practice: Average 17 years (Range 0-41 years)	263
Number of years in current position: Average 6 years (Range 0-30 years)	263
45.7% were working for the organization before assuming current position.	267
74.5% consider job full time. 25% consider job part time.	267
45.7% maintain a private medical practice.	267
85.8% are either somewhat satisfied or very satisfied with their job.	267



medicine being the predominant specialty in this group of physician managers were not explored in this study.<sup>19</sup>

Boards represent the highest level of credential for specialists. The vast majority (81%) of physician managers in hospitals have passed the boards in their area of specialization. This finding is consistent with what the literature suggests about physician managers in general, that they are most often selected because they are good clinicians, not because they have demonstrated management skills (Schenke, 1976; Wood, 1980). Another indication of the importance of their continuing in clinical practice is the finding that although 75 percent of these physicians consider their job to be full time, about 47 percent continue to maintain a private medical practice.

Physician managers in hospitals have been in medical practice an average of 17 years, and in their current position for an average of six years. While this survey did not ask what these physicians were doing prior to assuming their current job, it is likely that they were engaged in some form of medical practice. The majority of these physician managers have written contracts with the hospital (69.0%) and have written job descriptions (83%). A smaller number

(56%) have formal job evaluations. Most of these physicians (86%) reported being either somewhat satisfied or very satisfied with their jobs.

Responsibilities. There are no tasks for which 100 percent of physician managers working in hospitals are responsible. Neither are there any tasks for which zero percent are responsible. For all of the tasks, "No" was selected as a response more frequently than N/A.<sup>20</sup>

Table 4.8 shows the 10 tasks for which the highest and lowest percentage of physicians have responsibility. These tasks are grouped by management function category. Of the tasks reported with the highest frequency, eight of the 10 are considered policy management and two program management. An analysis of these tasks revealed that one-half deal directly with the medical staff. While the language of the remaining one-half does not specify "medical staff," an association is likely. For example, physician managers who are responsible for assuring accreditation with JCAH are likely to be performing functions associated with physician activity. When physician managers are preparing policies or procedures, these are probably dealing with medical care or physicians.

TABLE 4.8

TASKS FOR WHICH PHYSICIAN MANAGERS IN HOSPITALS  
ARE MOST AND LEAST RESPONSIBLE

MOST		LEAST	
TASK	PERCENT	TASK	PERCENT
POLICY MANAGEMENT		POLICY MANAGEMENT	
Attending medical staff committees	95.1	Deciding prices for services	26.4
Monitoring and reporting to administration issues of interest to medical staff	93.7	Lobbying regulatory agencies	24.2
Preparing policies or procedures	93.3	Chairing board comm.	9.3
Communicating information to medical staff and governing body	92.1	PROGRAM MANAGEMENT	
Designing or reviewing new programs	90.1	Designing CE pgms. for non-physicians	25.4
Monitoring and reporting to med. staff issues of interest to administration	89.8	Designing general educational pgms.	12.0
Attending administrative committees	87.8	RESOURCE MANAGEMENT	
Preparing goals and objectives	85.6	Obtaining consulting services	27.2
PROGRAM MANAGEMENT		Supervising construction projects	20.3
Ensuring accreditation	88.4	Designing wage/benefit schedules for non-physicians	13.0
Ensuring system for review and evaluation of med. staff competency exists	85.7	Designing contracts for non-physicians	12.6
		Negotiating with unions	6.8

An examination of the tasks for which the lowest percentage of physician managers are responsible reveals three tasks considered policy management, two program management and five resource management. An analysis of these tasks shows that none deals with the medical staff or physicians. Half of these tasks do involve financial aspects of management (e.g., deciding pricing for services) and two tasks relate to designing educational programs for non-physicians.

Tables 4.9 through 4.11 illustrate the tasks for which 75 percent or more of physicians in hospitals are responsible. As these three tables show, 11 (52%) of the 21 tasks represented are policy management, six (28.%) are program management, and four (19%) are resource management tasks. An analysis of these tasks reveals that 15 out of the 21 tasks (71%) deal with physician-related activities.

There are only two tasks for which less than 10 percent of physician managers are responsible. Neither deals with physicians. One, (9%) chairing board committees is a policy management task. The other, negotiating with unions (0.8%) is a resource management task.

Frequency of Occurrence. Similar to responsibility, all of the tasks were performed by some

TABLE 4.9

POLICY MANAGEMENT TASKS FOR WHICH MORE THAN 75%  
OF PHYSICIANS ARE RESPONSIBLE IN HOSPITALS

TASK	% OF PHYSICIANS RESPONSIBLE
Attend medical staff committees	95.1
Monitoring and reporting on issues of medical staff to administration	93.7
Preparing policies or procedures	93.3
Communicating information to medical staff and governing body of organiza- tion	92.1
Designing or reviewing new programs	90.1
Monitoring and reporting to medical staff issues of interest to adminis- tration	89.8
Attending administrative committees	87.8
Preparing goals and objectives for organization	85.6
Preparing agenda items for medical staff meetings	80.9
Ensuring standards of care are written and disseminated	76.8
Deciding on programs and medical services for organization	76.1

TABLE 4.10

PROGRAM MANAGEMENT TASKS FOR WHICH MORE THAN 75%  
OF PHYSICIANS ARE RESPONSIBLE IN HOSPITALS

TASK	% OF PHYSICIANS RESPONSIBLE
Ensuring accreditation	88.4
Ensuring system for review and evaluation of medical staff competency exists	85.7
Ensuring system for review and evaluation of medical staff competency operates effectively	83.4
Designing programs to compare physicians' behavior to established standards of care in organization	82.8
Ensuring system for review and evaluation of credentials for new physicians exists	82.6
Ensuring data relevant to medical care issues are used appropriately	80.0

TABLE 4.11

RESOURCE MANAGEMENT TASKS FOR WHICH MORE THAN 75%  
OF PHYSICIANS ARE RESPONSIBLE IN HOSPITALS

TASK	% OF PHYSICIANS RESPONSIBLE
Mediating conflict among physicians	84.3
Mediating conflict among physicians and non-physician personnel	83.5
Mediating conflict among physicians and administration or governing body	78.4
Reviewing budget (or part)	75.2

physicians. Conversely, there were no tasks performed by 100 percent of the physicians. In addition, every task is performed by some physicians, even when not officially responsible for the task. As previously discussed, the choices "frequently" and "very frequently" were combined for this analysis and are called "often" in their combined form.

The data indicate that only seven of the 86 tasks (8%) are not performed "often" by at least some of the physicians, despite their not being responsible for the task. In other words, even when "No" is selected as a response to the responsibility question 92 percent of the tasks are performed "often" by some physicians. However, when "N/A" was selected, only 25 percent of the tasks were performed often.

The 10 tasks physicians perform most and least often are shown in Table 4.12. Of the tasks performed most often, seven are policy management and three are program management. Of those performed least, one is policy management, three are program management, and six are resource management functions.

A Spearman's correlation coefficient was calculated to measure the association between tasks for which physicians in hospitals are responsible and those they perform often. A coefficient of .6456 was obtained, indicating a positive relationship. That



TABLE 4.12

TASKS PHYSICIAN MANAGERS PERFORM MOST  
AND LEAST OFTEN IN HOSPITALS

MOST		LEAST	
TASK	PERCENT	TASK	PERCENT
POLICY MANAGEMENT		POLICY MANAGEMENT	
Attending medical staff committees	86.0	Chairing bd. committees	14.3
PROGRAM MANAGEMENT		PROGRAM MANAGEMENT	
Monitoring & reporting to administration issues of interest to medical staff	81.5	Teaching CE programs non-physicians	16.9
Communicating information to med. staff and governing body	80.8	Designing general educational programs	13.6
Monitoring & reporting to medical staff issues of interest to administration	75.9	Monitoring risk management programs	12.2
PROGRAM MANAGEMENT		RESOURCE MANAGEMENT	
Preparing agenda for medical staff	73.5	Designing wage/benefit schedules for physicians	15.1
Attend admin. comm.	69.1	Advising physicians on professional issues	15.0
Prepare policies or procedures	66.3	Designing contracts for physicians	11.7
Ensure system for review and evaluation of new physicians	75.1	Obtain/buy consulting services for org.	11.0
Ensuring accreditation	69.0	Identifying need for outside consulting service	8.4
Ensuring system for review and evaluation of medical staff competency	66.8	Ensuring grievance procedure for non-physicians is followed	8.1

is, in general, if physicians are held responsible for a task, they are likely to perform it often.

#### Physician Managers in Physician Organizations

As shown in Table 4.13, over 98 percent of the physician managers in physician organizations are men. This is higher than the distribution for either all survey respondents or physician managers in hospitals. The average age for these physicians is 52 years.

With regard to clinical specialty, Table 4.13 shows that internal medicine remains the predominant specialty (40%). The majority of physician managers in physician organizations (78%) have passed their boards in their area of specialization. The discussion about clinical specialty and Boards for physician managers in hospitals also applies here.

These physicians have been in medical practice an average of 15 years. They have been in their current positions an average of six years. Three fourths (75%) of these physician manager worked for the organization before assuming their current position. Less than half (43%) consider their job full time, and 64 percent maintain a private practice. Slightly more than half of these physicians (53%) have written contracts with their organizations but 65 percent have written job descriptions. Less than half

TABLE 4.13  
CHARACTERISTICS OF SURVEY RESPONDENTS  
IN PHYSICIAN ORGANIZATIONS

	n
Sex: Male n=119 (98.3%)      Female n=2 (1.7%)	121
Age: Average = 52 years      (Range: 31-71 yrs.)	120
Clinical specialties:	121
Internal med.      39.7%      Radiology      2.5%	
Pediatrics      14.0%      Urology      1.7%	
Family practice      11.6%      Preventive med.      0.8%	
Other      10.7%      Emergency med.      0.8%	
General surgery      6.6%      Anesthesiology      0.8%	
Ob/gyn      5.8%      Pathology      0.8%	
Psychiatry      4.1%	
Board certification in area of specialization: 77.9%	121
Number of years in medical practice: Average 15 years (Range 0-42 years)	121
Number of years in current position: Average 6 years (Range 0-35 years)	121
74.8% were working for the organization before assuming current position.	121
43.3% consider job full time. 56.7% consider job part time.	121
64.4% maintain a private medical practice.	121
88.3% are either somewhat satisfied or very satisfied with their job.	121

(47%) have formal job evaluation. The vast majority of these physicians (88%) also report being either somewhat satisfied or very satisfied with their jobs.

Responsibilities. As with the hospital group, there are no tasks for which all physicians in physician organizations either are or are not responsible. There were four tasks for which the "N/A" response was higher than the "No" response.

Table 4.14 shows the ten tasks for which the highest and lowest percentage of physicians in this group are responsible. Of those with the highest frequency, nine are policy management and one is a resource management task. An analysis of these tasks show that seven relate directly to physician activities. Of those with the lowest frequency, two refer to policy management, three to program management and five to resource management. A review of the content of these tasks reveals that one task, designing continuing education programs for physicians, deals with physicians.

Tables 4.15 through 4.17 illustrate the tasks for which 75 percent or more of the physicians in physician organizations are responsible. As these tables show, 12 (57%) of the 21 tasks relate to policy, three (14%) to program management, and six

TABLE 4.14

TASKS FOR WHICH PHYSICIAN MANAGERS IN PHYSICIAN ORGANIZATIONS ARE MOST AND LEAST RESPONSIBLE

MOST		LEAST	
TASK	PERCENT	TASK	PERCENT
POLICY MANAGEMENT		POLICY MANAGEMENT	
Preparing policies or procedures	94.1	Deciding on research activity	36.4
Designing or reviewing new programs	93.3	Lobbying regulatory agencies	26.4
Communicating information to med. staff and governing body		PROGRAM MANAGEMENT	
	88.5	Designing CE programs for physicians	33.6
Preparing goals and objectives	88.5	Teaching CE pgms. to non-physicians	29.6
Preparing agenda for physician meetings	86.5	Designing CE pgms. for non-physicians	24.5
Deciding number and type of phys. that practice in org.		RESOURCE MANAGEMENT	
	86.0	Ensuring a grievance procedure for non-physicians is followed	36.3
Deciding on pgms. and med. services	85.7	Designing wage/benefit schedules for non-phys.	33.6
Monitoring and reporting to med. staff issues of interest to administration	83.6	Supervising construction projects	31.9
Monitoring and reporting to administration issues of interest to medical staff	83.4	Designing contracts for non-physicians	25.8
RESOURCE MANAGEMENT		Negotiating with unions	8.2
Mediating conflicts among physicians	85.1		

TABLE 4.15  
POLICY MANAGEMENT TASKS FOR WHICH MORE THAN  
75% OF PHYSICIANS ARE RESPONSIBLE  
IN PHYSICIAN ORGANIZATIONS

TASK	% PHYSICIANS RESPONSIBLE
Preparing policy or procedures	94.1
Designing or reviewing new programs	93.3
Communicating information to medical staff and governing body	88.5
Preparing goals and objectives for the organization	88.5
Preparing agenda for physician meetings	86.5
Deciding number and type of physicians that practices in organization	86.0
Deciding on programs and medical services for organization	85.7
Monitoring and reporting to medical staff issues of interest to administration	83.6
Monitoring and reporting to administration issues of interest to medical staff	83.4
Attending medical staff committees	79.1
Deciding size of programs and medical services	76.2
Deciding patient care equipment needs	75.2

TABLE 4.16

PROGRAM MANAGEMENT TASKS FOR WHICH MORE THAN  
75% OF PHYSICIANS ARE RESPONSIBLE  
IN PHYSICIAN ORGANIZATIONS

TASK	% PHYSICIANS RESPONSIBLE
Ensuring system for review and evaluation of credentials of new physicians	79.5
Ensuring system for review and evaluation of medical staff competency operates effectively	76.2
Ensuring system for review and evaluation of medical staff competency exists	76.2

TABLE 4.17

RESOURCE MANAGEMENT TASKS FOR WHICH MORE THAN  
75% OF PHYSICIANS ARE RESPONSIBLE  
IN PHYSICIAN ORGANIZATIONS

TASK	% PHYSICIANS RESPONSIBLE
RESOURCE MANAGEMENT	
Mediating conflicts among physicians	85.1
Ensuring physician recruiting program operates as needed	79.3
Mediating conflicts among physicians and non-physicians	78.5
Reviewing budget (or part)	77.1
Hiring physicians	76.8
Mediating conflicts among physicians and administration or governing body	75.0



(29%) are resource management tasks. An analysis of these tasks reveal that 17 (81%) deal with physicians or medical care. Examining the tasks for which fewer than 10 percent of physicians are responsible shows only one, negotiating with unions (8%), which is a resource management task.

Frequency of Occurrence. As with the responsibility dimension for physicians in physician organizations, all tasks are performed by some physicians, and no tasks for which physicians are responsible are performed by 100 percent of the physicians. When these physicians indicated no responsibility, 88 percent of the tasks are nonetheless performed often by some physicians. In one case, that of reviewing the budget for the organization, 100 percent of the physician managers not responsible for the task performed it "often".

The 10 tasks physician managers in physician organizations perform most and least often are presented in Table 4.18. Of the tasks performed most often, seven are policy management and three are resource management. Of those performed least often, four are policy management, four are program management, and two are resource management tasks. The Spearman's correlation coefficient between tasks for which

TABLE 4.18

TASKS PHYSICIAN MANAGERS PERFORM MOST AND  
LEAST OFTEN IN PHYSICIAN ORGANIZATIONS

MOST		LEAST	
TASK	PERCENT	TASK	PERCENT
POLICY MANAGEMENT		POLICY MANAGEMENT	
Prepare agenda for med. staff meetings	74.4	Lobbying regulatory agencies	22.0
Monitor & report to admin. on issues of interest to med. staff	73.4	Write new or modify privileges of physicians	17.7
Attend med. staff committees	73.4	Deciding research activities	17.5
Communicate info. to both med. staff and governing body	71.8	Prepare new or modify by-laws	8.6
PROGRAM MANAGEMENT		PROGRAM MANAGEMENT	
Deciding number/type of phys. to practice in organization	69.1	Evaluate ed. programs	18.9
Prepare new or modify policies/procedures	68.1	Design CE pgms. for non-physicians	11.6
Monitor & report to med. staff issues of interest to admin.	68.0	Design general educational programs	7.7
RESOURCE MANAGEMENT		RESOURCE MANAGEMENT	
Review financial performance of org.	83.9	Teaching CE pgms. to non-physicians	6.4
Design incentive pgms. to increase physician productivity	76.8	RESOURCE MANAGEMENT	
Design wage/benefit schedules. for non-physicians	70.3	Mediate conflicts among phys. & admin./gov. body	16.7
		Ensure grievance procedure for non-physicians is followed	5.0

physicians in physician organizations are responsible and those they perform often was positive at .4658. While this is positive, it is not as high as in hospitals, indicating less association between responsibility and frequency of performance than in hospitals.

#### Comparison of Physician Managers in Hospitals and Physician Organizations

These findings indicate that physician managers in physician organizations are more likely to have been selected for their current position from within the organization than their counterparts in hospitals. In addition, they are more apt to work part time and to maintain a private medical practice. On the other hand, physician managers in hospitals are more likely to have written contracts with their organizations, have written job descriptions, and have a formal job evaluation than physicians in physician organizations.

There are both differences and similarities between the tasks for which physician managers in these two organizations are responsible and perform often. Table 4.19 presents a comparison of the 10 common tasks for which most physicians in hospitals and physician organizations have responsibility. Of these tasks, six are shared by the two groups. All shared tasks are policy management functions.

TABLE 4.19

COMPARISON OF 10 TASKS FOR WHICH THE HIGHEST  
PERCENT OF PHYSICIANS HAVE RESPONSIBILITY IN  
HOSPITALS AND PHYSICIAN ORGANIZATIONS

TASK #	PERCENT IN HOSPITALS	TASK	PERCENT IN PHYSICIAN ORGS.
POLICY MANAGEMENT		POLICY MANAGEMENT	
21	95.0	2	94.1
12	93.7	4	93.3
2	93.3	14	88.5
14	92.1	3	88.5
4	90.1	26	86.5
13	89.8	8	86.0
23	87.8	5	85.7
3	85.6	13	83.6
		12	83.4
PROGRAM MANAGEMENT		RESOURCE MANAGEMENT	
42	88.4	84	85.1
39	85.7		

\* Number corresponds with task

- 2 Preparing new or modifying existing policies and procedures
- 3 Preparing goals and objectives for the organization
- 4 Designing or reviewing new programs
- 5 Deciding which programs and medical services organization offers
- 8 Deciding the number and type of physicians that practice in organization
- 12 Monitoring and reporting to administration issues of interest to medical staff
- 13 Monitoring and reporting to medical staff issues of interest to administration
- 14 Communicating information to both the medical staff and governing body
- 21 Attending medical staff committees
- 23 Attending administrative committees
- 26 Preparing agenda for medical staff or physicians' meetings
- 39 Ensuring that a system for review and evaluation of medical staff competency exists
- 42 Ensuring accreditation with JCAH, AAAHC, or other accrediting bodies
- 84 Mediating conflict among physicians

An examination of the tasks for which 75 percent or more of the physicians in hospitals and physician organizations are responsible shows that 16 out of 21 (76%) of the tasks, are common to both groups. Of these, nine (57%) are policy management, three (14%) are program management, and four (19%) resource management. All of the resource management tasks for which 75 percent or more of the physician managers were responsible were common to both groups. When examining tasks common to both groups for which 10 percent or fewer physicians were responsible, only one task, negotiating with unions, appeared.

Of the tasks for which both groups have responsibility, 57 percent deal directly with physician aspects of management. It could be argued that several tasks where "medical staff" or "physician" is not articulated in the task statement nonetheless relate to physician aspects of management. For example, when physician managers prepare policies and procedures, a task shared by the two groups, these policies and procedures most likely to deal with physicians.

A Spearman's correlation coefficient to measure the association between the ranked tasks for which physician managers were responsible in hospitals and physician organizations was positive and had a value of .8071. In other words, there is a high degree of association

between the most frequently occurring tasks in the hospital group and the physician organization group.

As illustrated by Table 4.20, 60 percent of the tasks performed often by physicians in the two groups are shared and are also all policy management tasks. Of these, all but one relate to medical staff or physician activities. A Spearman's correlation coefficient to measure the association between tasks for which physician managers in hospitals and physician organizations perform "often" was positive at .6749.

Clearly, the data reviewed indicate that physician managers in both hospitals and physician organizations are responsible and perform many of the same tasks. Further, findings indicate that these tasks are likely to be policy management tasks that relate directly or indirectly to medical staff or physicians in general. An analysis of the tasks for which few physicians are responsible and perform often uncover no obvious patterns. However, negotiating with unions, a resource management function, is a task for which physicians are consistently not responsible and do not perform often.

Differences between hospitals and physician organizations become evident when the tasks are analyzed by policy management, program management, and resource management categories. For 23 of the 36

TABLE 4.20

COMPARISON OF 10 TASKS WHICH THE HIGHEST PER-  
CENTAGE OF PHYSICIANS PERFORM OFTEN IN  
HOSPITALS AND PHYSICIAN ORGANIZATIONS

TASK *	% PHYSICIANS PERFORM MOST OFTEN IN HOSPS.	TASK	% PHYSICIANS PERFORM MOST OFTEN IN PHYS. ORGS.
POLICY MANAGEMENT		POLICY MANAGEMENT	
21	86.0	26	74.4
12	81.5	12	73.4
14	80.8	21	73.4
13	75.9	14	71.8
26	73.5	8	69.1
23	69.1	2	68.1
2	66.3	13	68.0
PROGRAM MANAGEMENT		RESOURCE MANAGEMENT	
38	75.1	58	83.9
42	69.0	65	76.8
40	66.8	71	70.3

\* Number corresponds with task

- 2 Preparing new or modifying existing policies and procedures  
8 Deciding the number and type of physicians that practice in organization  
12 Monitoring and reporting to administration issues interest to medical staff  
13 Monitoring and reporting to medical staff issues of interest to administration  
14 Communicating information to the medical staff and governing body of organization  
21 Attending medical staff committees  
23 Attending administrative committees  
26 Preparing agenda for medical staff or physicians' meetings  
38 Ensuring a system for review and evaluation of credentials of new physicians  
40 Ensuring that a system for review and evaluation of medical staff competency operates efficiently  
42 Ensuring accreditation with JCAH, AAAHC, or other accrediting bodies  
58 Reviewing the financial performance of the organization  
65 Designing incentive programs to increase physician productivity  
71 Designing wage/benefit schedules for non-physicians

policy management tasks, physicians in physician organizations had a higher percentage of responsibility than physicians in hospitals. For 28 of the 36 resource management tasks, physicians in physician organizations also had a higher percentage of responsibility. However, for 13 of the 14 program management tasks, physicians in hospitals had a higher percentage of responsibility than physicians in physician organizations.

For 21 of the 36 policy management tasks, a higher percentage of physicians in hospitals performed the tasks often. For all of the 14 program management tasks, a higher percentage of physicians in hospitals performed the tasks often. However, for 26 of the 36 resource management tasks, a higher percentage of physicians in physician organizations performed the task often.

#### Summary of Physician Manager Responsibilities and Frequency of Task Performance

In the analysis of the tasks for which most physician managers are responsible in hospitals and in physician organizations, the data indicate that there is a core group of tasks common to both groups. These are predominantly policy management tasks relating to the medical staff or to physicians in general. When the 10 tasks for which physicians in hospitals and



physician organizations are most and least responsible are examined, tasks dealing with the financial aspects of management are those for which physician managers are least responsible. Similar findings are evident with the 10 tasks performed most and least "often" by physician managers in both groups.

The major difference between hospital and physician organizations as to tasks for which physician managers are responsible and perform is that physicians in hospitals are generally more involved with program management, and physicians in physician organizations are more involved in resource management tasks.

#### Chi Square Analysis

Crosstabulations were done on 10 representative tasks by each of the 21 independent variables.<sup>23</sup> Table 4.21 lists the 10 tasks. Table 4.22 shows the independent variables grouped by personal and organizational characteristics and the tasks for which there was a p value of .05 or less.<sup>22</sup> Only task #13 showed no significant association with any of the independent variables. Clearly, although there are a greater number of personal characteristic variables, organizational characteristics account for task responsibility in many more of the tasks. These associations are

TABLE 4.21  
 REPRESENTATIVE TASKS SELECTED  
 FOR CHI SQUARE ANALYSIS

TASK #	TASK
5	Deciding which programs and medical services the organization offers.
6	Deciding the size of programs and medical services.
13	Monitoring and reporting to medical staff issues of interest to administration.
33	Promoting the organization.
40	Ensuring that a system for review and evaluation of medical staff competency operates.
51	Monitoring and reporting on data from systems designed to obtain information about medical care.
55	Designing ways to improve efficiency of professional departments within the organization.
60	Designing new or modifying existing risk management programs.
68	Designing contracts for physicians.
82	Advising and/or counseling physicians on career or professional issues.

TABLE 4.22

INDEPENDENT VARIABLES AND TASKS  
WITH SIGNIFICANT ASSOCIATION

INDEPENDENT VARIABLES	TASKS WITH $p < .05$
ORGANIZATIONAL CHARACTERISTICS	
Type of organization	6, 55, 5
Job description	33, 40, 51
Number of licensed beds	6, 68
Physician org. size	5, 40, 60
Ownership	5
Line or staff	5, 6, 33, 55, 68, 82
Full time/part time	55, 60, 82
PERSONAL CHARACTERISTICS	
Education	
Training in management	
Masters public health	
Masters business admin.	
Masters health admin.	
Graduate courses	55
Continuing education	
Experience	
Yrs. in med. practice	82, 60
Yrs. in paid management	33
Yrs. in other work	
Yrs. in Armed Service	51
Voluntary mgmt. exp.	68
Yrs. in job	68, 33
Work for org. before	

discussed below.

### Policy Management Tasks

Task #5: Deciding which programs and medical services the organization offers. As shown in Table 4.23, four independent variables are significantly associated with physician manager responsibility for this task. All are considered organization characteristics. Type of organization is the first variable considered. Of physician managers whose organization is a hospital, 79 percent have responsibility for this task. Of physician managers whose organization is a physician organization, 88 percent have responsibility for this task.

The size of the physician organization is the second factor significantly associated with this task. Of physician managers in organizations with zero to five full-time physician employees (FTEs), 79 percent have responsibility for the task. Of physicians in organizations with six to 20 physician FTEs, 100 percent have responsibility for the task, and of physician managers in organizations with 21 or more FTEs, 86 percent have responsibility for the task.

This is the only task where ownership of the organization or the form of governance is significantly associated with physician responsibility.

TABLE 4.23

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #5, DE-  
CIDING WHICH PROGRAMS AND MEDICAL SERVICES  
THE ORGANIZATION OFFERS

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATION CHARACTERISTICS</b>						
Type			364	3.955	1	.0467
Hospital	195 (68.6%)	53 (21.4%)				
Physician organization	102 (87.9%)	14 (12.1%)				
Size of phys. org.			364	6.994	2	.0303
0-5 phys. FTEs	199 (78.7%)	54 (21.3%)				
6-20 phys. FTEs	20 (100%)	0				
21+ phys. FTEs	78 (85.7%)	13 (14.3%)				
Ownership			364	14.899	5	.0108
For-profit	78 (87.6%)	11 (12.4%)				
Non-profit	187 (79.2%)	49 (20.8%)				
Fed. govt.	4 (100%)	0				
State govt.	2 (33.3%)	4 (66.7%)				
Local govt.	15 (93.8%)	1 (6.3%)				

Table 4.23 (continued)

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #5, DE-  
CIDING WHICH PROGRAMS AND MEDICAL SERVICES  
THE ORGANIZATION OFFERS

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
Other	11 (84.6%)	2 (15.4%)				
Line	225 (85.9%)	37 (14.1%)	363	10.745	1	.0010
Staff	71 (70.3%)	30 (29.7%)				

As Table 4.23 shows, the number of physician managers in federal government organizations is small. However, of these, 100 percent have responsibility for this task. In contrast, of physician managers in organizations owned by state governments, only 33 percent have responsibility for the task. An additional finding regarding ownership is that more physician managers in for-profit organizations have responsibility for this task than physician managers in non-profit organizations.

Having a line position in the organization is the last factor that has a significant association with responsibility for this task. Of physician managers with line positions, 86 percent have responsibility. In contrast, 70 percent of physicians with staff positions are responsible.

Task #6, deciding the size of programs and medical services. Table 4.24 shows the three organizational variables that are significantly associated with physician manager responsibility for deciding the size of programs and medical services. Of physician managers in hospitals, 74 percent have responsibility for this task. Of physician managers in physician organizations, 85 percent have responsibility.

The number of licensed beds is the size

TABLE 4.24

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #6, DECID-  
ING THE SIZE OF PROGRAMS AND MEDICAL SERVICES

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATION CHARACTERISTICS</b>						
Type			344	4.221	1	.0399
Hospital	173 (73.9%)	61 (26.1%)				
Physician organization	93 (84.5%)	17 (15.5%)				
Number of licensed beds			344	5.964	2	.0507
50 or fewer	99 (83.9%)	19 (16.1%)				
51 to 199	31 (81.6%)	7 (18.4%)				
200+	136 (72.3%)	52 (27.7%)				
Line	207 (83.5%)	41 (16.5%)	344	17.887	1	.0000
Staff	59 (61.5%)	37 (38.5%)				



variable associated with physician manager responsibility for this task. Of physician managers who work in hospitals with 50 or fewer beds, 84 percent have responsibility. In hospitals with 51-199 beds, 82 percent have responsibility, and in hospitals with 200 or more beds, 72 percent have responsibility.

The last variable significantly associated with this task is line position. Of physician managers with line position, 84 percent have responsibility for the task. Of physician managers with staff position, 62 percent have responsibility for the task.

Task #33, promoting the organization. As illustrated in Table 4.25, two organizational characteristics and two personal characteristics are significantly associated with physician manager responsibility for promoting the organization. Of physician managers with a written job description, 74 percent have responsibility for the task. Of physician managers without a job description, 62 percent have responsibility for the task.

Having a line position is significantly and positively associated with physician responsibility for promoting the organization. Of physician managers with line positions, 75 percent have responsibility,

TABLE 4.25

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #33,  
PROMOTING THE ORGANIZATION

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
Written job description			342	3.958	1	.0466
Yes	200 (74.3%)	69 (25.7%)				
No	45 (61.6%)	28 (38.4%)				
Line	183 (75.3%)	60 (24.7%)	340	5.511	1	.0189
Staff	60 (61.9%)	37 (38.1%)				
<b>PERSONAL CHARACTERISTICS</b>						
Experience						
Years in paid management			345	6.124	2	.0468
0-4	166 (76.1%)	52 (23.9%)				
5-10	58 (63.0%)	34 (37.0%)				
11+	23 (65.7%)	12 (34.3%)				

Table 4.25 (continued)

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #33,  
PROMOTING THE ORGANIZATION

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
Years in . current job			339	6.832	2	.0328
0-4	118 (67.8%)	56 (32.2%)				
5-10	91 (71.1%)	37 (28.9%)				
11+	33 (89.2%)	4 (10.8%)				

while 62 percent of physician managers with staff positions have responsibility for the task.

The years spent in a paid management position prior to accepting the current job is a personal characteristic variable significantly associated with this task. More physician managers with zero to four years of experience have responsibility for this task (76%) than physician managers with five to 10 years (63%), or 11 or more years (66%). The reverse is found when the association between this task and the number of years in the current position is examined. Of physician managers with zero to four years of experience, 68 percent had responsibility for the task. This is less than physician managers with five to 10 years (71%) or those with 11 or more years (89%).

#### Program Management Tasks

Task #40, ensuring that a system for review and evaluation of medical staff competency operates effectively. As shown in Table 4.26, two variables, both organizational characteristics, are significantly associated with the task of ensuring that a system for review and evaluation of medical staff competency operates effectively. Of physician managers with a job description, 91 percent have responsibility for

TABLE 4.26

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #40, ENSUR-  
ING THAT A SYSTEM FOR REVIEW AND EVALUATION OF  
MEDICAL STAFF COMPETENCY OPERATES

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
<b>Written job description</b>			353	15.036	1	.0001
Yes	253 (91.0%)	25 (9.0%)				
No	55 (73.3%)	20 (26.7%)				
<b>Size of physi- cian organization</b>			356	6.306	2	.0427
0-5 phys. FTEs	223 (89.2%)	27 (10.8%)				
6-20 phys. FTEs	17 (94.4%)	1 (5.6%)				
21+ phys. FTEs	70 (79.5%)	18 (20.5%)				

this task, and of physician managers without a job description, 73 percent have responsibility for this task.

The size of a physician organization also influences physician manager responsibility for this task. Of physician managers in organizations with zero to five FTEs, 89 percent have responsibility. This increases to 94 percent when the organization has six to 20 FTEs. Of physician managers in organizations with 21 or more FTEs, 80 percent have responsibility for this task.

Task #60, designing new or modifying existing risk management functions. As shown on Table 4.27, two organizational characteristics and one personal characteristic are significantly associated with responsibility for designing new or modifying existing risk management functions. Physician organization size affects responsibility as follows: of physician managers who work in organizations with zero to five FTEs, 58 percent have responsibility. This increases to 88 percent with six to 20 FTEs, and drops to 44 percent with 21 or more full-time physician employees.

The other organizational characteristic associated with this task is whether or not the position is full time. Of physician managers with full time

TABLE 4.27

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #60, DESIGNING  
NEW OR MODIFYING EXISTING RISK MANAGEMENT PROGRAMS

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
Size of phys. org.			254	6.516	2	.0385
0-5 phys. FTEs	114 (58.2%)	82 (41.8%)				
6-20 phys. FTEs	7 (87.5%)	1 (12.5%)				
21+ phys. FTEs	22 (44.0%)	28 (56.0%)				
Full time	105 (61.0%)	67 (39.0%)				
Part time	37 (45.7%)	44 (54.3%)				
<b>PERSONAL CHARACTERISTICS</b>						
Experience			254	7.945	2	.0188
Yrs. in med. practice						
0-10	47 (60.3%)	31 (39.7%)				
11-20	43 (45.3%)	52 (54.7%)				
21+	53 (65.4%)	28 (34.6%)				

positions, 61 percent have responsibility for the task, while only 46 percent have responsibility when the position is part time.

The personal characteristics associated with this task is the number of years of experience in medical practice. Of physicians with zero to 10 years in practice, 60 percent have responsibility. Of those with 11-20 years, only 45 percent have responsibility. Of those with 21 or more years, 65 percent have responsibility for this task.

#### Resource Management Tasks

Task #51, monitoring and reporting on data from systems designed to obtain information about medical care. The task of monitoring and reporting on data from systems designed to obtain information about medical care is significantly influenced by two independent variables. These are job description, an organizational characteristic, and the number of years in the armed services, a personal characteristic related to experience. As shown in Table 4.28, of physician managers with a job description, 77 percent have responsibility, and without a job description, 59 percent have responsibility for this task.

With regard to years in the armed services, of physician managers with zero to three years



TABLE 4.28

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #51, MONITOR-  
ING AND REPORTING ON DATA FROM SYSTEMS DESIGNED TO  
OBTAIN INFORMATION ABOUT MEDICAL CARE

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
Written job description			340	9.027	1	.0027
Yes	204 (77.0%)	61 (23.0%)				
No	44 (58.7%)	31 (41.3%)				
<b>PERSONAL CHARACTERISTICS</b>						
<b>Experience</b>						
Years in armed services			340	6.599	2	.0369
0-3	196 (74.8%)	66 (25.2%)				
4-10	35 (60.3%)	23 (39.7%)				
11+	17 (85.0%)	3 (15.0%)				

experience, 75 percent have responsibility for this task. This drops to 60 percent with four to 10 years of experience, and of physician managers with 11 or more years of experience, 85 percent have responsibility.

Task #55, designing ways to improve efficiency of professional departments. As shown in Table 4.29, the task of designing ways to improve efficiency of professional departments is significantly associated with five factors. Three are organizational characteristics: organizational type, line position, and full or part-time position. One is a personal characteristic: graduate courses.

Of physician managers in hospitals, 62 percent have responsibility for this task. Of physician managers in physician organizations, 75 percent are responsible.

Line or staff position is associated with this task as follows. Of physician managers with line positions, 75 percent have responsibility. When the position is considered staff, 47 percent have responsibility. The significant association between full-time positions and this task is as follows: Of physician managers with full-time positions, 71 percent have responsibility. If the job is part-time, 58

TABLE 4.29

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #55, DESIGN-  
ING WAYS TO IMPROVE EFFICIENCY OF  
PROFESSIONAL DEPARTMENTS

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
Type			331	5.378	1	.0204
Hospital	137 (61.7%)	85 (38.3%)				
Physician organization	82 (75.2%)	27 (24.8%)				
Line	174 (74.0%)	61 (26.0%)	326	19.967	1	.0000
Staff	43 (47.3%)	48 (52.7%)				
Full time	153 (70.5%)	64 (29.5%)	330	5.023	1	.0250
Part time	65 (57.5%)	48 (42.5%)				
Education						
Grad. courses			331	3.721	1	.0537
Yes	48 (77.4%)	14 (22.6%)				
No	171 (63.6%)	98 (36.4%)				

percent have responsibility.

This task is the only one of the 10 representative tasks significantly associated with an education variable. Physicians with graduate courses in a university setting have higher rates of responsibility for this task. Of physician managers with graduate courses, 77 percent have responsibility, and without graduate courses 64 percent have responsibility.

Task 68, designing contracts for physicians.

Four independent variables are significantly associated with the task of designing contracts for physicians. Two are organizational characteristics: the number of licensed beds, and line or staff position. Two are personal characteristics that have to do with experience, voluntary management experience, and the number of years in the current position.

As shown in Table 4.30, of physician managers who work in hospitals with 50 or fewer licensed beds, 66 percent have responsibility for the task. This drops to 46 percent in organizations with 51-199 beds, and increases to 57 percent in organizations with 200 or more beds. Of physicians with line positions, 64 percent have responsibility. This contrasts to the 45 percent of those who have staff positions.

The personal characteristics variables

TABLE 4.30

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #68,  
DESIGNING CONTRACTS FOR PHYSICIANS

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
Number of licensed beds			321	5.084	2	.0549
50 or fewer	81 (66.4%)	41 (33.6%)				
51-199	18 (46.2%)	21 (53.8%)				
200+	94 (56.6%)	72 (43.4%)				
Line	147 (64.2%)	82 (35.8%)	322	9.111	1	.0025
Staff	42 (45.2%)	51 (54.8%)				
<b>PERSONAL CHARACTERISTICS</b>						
Experience						
Voluntary management			327	5.923	1	.0149
Yes	150 (55.8%)	119 (44.2%)				
No	43 (74.1%)	15 (25.9%)				

Table 4.30 (continued)

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #68,  
DESIGNING CONTRACTS FOR PHYSICIANS

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
Years in current job			322	7.832	2	.0199
0-4	84 (51.5%)	79 (48.5%)				
5-10	78 (62.9%)	46 (37.1%)				
11+	26 (74.3%)	9 (25.7%)				

associated with responsibility for this task are as follows: Of physician managers with voluntary management experience, 56 percent have responsibility for the task. Of physician managers without this experience, 74 percent have responsibility. The other experience variable is the number of years in the current position. Of physician managers in this position zero to 4 years, 52 percent have responsibility for the task. This increases to 63 percent with five to 10 years on the job, and to 74 percent with 11 or more years.

Task #82, advising physicians on career or professional issues. As shown in Table 4.31, three factors are significantly associated with the task of advising physicians on career or professional issues. Two are organizational characteristics. These are line, and full-time position.

Of physician managers with line positions, 76 percent have responsibility for this task, while 64 percent of physician managers with staff positions have responsibility. Of full-time physician managers 81 percent have responsibility, while 57 percent of those with part-time positions have responsibility.

The personal characteristic associated with this task is the number of years in medical practice.

TABLE 4.31

EXTENT OF ASSOCIATION BETWEEN INDEPENDENT VARIABLES  
AND PHYSICIAN RESPONSIBILITY FOR TASK #82, ADVIS-  
ING PHYSICIANS ON CAREER OR PROFESSIONAL ISSUES

INDEPENDENT VARIABLE	YES	NO	n	$\chi^2$	d.o.f.	p
<b>ORGANIZATIONAL CHARACTERISTICS</b>						
Line	189 (75.9%)	60 (24.1%)	345	4.705	1	.0301
Staff	61 (63.5%)	35 (36.5%)				
Full time	184 (81.1%)	43 (18.9%)	347	22.278	1	.0353
Part time	68 (56.7%)	52 (43.3%)				
<b>PERSONAL CHARACTERISTICS</b>						
<b>Experience</b>						
Years in med. practice			351	6.454	2	.0397
0-10	80 (67.8%)	38 (32.2%)				
11-20	102 (81.0%)	24 (19.0%)				
21+	74 (69.2%)	33 (30.8%)				



Of physician managers with zero to 10 years in medical practice, 68 percent have responsibility for this task. This increases to 81 percent with 11 to 20 years of medical practice, and decreases to 69 percent with over 21 years of experience.

### Summary of Findings

The most important finding from the chi-square analysis is that organizational characteristics are significantly associated with more of the representative tasks than are personal characteristics. Nine of the 10 tasks are associated with at least one of the 21 independent variables. However, as shown in Table 4.32, none of the tasks was associated with more than five of these factors.

Beginning with organizational characteristics, a line as opposed to a staff position was found to be associated with six of the 10 tasks. These are: #5, #6, #33, #55, #68 and #82 (see Table 4.22). Consistently, physician managers with line positions have higher rates of responsibility than those with staff positions.

The type of organization, hospital or physician organization, was found to be significantly associated with three tasks, #5, #6, and #55. In each case, physician managers in physician organizations

TABLE 4.32

ASSOCIATION BETWEEN PHYSICIAN MANAGER RESPONSIBILITY  
FOR TASKS AND INDEPENDENT VARIABLES

TASK	INDEPENDENT VARIABLE WITH $p < .05$
#5 Deciding which programs and medical services the organization, department/service or agency offers	ORG. CHARACTERISTICS Type of organization Physician org. size Line position Ownership
#6 Deciding the size of programs and medical services	ORG. CHARACTERISTICS Type of organization Number of licensed beds Line position
#13 Monitoring and reporting to medical staff issues of interest to administration	NONE
#33 Promoting the organization, department/service or agency	ORG. CHARACTERISTICS Job description Line position PERSONAL CHARACTERISTICS Yrs. in paid management Yrs. in current job
#40 Ensuring that a system for review and evaluation of medical staff competency operates efficiently	ORG. CHARACTERISTICS Job description Phys. org. size
#51 Monitoring and reporting on data from systems designed to obtain information about medical care	ORG. CHARACTERISTICS Job description PERSONAL CHARACTERISTICS Yrs. in armed service

Table 4.32 (continued)

ASSOCIATION BETWEEN PHYSICIAN MANAGER RESPONSIBILITY  
FOR TASKS AND INDEPENDENT VARIABLES

TASK	INDEPENDENT VARIABLES WITH $p < .05$
#55 Designing ways to improve efficiency of professional departments within the organization or agency	ORG. CHARACTERISTICS Type Line position Full-time position PERSONAL CHARACTERISTICS Graduate courses
#60 Designing new or modifying existing risk management functions and/or programs	ORG. CHARACTERISTICS Phys. org. size Full-time position PERSONAL CHARACTERISTICS Yrs. in med. practice
#68 Designing contracts for physicians	ORG. CHARACTERISTICS Number of licensed beds Line position PERSONAL CHARACTERISTICS Voluntary management experience Yrs. in current job
#82 Advising and/or counseling physicians on career or professional issues	ORG. CHARACTERISTICS Line position Full-time position PERSONAL CHARACTERISTICS Years in med. practice

have higher rates of responsibility. The size of the physician organization is also associated with three tasks. Only task #5 is common to both the type and the size variable. The other two tasks are #40 and #60. In each case, physician managers who work in physician organizations with six to 20 physician FTEs (as opposed to zero to five, or 21 or more) have the highest rates of responsibility.

Having a job description is significantly associated with three tasks. These are: #33, #40 and #51. In each case, physician managers with a written job description have higher rates of responsibility for the task than those without a job description. Working full time is also associated with three tasks. These are, #55, #60 and #82. For all three, physician managers with full time positions have higher rates of responsibility than those with part-time positions.

The number of licensed beds, which is one way to measure hospital size, was significantly associated with responsibility for two tasks. These are #6 and #68. In both cases, physician managers who worked in hospitals with 50 or fewer beds have the highest rates of responsibility. With task #6, physician managers in hospitals with between 51-199 beds had higher rates of responsibility than those working in organizations with over 200 beds. However, with task #68, more

physician managers in the larger institution have responsibility for the task.

The last organizational characteristic examined in this study is ownership, or the form of governance. This characteristic is associated with only one task, #5. Here, more physician managers in organizations owned or run by the federal government have responsibility for the task, while fewest have responsibility in state-run hospitals. Another finding regarding ownership is that physician managers in for-profit organizations have higher rates of responsibility than those working in non-profit organizations.

With regard to personal characteristics, it was found that various types of experience is associated with responsibility for several tasks. Education, on the other hand, is associated with responsibility for only one task. Factors such as training in management, a Master's degree, and continuing education, were not found to be associated with responsibility for any of the 10 tasks. Only graduate course work in a university setting is associated with physician responsibility, and this occurs in task #55. More physician managers with graduate courses have responsibility for this task than do those without graduate courses.

The years of experience in medical practice, the years spent in the current position, and the number of years in the armed services are all associated with physician manager responsibility. In each case, the longer the experience, the more physician managers have responsibility for the task. The number of years in medical practice is associated with responsibility for tasks #60 and #82. The years in current position is associated for tasks #33 and #68. The number of years in the armed services is associated with task #51.

A negative association is found between physician managers with voluntary management experience and responsibility. Fewer physician managers with voluntary management experience have responsibility for task #68 than those without this experience. The same is true for the number of years in paid management. Physician managers with zero to four years of experience had higher rates of responsibility than those with more years of paid management experience.

The number of years in other work before assuming the current position, and working for the organization prior to accepting the current position, were not found to be significantly associated with responsibility for any of the 10 tasks.

## NOTES - CHAPTER IV

1. A comparison of job titles among respondents and non-respondents suggests that the physician managers who responded to the survey are representative of the total population of physician members of AAMD.
2. Since so few women (n=20) were involved, sex was not used as an independent variable.
3. Not all findings are presented in tabular form. See Appendix B, p. 251 for data.
4. See Appendix B, p. 253 for data.
5. Many averages reported in this section were calculated without the responses of physicians whose reported values were so high that they skewed the averages. For this particular average, three outliers were excluded. When included, this average is 375.
6. For this particular average, six outliers were excluded. When included, the average is 19.8.
7. For this particular average, four outliers were excluded. When included, the average is 91.8.
8. For this particular average, one outlier was excluded. When included, the average is 18.6.
9. For this particular average, five outliers were excluded. When included, the average is 651. An example of one outlier was the medical director of a large group in southern California who included multiple facilities in his responses.
10. For a list of specific affiliations see Appendix B, p. 256.
11. For this particular average, two outliers were excluded. When included, the average is 208.
12. For this particular average, three outliers were excluded. When included, the average is 66.
13. For this particular average, two outliers were excluded. When included, the average is 2665.
14. For list of "other" types of organizations see Appendix C, p. 278.

15. Definitions of influence and authority were not provided in the survey. However, authority is generally defined as the power associated with a position in the organization (Katz and Kahn, 1978). Influence is "the process whereby A modifies the attitudes or behavior of B. Power is that which enables him to do it." (Handy, 1976, p. 111).

16. See Appendix B, p. 258 for data.

17. This figure is lower than the average physicians' income in the United States for 1982, which was reported to be \$99,500 (Rich, 1984).

18. Tasks added by respondents are listed in Appendix C, p. 284.

19. In a study of behavior and leadership styles of physician manager members of AAMD, Kurtz (1980) found that internists differed significantly from the total group. Using self-assessment feedback instruments, internists reported not experiencing a high degree of discomfort in conflict settings. In these situations they moved quickly into authority stances in order to control the situation. Kurtz speculated that the low discomfort levels might indicate a higher tolerance for stress and conflict than other specialty groups.

20. It is important to distinguish between responses of "No" and that of "Not Applicable (N/A)". "No" was intended to mean the respondent did not have responsibility for the task. However, a "No" response does not preclude the possibility that the task was the responsibility of someone else in the organization. "N/A" is more complex. As the instructions implied, it was intended to mean that in the perception of the respondent, the task is irrelevant to the type of organization within which she/he works and hence, the task may not be anyone's responsibility. However, "N/A" might also mean that the respondent clearly knew the task was someone else's responsibility and therefore not applicable to him or herself.

21. As discussed in Chapter III, a factor analysis was used to select a subset of 10 representative tasks.

22. Title was treated as an independent variable and found to be statistically significant in eight of the 10 representative tasks. However, there



were 11 categories of titles and no way in which they could be collapsed. It is probable that the significance was due to the large number of categories, and therefore title has been removed from further analysis.

CHAPTER V  
CONCLUSIONS AND RECOMMENDATIONS  
FOR FURTHER STUDY

This chapter presents the conclusions from the study, beginning with the analysis of physician managers in hospitals and physician organizations. Next, conclusions from the chi-square analysis are discussed. The chapter ends with several recommendations for further study.

Conclusions from Analysis of Physician Managers  
in Hospitals and Physician Organizations

The first most significant conclusion of this study is that, regardless of organizational affiliation, physician managers have responsibility for and perform tasks that are appropriate. In essence, physician managers are doing what the literature on this topic suggests they ought to do in order to maximize their influence on the efficiency and effectiveness of their organizations.

Table 5.1 lists the tasks by management functions that are common to both groups of physician managers and for which more than 75 percent of physicians have responsibility. Unlike managers in other

TABLE 5.1

TASKS FOR WHICH MORE THAN 75% OF PHYSICIAN  
MANAGERS ARE RESPONSIBLE IN HOSPITALS  
AND PHYSICIAN ORGANIZATIONS

TASK	ORGANIZATIONAL ACTIVITY
<b>POLICY MANAGEMENT</b>	
Attend med. staff committees	Coordination, org. decision making
Monitoring and reporting to administration issues of in- terest to med. staff	Coordination
Preparing policies or procedures	Org. decision making
Communicating information to med. staff and governing body of org.	Coordinating
Designing or reviewing new pgms.	Org. decision making, cost/quality assurance
Monitoring and reporting on issues of admin. to med. staff	Coordinating
Preparing goals and objectives for organization	Org. decision making, cost/quality assurance
Preparing agenda items for med. staff meetings	Coordinating
Deciding on pgms. and med. services for organization	Org. decision making, cost/quality assurance
<b>PROGRAM MANAGEMENT</b>	
Ensuring system for review and evaluation of med. staff competency exists	Org. decision-making, cost/quality assurance, regulation
Ensuring system for review and evaluation of credentials of new physicians exists	Organizational decision- making

Table 5.1 (continued)

**TASKS FOR WHICH MORE THAN 75% OF PHYSICIAN  
MANAGERS ARE RESPONSIBLE IN HOSPITALS  
AND PHYSICIAN ORGANIZATIONS**

TASK	ORGANIZATIONAL ACTIVITY
<b>RESOURCE MANAGEMENT</b>	
Mediating conflicts among physicians	Reducing tension, leading to coordination
Mediating conflicts among physician and non-physician personnel	Reducing tension
Reviewing budget (or part)	Reducing tension
Mediating conflicts among physicians and administration or governing body	Reducing tension

organizations, physician managers have taken on significant policy management responsibilities (Burgess, 1984). According to Burgess, this is most appropriate. It seems that when managers in non-health care organizations, especially in public institutions, are faced with the challenge of having to increase efficiency and effectiveness, they inappropriately focus on resource management functions. Although this may result in short-term benefits, only a focus on policy management functions promotes the processes of policy analysis, diagnosis, and evaluation. This, in turn, facilitates invention of remedial alternatives that promote the long-term efficiency and effectiveness of the organization (Burgess, 1975; Burgess, 1984).

Table 5.1 also illustrates the tasks that relate to the medical staff and to three activities known to be important to the efficiency and effectiveness of health care organizations. The majority of tasks common to physician managers are related to the medical staff and deal with either coordination, conflict management, and/or organizational decision making.

There is additional support for the conclusion that physician managers are responsible for appropriate tasks. As discussed in Chapter II, when

physicians participate in organizational decision-making, it results in a higher quality of care and decreased costs (Shortell and LoGerfo, 1981; Sloan and Becker, 1981). Scott and Shortell (1983) suggest a number of specific actions for health care managers to take in order to increase the efficiency and effectiveness of their organizations. These are: (1) emphasize structural and process control vs. outcome control, (2) create substitutes for formal leadership by developing cohesive work groups, and (3) help to enact reality for people by articulating shared concerns, attitudes, values, and capabilities of staff members and by directing the flow of information.

Table 5.2 compares the tasks common to physician managers with the actions suggested by Scott and Shortell. Clearly, every task listed can be matched with one of these activities. For example, mediating conflict will help create cohesive work groups; attending meetings and communicating information is directing the flow of information; and preparing policy and procedures, and/or goals and objectives, is emphasizing structural vs. outcome control.

That physician managers are doing what the literature suggests they should, is thus established. What can be implied by this conclusion is that physicians take a broad view of their management

TABLE 5.2

COMPARISON OF PHYSICIAN MANAGER TASKS WITH SPECIFIC EFFICIENCY AND EFFECTIVENESS ACTIONS

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<b>ACTION:</b>	Emphasize structural and process control vs. outcome control.
<b>TASKS:</b>	<ul style="list-style-type: none"> <li>Preparing policies and procedures</li> <li>Designing or reviewing new programs</li> <li>Preparing goals and objectives.</li> <li>Deciding on programs and medical services for organization</li> <li>Ensuring system for review and evaluation of medical staff competency exists</li> <li>Reviewing budget</li> </ul>
<b>ACTION:</b>	Create substitutes for formal leadership by developing cohesive work groups
<b>TASKS:</b>	<ul style="list-style-type: none"> <li>Mediating conflict among physicians</li> <li>Mediating conflict among physicians and non-physician personnel</li> <li>Mediating conflict among physicians and administration or governing body</li> </ul>
<b>ACTION:</b>	Help to enact reality for people by articulating shared concerns, attitudes, values, and capabilities of staff members and by directing the flow of information.
<b>TASKS:</b>	<ul style="list-style-type: none"> <li>Attending medical staff committees</li> <li>Monitoring and reporting to medical staff issues of interest to administration</li> <li>Communicating information to medical staff and governing body of organization</li> <li>Monitoring and reporting on issues of administration to medical staff</li> <li>Preparing agenda items for medical staff meetings</li> </ul>

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responsibilities, take these responsibilities seriously, and are effective managers. Conventional wisdom says that those educated and trained in generic management should run health care organizations (Drucker, 1973). Evidently, what is occurring is that non-physician managers can not do it alone. Physicians must and should have a meaningful management role in the health care system.

The second conclusion of this study stems from the finding about the major difference between the tasks for which physician managers in hospitals and physician organizations are responsible. In hospitals, more physicians are responsible for program management functions, and in physician organizations, more are responsible for resource management functions. The conclusion, supported by the literature, is that these task differences result from differences in the organizational structure of hospitals and physician organizations. This is not surprising and essentially reinforces what is known about the two types of organizations.

Hospitals are generally formal, bureaucratic organizations. They are more likely to have a variety of programs, such as quality assurance and risk management, in which physician managers would be involved. In addition, as bureaucratic structures,



hospitals create a division of labor, (Katz and Kahn, 1978). For example, most have personnel departments that are responsible for many tasks considered to be resource management functions. Therefore it follows that resource management tasks would not be the responsibility of physician managers.

On the other hand, physician organizations are likely to be smaller than hospitals and singularly dedicated to service. They generally provide minimal professional support to physicians in terms of organized programs. Physician organizations rely on more of a decentralized self-administered system versus the more centralized bureaucratically administered system of the hospital.<sup>1</sup>

Additional explanations for more physician managers in physician organizations being responsible for resource management tasks include: an incentive to conserve resources by performing these tasks themselves; a desire to deal directly with their personnel, with contracts with physicians, etc.; and a desire to obtain or maintain direct control of their organizational environments. For example, these physicians can hire individuals (receptionists, nurses, and other physicians), that will mesh with their patient population and their own personalities. Finally, because they are smaller, physician

organizations would most likely be severely affected by internal conflict and tension. This might explain why mediating conflict among physicians is among the tasks for which the vast majority of physicians in physician organizations are responsible.

Another finding of this study is that physician managers are not generally involved with the financial aspects of management. However, no clear cut conclusions can be made about the reasons more physicians are not responsible for financial management tasks. Some authors suggest this may be due to inadequate knowledge of financial management on the part of physician. (Herzlinger, 1978). However, it may also be due to other factors such as a conscious choice on the part of the physician not to participate, or the unwillingness of the board of directors to permit this type of participation. Nonetheless, physician involvement in this area must be increased if they are to reach their potential as managers.

Physician managers in hospitals and physician organizations have different working arrangements with their organizations. Physicians in physician organizations are more likely than their counterparts to have been selected for their position from within the organization, work part time, and maintain a private medical practice. It appears that physician managers

in physician organizations agree with Slater (1980a), who argues that physicians need to continue private practices to maintain their credibility. (This is consistent with the fact that more of these physician managers work part time). In contrast, physician managers in hospitals are more likely to have formal contracts with the organization, a written job description, and regular job evaluations.

Once again, it can be concluded that differences in organizational structure account for differences between physician managers. According to Katz and Kahn (1978), larger, more complex organizations need to develop formal control mechanisms to ensure conformity with organizational goals. Contracts, job descriptions, and evaluations are all considered control mechanisms. It is probable that the smaller, more informal structure of physician organizations, is able to accommodate to the needs and/or desires of the organization and the individual, while the hospital can not.

#### Conclusions from Chi-Square Analysis

The most important conclusion resulting from the chi-square analysis is that organizational characteristics are more influential in determining physician manager responsibility for the 10 representative

tasks than personal characteristics.<sup>2</sup> Specifically, having a line as opposed to staff position is associated with responsibility for six of the 10 tasks. Type of organization, job description, size of the physician organization, and full versus part-time position are all significantly associated with responsibility for three tasks. The number of licensed beds is associated with responsibility for two tasks, and ownership with one task.

The distinction between line and staff has long been accepted as a way to differentiate between types of positions within organizations. In this study, line positions are consistently associated with physician managers having higher rates of responsibility for the tasks. Recently the American Academy of Medical Directors (AAMD) has chosen to use a line position as a criterion for fellowship in the recently formed American College of Physician Executives. This reinforces the perceived importance of a line position to physician managers.

With regard to job description and full versus part-time positions, the association with physician managers' responsibility is not surprising. More physician managers who work full time and who have written job descriptions have responsibility for certain tasks. However, organizational type, size and

ownership deserve additional comment.

Organizational type, ownership, and size are often considered important factors in explaining various characteristics of organizational structure (Pugh et. al., 1969). These in turn are known to affect the role of health administrators (Kuhl, 1977). In this study, physician managers in physician organizations had higher rates of responsibility for three tasks. Two of these are considered policy management: #5, deciding which programs and medical services the organization offers; and #6, deciding the size of programs and medical services. If physician organizations are smaller, less formal organizations, it is intuitively appealing to assume that physician managers would have responsibility for these tasks. In fact, there is likely to be no one else in the organization who could or would make these decisions.

The same argument could be made regarding task #55, designing ways to improve efficiency of professional departments. This is a resource management function and it has been previously established that physician managers in physician organizations have higher rates of responsibility for resource management tasks than their counterparts in hospitals. However, it is understandable that because physician organizations are less bureaucratic, physician managers could

be imaginative and inventive and might experiment with ways to improve efficiency. They are unencumbered by the massive red tape common to most bureaucratic organizations.

A specific pattern is evident when the association between the size of a physician organization and responsibility is examined. Physician managers in medium-sized physician organizations (6-20 FTEs) have higher rates of responsibility than small (0-5 FTEs) or large organizations (21+). One explanation of this finding may be that in larger physician organizations, as with hospitals, a division of labor results in specialists being hired to assume responsibility for tasks that were previously the responsibility of physician managers (e.g., personnel, scheduling, etc.). In smaller physician organizations, certain tasks may not be appropriate to the organization. Therefore, physician managers are simply not responsible for these tasks.

A dissimilar pattern emerges when examining the association between licensed beds (hospital size) and responsibility. In both cases, more physician managers in smaller hospitals (under 50 beds) have responsibility than in medium size (51-199 beds) or large hospitals (200+ beds). However, the explanation may be similar to the above discussion. That is,

smaller hospitals may have more in common with medium-sized physician organizations than they do with larger hospitals. There may be less specialization and division of labor, resulting in more physician managers having responsibility for the tasks.

Ownership is significantly associated with only one task: #5, deciding which programs and medical services the organization offers. More managers working in organizations owned by the federal government are found to have responsibility for this association task. The meaning of this is not entirely clear. However, one explanation is that physician managers in highly structured organizations, such as veterans administration hospitals, are simply assigned responsibility for this task, while physician managers in other types of government-owned organizations or in non-governmental organizations are not.

The second major conclusion resulting from chi square analysis is that of the personal characteristics studied, experience has a more important influence on responsibility than education. Only one educational variable, graduate courses in a university setting, is significantly associated with physician manager responsibility for a task. On the other hand, five experience variables are associated with physician manager responsibility for seven tasks.

To illustrate this association, it was found that the longer physicians spent in their medical practices before assuming their current position, the higher rates of responsibility for two of the ten tasks: #60, designing new or modifying existing risk management programs; and #82, advising and/or counseling physicians on career or professional issues. This coincides with what the literature suggests about the physician's work environment. As discussed in Chapter III, Friedson (1975) argues that the work environment is more important than education in explaining important elements of professional performance.

Although for the most part, more experience results in a higher rate of responsibility, this is not always the case. Voluntary management experience is significantly associated with physician manager responsibility for task #68, designing contracts for physicians. However, fewer physician managers with this type of experience have responsibility for this task. A similar situation is found with physician managers who have experience in paid management positions. The longer the experience, the fewer physicians who have the responsibility for task #33, promoting the organization.

The reason for this inverse association may be that experience (and education) are correlated with



age. Although an increasing number of physicians are entering contractual relationships with health care organizations, and health care marketing (promoting the organization) is currently receiving considerable attention, these tasks are not traditionally part of health care management. It is possible that older physicians who most likely have voluntary management experience and/or experience in paid management positions, are unfamiliar with either of these concepts.

Therefore physician managers with this experience may either choose not to assume responsibility or are not given responsibility for these tasks. Conversely, the implication is that younger physician managers are the ones who are more likely to have additional non medical education and are therefore assuming responsibility for designing contracts and promoting the organization. Depending on the goals of the organization, this may or may not be a factor when hiring physician managers.

#### Summary of Conclusions

In summary, the important conclusions from this study are enumerated below:

1. Regardless of organizational type, physician managers have responsibility for and perform tasks that are appropriate for their position in the

organization.

2. The major differences between tasks for which physician managers in hospitals and physician organizations are responsible and perform often can most likely be explained by differences in the organizational structure of hospitals and physician organizations.

3. The differences in working arrangements between physician managers in hospitals and physician organizations are also likely to be a result of differences in organizational structure.

4. Organizational characteristics such as line position, or size, influence physician manager responsibility more often than personal characteristics such as education or experience.

5. Of the personal characteristics, experience influences responsibility more often than education.

#### Suggestions for future research

There are two categories of work which are suggested as a result of this study. First are studies that would enhance the ability to generalize about the job of physician managers. Second, comparative research is needed that would demonstrate the effect of physician managers on the effectiveness and efficiency in health care organizations.

### Research on the Job of Physician Managers

Since this research is limited to physician managers who are members of the American Academy of Medical Directors (AAMD), it would be useful to study physician managers who are not members of AAMD. Alternatively, the general population of physician managers without regard for AAMD membership could be studied. The difficulty in either of these studies lies in obtaining an appropriate population. Other than professional organizations, there is no clear way to identify which institutions employ physician managers. Nonetheless, the findings of such research could be compared with the findings of this study and result in the ability to make meaningful generalizations about the work of all physician managers.

Along the same line, this study was limited to physician managers in hospitals and physician organizations. Research on physicians in management positions in other types of organizations, such as industrial organizations, nursing homes, and community health centers, needs to be done. This would also lead to an increased knowledge about the job of all physician managers.

Previous research indicates that sex discrimination against women occurs in most stages of the employment and process (Terborg, 1977). In this study

the vast majority of the population was male. A study of women physician managers might address a number of questions: (1) Are male and female physicians responsible for and/or perform the same tasks? (2) Is the profile of women physician managers the same as that of males with regard to age, years in practice, specialty, etc.? 3) Is sex an issue when physicians are hired in management positions?

Research on Physician Managers and the Efficiency/  
Effectiveness of Organizations

Many of the studies reviewed in Chapter II demonstrated the benefits of coordination, conflict management, and physician participation in organization decision-making to the efficiency and effectiveness of health care organizations. This study examined the job of physicians in management positions. As previously discussed, one way to view the tasks for which most physicians were found to be responsible is as coordinating tasks, conflict management tasks, and tasks dealing with organization decision-making. A logical continuation would be a study of health care organizations that employed physician managers and compare those to organizations without physician managers. Another approach would be a longitudinal study of the same organization before and after hiring a physician manager. For either approach specific

criteria for measuring the efficiency/effectiveness would need to be defined and in the first design, organizations would need to be matched with regard to size, ownership, and other variables.

Findings from this study indicate that few physician managers were responsible for financial aspects of management. Research reviewed previously suggests that when physicians are involved in the financial aspects of management, there are improvements in cost containment and quality of care. However, little is known about the reasons physicians are not more involved in financial management of their organizations. Is it, as previously suggested (Herzlinger, 1978), because they do not have the necessary skills? Is it a function of personal preference, or is it that the organizations do not invite physician participation in financial management? If the answers to these questions were known, strategy to increase this type of physician involvement could be formulated.

Issues of power, authority and influence have long been of interest to students of organizational behavior. As Katz and Kahn have stated, ". . . every organization faces the task of somehow reducing the variability, instability, and unpredictability of individual human acts" (Katz and Kahn, 1978, p. 196).

Kurtz (1980a) studied the behavior and leadership styles of physician managers, but to date, there have been no definitive studies describing the way in which physician managers use power, authority, or influence.

Although authority and influence were not the focus of this study, the findings did indicate that physician managers perceive themselves to have more influence than authority (See survey, Appendix B, Part I). This issue provoked questions and should stimulate further research and investigation. This is important if organizations are to ensure that role requirements are carried out by each individual member, and if physician managers are to use power, authority, and influence in the most beneficial way for themselves and the organization.

Studies such as these would be extremely useful on several counts. First, they would provide the information necessary to help health care organizations decide whether or not to hire a physician manager. They would also highlight areas of need for skill development, e.g., use of power. Next, if physician managers were found to be cost effective, e.g., assisting the organization in cost containment efforts while increasing quality of care, then incentives for organizations to hire physicians in management positions might be designed by third party payors,

especially the government. Finally, if more health care organizations began hiring physician managers, it would provide employment opportunities for physicians who now and will increasingly experience a surplus in their numbers.

## NOTES - CHAPTER V

1. This may in part explain why services provided in physician organizations are less expensive than those provided in hospitals.

2. See Chapter III, p. 109.



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## APPENDICES

APPENDIX A  
THE SURVEY INSTRUMENT

## **Role/Compensation Survey**

**Conducted by the  
American Academy of Medical Directors  
in cooperation with the  
University of Colorado**

**Principal Researcher Carol Betson  
2183 South Dayton  
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## BACKGROUND

The vital rôle of physician managers in our health care delivery system is well recognized. The American Academy of Medical Directors (AAMD) is involved in a number of activities and research projects to better understand this group of physicians. The attached questionnaire represents one of these efforts.

Medical directors and other physician managers from hospitals, Prepaid Health Plans (PPHP), Group Practices and other organizations are being surveyed in order to identify the tasks which are typically performed. Multiple consultations with a group of physician managers from AAMD have been extremely helpful in developing relevant questions for this survey. In addition, to ensure relevance and ease the process of completion, the survey has been pretested with 44 AAMD members.

There are four parts to the survey. Part I asks questions about your personal background and training. It should take about eight minutes to complete. Part II asks questions about your Organization, Department/Service, or Agency. This section should take about nine minutes to complete. Part III asks questions about the compensation aspects of your job and should take about five minutes to complete. Part IV, the task list, asks about the tasks for which the physician managers are responsible, the frequency with which they are performed, and the perceived importance of these tasks to the overall effectiveness of your Organization, Department/Service or Agency. This extremely important section is the longest but should take no more than 25-30 minutes to complete. The entire questionnaire requires about 50 minutes of your time.

Results of this research will be useful to physician managers and to AAMD. First, it is generally acknowledged that the subject of physicians in management deserves further attention. There are now few empirical studies of physician managers. It is hoped that this research will provide a baseline for documenting the contributions of this group. Second, the data from this survey, reported in aggregate form, will enable an individual to compare tasks he/she does with tasks other physician managers perform. This might result in reassessing priorities, rewriting job descriptions, or renegotiating certain aspects of the job. Finally, AAMD will be able to use the data from this research as a guide for curriculum development. Seminars can be especially focused to meet the needs of physician managers working in specific settings.

INDIVIDUAL CONFIDENTIALITY IS ASSURED. Findings will be reported ONLY in aggregate form and respondents will be given the results through AAMD. Your assistance and time in completing this survey is greatly appreciated.

PART ONE

INSTRUCTIONS

(1-4)

This section asks questions about your personal background. Please mark the box next to the most appropriate answer. Remember that these questions relate to your management/administrative position.

INDIVIDUAL INFORMATION

1. Sex  Male  Female (5)

2. Date of Birth (mo./day/yr.) \_\_\_\_\_ (6-11)

3. Clinical Specialty (12-13)  
 1  Family Practice  
 2  Internal Medicine  
 3  General Surgery  
 4  Psychiatry  
 5  Pediatrics  
 6  OB/GYN  
 7  Radiology  
 8  Preventive Medicine  
 9  Physical Medicine & Rehab.  
 10  Other (please specify) \_\_\_\_\_

4. Are you board certified in your area of specialization?  
 1  Yes  No (14)

5a. Is membership on your medical staff or Independent Practice Association (IPA) a requirement for your position?  
 1  Yes  No  Not applicable (15)

5b. If yes, what is your status:  
 1  Active  Provisional  
 2  Courtesy  Other (please specify) \_\_\_\_\_  
 3  Inactive (16)

6. Mark the answer(s) that describe(s) your training in management or administration.  
 None (17)  
 Undergraduate degree in management or administration (18)  
 Masters in Public Health (19)  
 Masters in Business Administration (20)  
 Masters in Health Administration (21)  
 Graduate courses in a university based management or business program (22)  
 Continuing education in management (e.g. AAMO seminars) (23)  
 Other (please specify) \_\_\_\_\_ (24)

7. Before assuming your current position, please list:  
 a Years in medical practice \_\_\_\_\_ (25-28)  
 b Years in paid management position \_\_\_\_\_ (27-28)  
 c Years in other paid professional work relating to your current management position \_\_\_\_\_ (29-30)  
 d Years in armed services \_\_\_\_\_ (31-32)

8. Mark which of the following work experiences you have had:  
 Internship/residency (33)  
 Medical Practice (34)  
 Voluntary Management experience (e.g., chief of service; chair of standing committee; board member) (35)  
 Paid management experience (36)  
 Other paid professional work (e.g. Public Health Service; government programs) (37)  
 Armed Services (38)  
 Business experience (e.g. entrepreneurial activities, real estate, investments, etc.) (39)  
 None of the above (40)  
 Other (please specify) \_\_\_\_\_ (41-43)

9. Mark how helpful the following experiences have been in preparing you for your current position.

	HELPFULNESS				
	Very Helpful	Somewhat Helpful	Not Very Helpful	Not At All Helpful	
	1	2	3	4	
Clinical experience of Internship/residency .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(44)
Organizational or supervisory experience of Internship/Residency (e.g., Chief Resident) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(45)
Clinical aspects of Medical Practice .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(46)
Managerial aspects of medical practice .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(47)
Voluntary management experience .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(48)
Paid management experience (other than practice) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(49)
Other paid organizational work .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(50)
On the job training .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(51)
Armed Services .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(52)
Business experience .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(53)
Formal education as noted in Question 6 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(54)
Other (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(55-57)

10. How many years have you held your current position? \_\_\_\_\_ (58-59)

11. How many people preceded you in your current position? \_\_\_\_\_ If unknown, check here  (60-61)

12. Were you working for this Organization, Department/Service or Agency before you assumed your current position? (62)  
 1  Yes 2  No
13. Please mark the method used to select you for your current position. (63)  
 1  Elected (e.g. by Medical Staff, Executive Committee of Medical Staff, and/or Administration of Organization or Group)  
 2  Selected (e.g. by Medical Staff, Executive Committee of Medical Staff, Administrator, Dean, CEO, or search process)  
 3  Assigned (e.g. with military)  
 4  Other (please specify) \_\_\_\_\_
14. Do you now hold any paid administrative or management position in ADDITION to your current job? (64)  
 1  Yes 2  No
15. Is your position considered full or part time? (65)  
 1  full time (35 hours a week or more)  
 2  part time (less than 35 hours e.g. 1/4 time or 2/3 time)
16. Do you have a written contract or memorandum of understanding with your Organization or Agency? (66)  
 1  Yes 2  No
- 17a. Is there a written job description for your position? (67)  
 1  Yes 2  No
- 17b. If yes, by whom was it written? Mark as many as apply. (e.g. for job descriptions written by committees, indicate members) (68)  
 Self (69)  
 Medical Director (70)  
 CEO (71)  
 Vice Pres. of Professional or Medical Affairs (72)  
 Vice President of Organization (73)  
 Medical staff (or Exec. Committee of Medical Staff) (74)  
 Service or Department Chief (75)  
 Personnel Director of Organization (76)  
 External Consultants (77)  
 Dean (78)  
 Board of Trustees (79-81)  
 Other (please specify) \_\_\_\_\_
- 18a. Is there a formal evaluation of your job performance? (82)  
 1  Yes (answer questions 18b. & 18c.)  
 2  No (skip to question 19)
- 18b. If yes, who evaluates your performance? (83)  
 Self (84)  
 Medical Director (85)  
 CEO (86)  
 Vice Pres. of Professional or Medical Affairs (87)  
 Vice President of Organization (88)  
 Medical staff (or Exec. Committee of Medical Staff) (89)  
 Service or Department Chief (90)  
 Personnel Director of Organization (91)  
 External Consultants (92)  
 Dean (93)  
 Board of Trustees (94-96)  
 Other (please specify) \_\_\_\_\_
- 18c. How often does the evaluation occur? (97)  
 1  Annually 2  Other (please specify) \_\_\_\_\_
19. Do you maintain a private medical practice? (98)  
 1  Yes 2  No
20. If yes, since assuming your current position has time spent in your practice: (99)  
 1  substantially increased  
 2  somewhat increased  
 3  not changed  
 4  somewhat decreased  
 5  substantially decreased
21. Do you feel your primary professional commitment is: (100)  
 1  to your private medical practice  
 2  to your management/administrative responsibilities  
 3  to other professional duties
- JOB SATISFACTION**
22. Please mark the answer that best describes how you feel about your job. (101)  
 1  very dissatisfied 3  somewhat satisfied  
 2  somewhat dissatisfied 4  very satisfied

## PART TWO

## INSTRUCTIONS

This section asks questions about the Organization, Department/Service or Agency with which you are associated. Please place a mark in the box next to the most appropriate answer. Remember that these questions relate to your management/administrative position.

## ORGANIZATIONAL CHARACTERISTICS

1. Title. (102-103)  
When you select the most appropriate answer to this question, it should reflect the *principal* position you hold in your organization or agency. If your time is shared between two positions, choose only one and answer the remainder of the questionnaire with that perspective in mind.
- 1 Chief Executive Officer
  - 2 Vice President of Medical or Professional Affairs
  - 3 Medical Director of an Organization
  - 4 Director of Medical Affairs
  - 5 Medical Director of a Service, Department or Program
  - 6 Assistant Medical Director
  - 7 Clinical Director of Dept., Service or Program
  - 8 Chairman or Chief of Dept. or Services
  - 9 Director of Medical Education
  - 10 Chief of Staff
  - 11 Other (specify) \_\_\_\_\_
2. Type of organization: (104-105)  
Please mark the answer that best describes your Organization. If you work with more than one organization, choose the one that is consistent with the title you marked in Question One.
- 1 General Hospital (University based)
  - 2 General Hospital (non-University based)
  - 3 Specialty Hospital (University based)
  - 4 Specialty Hospital (non-University based)
  - 5 Long-term Care Hospital
  - 6 Single Specialty Group Practice
  - 7 Single Specialty Group Practice with over 50% associated with a health plan.
  - 8 Single Specialty Group Practice with less than 50% associated with health plan.
  - 9 Multi-specialty Group Practice
  - 10 Multi-specialty Group Practice with over 50% associated with a health plan.
  - 11 Multi-specialty Group Practice with less than 50% associated with health plan.
  - 12 Staff (or Group) Model Prepaid Health Plan (PPHP)
  - 13 Independent Practice Association (IPA)
  - 14 Nursing Home (or extended care facility)
  - 15 Industrial Organization
  - 16 Pharmaceutical Company
  - 17 Government Agency
  - 18 Military
  - 19 Community Health Center
  - 20 Other (specify) \_\_\_\_\_
3. Ownership (mark one) (106)
- |  |   |
|--|---|
| <input type="checkbox"/> 1 For profit                  | <input type="checkbox"/> 5 State Government             |
| <input type="checkbox"/> 2 Non profit, non govt.       | <input type="checkbox"/> 6 Local Government             |
| <input type="checkbox"/> 3 Non profit, govt. sponsored | <input type="checkbox"/> 7 Other (please explain) _____ |
| <input type="checkbox"/> 4 Federal Government          |   |
4. Which of the following positions does your Organization or Agency have? (Mark as many as apply)
- Medical Director (107)
  - Chief of the Medical Staff (108)
  - Director of Medical Education (109)
5. Does your Organization or Agency have or is it affiliated with a residency program?  
1  Yes 2  No (110)

## REPORTING/COMMUNICATION ARRANGEMENTS

6. To whom do you FORMALLY report in the Organization or Agency? (Mark as many as may apply) Record 2
- Governing body as a whole (1)
  - Few selected members of the governing body (e.g. Exec. Comm.) (2)
  - Chief Executive Officer (3)
  - Dean or Chancellor (4)
  - Medical Director (5)
  - Executive of Parent Organization (6)
  - Executive Committee of Medical staff (7)
  - Medical Staff (8)
  - Chief of staff (9)
  - Chief of Service or Dept. Chair (10)
  - Vice President of Medical Affairs or other Vice President in the Organization (11-12)
  - Other (specify) \_\_\_\_\_ (13-15)

- 7a In addition to the above, are you **INFORMALLY** accountable to anyone else in the Organization or Agency? (16)  
 Yes      2  No
- 7b If yes, to whom? (mark as many as apply) (17)  
 Medical staff (17)  
 Exec. Comm. of Med. Staff (18)  
 Pres. of Organization (19)  
 CEO (20)  
 Chair of Dept. or Service (21)  
 Board of Trustees (22)  
 Other (please specify) \_\_\_\_\_ (23-24)
8. How would you describe the position you hold within your Organization or Agency? Please note: LINE position is defined as managerial with delegated authority to make certain organizational decisions. STAFF position is defined as advisory not usually requiring final decision making activity (25)  
 1  Line                                      3  Mostly Line  
 2  Staff                                      4  Mostly Staff
9. Do you think your position should be: Record 3 (1)  
 1  Line                                      3  Mostly Line  
 2  Staff                                      4  Mostly Staff
10. How much formal authority do you feel you have in your organization or agency? (2)  
 1  A great deal                              3  Very little  
 2  Some                                      4  Almost none
11. How much influence do you feel you have in your organization or agency? (e.g. in general decision making) (3)  
 1  A great deal                              3  Very little  
 2  Some                                      4  Almost none
- 12a. Do you generally attend Governing Board meetings? (4)  
 1  Yes                                      2  No
- 12b. Are you a member of the Governing Board? (5)  
 1  Yes                                      2  No
- 12c. Do you have a vote on the Governing Board? (6)  
 1  Yes                                      2  No
13. Which of the following formal or informal mechanism does your Organization, Agency or Group use to ensure communication between the Medical Staff Organization or physicians, and the Administration or Business Staff? (Mark as many as apply) (7)  
 Regularly scheduled staff meetings (e.g. Medical Staff, Executive Committee of Medical Staff) (7)  
 Regularly scheduled management/decision making Policy Committee meetings (8)  
 Regularly scheduled breakfast, lunch or dinner meetings (incl. brown bag lunches) (9)  
 Assigned agenda time for reports, updates, announcements in Committee meetings. (10)  
 Cross representation on Committees (e.g. physician to Board; CEO to Medical Staff) (11)  
 Informal on the job meetings (12)  
 Informal off the job meetings (13)  
 Off site retreats (14)  
 Staff memoranda (15)  
 Administrative directives/guidelines (16)  
 Files of communications, messages, memos, etc. (17)  
 Bulletin boards (18)  
 Newsletters (19)  
 Other (specify) \_\_\_\_\_ (20-22)

**IF YOUR ORGANIZATION IS A HOSPITAL, ANSWER QUESTIONS 14 THROUGH 22. IF NOT, SKIP TO QUESTION 23**

- 14a. Does your hospital have a national or regional affiliation (e.g. HCA, Sisters of Charity, etc.)? (23)  
 1  Yes      2  No
- 14b. If Yes, specify \_\_\_\_\_ (24-25)
15. How many physicians are there on your Medical Staff? (total for all categories, e.g. active, courtesy, etc.) \_\_\_\_\_ (26-29)
16. How many full time physicians are employed by your Organization? (2 half time = 1 full time) \_\_\_\_\_ (30-33)
17. How many full time contract physicians are there in your Organization? \_\_\_\_\_ (34-37)
18. What was the (approximate) number of in-patient days in 1982? \_\_\_\_\_ (38-43)
19. How many licensed beds are there in your Organization? \_\_\_\_\_ (44-48)
20. How many ICU beds are there in your Organization? (total, including CCU, neonatal, etc.) \_\_\_\_\_ (49-52)
21. Does your Organization participate in a Prepaid Health Plan (PPHP)? (53)  
 1  Yes      2  No
22. Does your organization participate in a Preferred Provider Organization (PPO) or an Exclusive Provider Organization (EPO)? (54)  
 1  Yes      2  No

When you have finished this section, you may skip to Part 3



IF YOUR ORGANIZATION IS A GROUP PRACTICE, ANSWER QUESTIONS 23 THROUGH 27. IF NOT, SKIP TO QUESTION 28.

- 23a. Does your group provide any prepaid health care (e.g. involved with HMO, IPA, or own contract plan)?  
 1  Yes      2  No (55)
- 23b. If Yes, approximately what percent of your group's annual revenue is derived from Prepaid Health Care arrangement? \_\_\_\_\_ % (56-58)
24. How many full time physicians are there in your Group? \_\_\_\_\_ (59-62)
25. How many part time physicians are there in your Group? \_\_\_\_\_ (63-66)
26. What is the total number of full time non-physician employees in your Group? \_\_\_\_\_ (67-71)
27. Does your Group participate in a Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO)?  
 1  Yes      2  No (72)

When you have finished this section, you may skip to Part 3

IF YOUR ORGANIZATION IS ANY TYPE OF A PREPAID HEALTH PLAN, ANSWER QUESTIONS 28 AND 29. IF NOT, SKIP TO QUESTION 34.

- 28a. Does your Organization have a national or regional affiliation (e.g. Kaiser, INA)?  
 1  Yes      2  No (73)
- 28b. If Yes, specify \_\_\_\_\_ (74-75)
29. How many enrollees does your Organization have? \_\_\_\_\_ (76-83)

IF YOUR ORGANIZATION IS A STAFF MODEL PREPAID HEALTH PLAN, ANSWER QUESTIONS 30-32. IF NOT, SKIP TO QUESTION 33.

30. How many full time physicians are there in your facility? \_\_\_\_\_ (84-88)
31. How many part time physicians are there in your facility? \_\_\_\_\_ (89-93)
32. How many non-physician full time employees are there in your facility? \_\_\_\_\_ (94-98)

When you have completed this section, you may skip to Part 3.

IF YOUR ORGANIZATION IS AN IPA MODEL PREPAID HEALTH PLAN, ANSWER QUESTION 33. IF NOT, YOU MAY SKIP TO PART 3.

33. How many physicians participate in the IPA? \_\_\_\_\_ (99-103)

When you have completed this section, you may skip to Part 3

IF YOUR ORGANIZATION, DEPARTMENT/SERVICE OR GROUP DOES NOT FALL INTO ANY OF THE ABOVE CATEGORIES, ANSWER QUESTIONS 34 THROUGH 36.

34. How many full time physicians work in your Organization, Department/Service or Agency? \_\_\_\_\_ (104-108)
35. How many part time physicians work in your Organization, Department/Service or Agency? \_\_\_\_\_ (109-113)
36. How many non-physician full time employees are there in your Organization, Department/Service or Agency? \_\_\_\_\_ (114-118)

## PART THREE

## INSTRUCTIONS

This section asks questions dealing with compensation aspects of your job. Again, *please be assured* that data will be reported in aggregate form only. Remember that these questions relate to your management/administrative position.

1. Approximately what percentage of your time do you think is devoted to management activities? Record 4  
Hours per week \_\_\_\_\_ (1-2)  
Percentage \_\_\_\_\_% (3-5)
2. Are you financially compensated for management activities?  
1  Yes      2  No      3  Sometimes (6)
3. What was the established annual salary for your position in 1982 (not including income from private practice or second job)?  
\$ \_\_\_\_\_ (7-12)
4. What was the total amount you received in bonuses from your Organization or Agency for your management role in 1982?  
\$ \_\_\_\_\_ (13-17)
5. What was the total share of profits or dividends you received from your Organization or Agency in 1982?  
\$ \_\_\_\_\_ (18-22)
6. What was the annual dollar amount of pension and retirement pay contributed by your Organization or Agency in 1982?  
\$ \_\_\_\_\_ (23-27)
7. Does the Organization or Agency pay the Premium for your malpractice insurance?  
1  Yes      2  No (28)
8. Did your Organization or Agency pay the Premium or provide:  
 Health Insurance (29)  
 Life Insurance (30)  
 Disability Insurance (31)  
 Other (please specify) \_\_\_\_\_ (32)  
\_\_\_\_\_ (33-35)
9. How many WEEKS of paid vacation were you authorized to receive in 1982? \_\_\_\_\_ (36)
10. How many DAYS of paid professional or educational leave were you authorized to receive in 1982? \_\_\_\_\_ (37-38)
- 11a. Please mark all other compensations or benefits you received from your Organization or Agency in 1982:  
 Membership dues for Professional Organizations (39)  
 Membership dues for other than Professional Organizations (e.g. country clubs, athletic clubs) (40)  
 Additional Life Insurance (41)  
 Additional Health Care Benefits (e.g., dental insurance) (42)  
 Travel and expenses to Professional Conferences or Conventions (e.g. AAMD seminars) (43)  
 Car (44)  
 Car including maintenance, insurance and/or gas (45)  
 Entertainment expenses (46)  
 Other private educational expenses (e.g. books, journals, etc.) (47)  
 Additional time off (48)  
 Stock options (49)  
 Other (please specify) \_\_\_\_\_ (50)  
\_\_\_\_\_ (51-52)
- 11b. What do you estimate the dollar value to be of additional benefits marked above? \$ \_\_\_\_\_ (53-57)
12. When you assumed your current job, your total financial compensation:  
1  Increased by \$ \_\_\_\_\_ representing \_\_\_\_\_% of total compensation (58)  
2  Decreased by \$ \_\_\_\_\_ representing \_\_\_\_\_% of total compensation (59-63)  
3  Remained the same (64-66)

PART FOUR

# Task List

**Instructions:** For each task you are being asked three questions. First, do you have **RESPONSIBILITY** for this activity in your Organization, Department/Service or Agency, as part of your job? Mark either: Yes, No, or N/A. If the question does not apply to your work situation, mark N/A and go on to the next question. If you share this responsibility with others, such as a Committee, mark Yes, that you are responsible, and address your own component when marking the other two columns.

**Second,** you are asked to mark the **FREQUENCY** column or how often you find yourself handling this task. Mark either: Rarely, Occasionally, Frequently or Very frequently. Please note: It is well recognized that although you are not formally responsible for doing so as part of your job, you may actually handle any of the activities listed. If this is the case, mark NO under the **RESPONSIBILITY** column, and then proceed to mark how frequently you handle the activity.

**Third,** you are being asked to indicate **HOW IMPORTANT** you perceive each task to be to the **OVERALL EFFECTIVENESS** of your Organization, Department/Service or Agency. Mark either: Very important; Somewhat important; or Not very important.

RESPONSIBILITY			FREQUENCY				IMPORTANCE TO OVERALL EFFECTIVENESS OF ORGANIZATION		
YES	NO	N/A	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY	NOT VERY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT

**A. INSIDE THE ORGANIZATION, DEPARTMENT/SERVICE, OR AGENCY**

1. Preparing new or modifying existing bylaws. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(67-69)
2. Preparing new or modifying existing policies and/or procedures. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(70-72)
3. Preparing goals and objectives for the Organization, Department/Service. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(73-75)
4. Designing or reviewing new programs. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(76-78)
5. Deciding which programs and medical services your Organization, Department/Service or Agency offers. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(79-81)
6. Deciding the size of programs and medical services. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(82-84)
7. Deciding patient care equipment needs. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(85-87)
8. Deciding the number and type of physicians that practice in your Organization, Department/Service or Agency. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(88-90)
9. Writing new or modifying existing criteria for the responsibilities of physicians. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(91-93)
10. Writing new or modifying existing criteria for the privileges of physicians. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(94-96)
11. Deciding on pricing for services. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(97-99)
12. Monitoring and reporting on issues of interest (and/or concern) of Medical Staff to Administration or Business Staff. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(100-102)
13. Monitoring and reporting on issues of interest (and/or concern) of Administration or Business Staff to Medical Staff. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(103-105)
14. Communicating information to both the Medical Staff and Governing Body of the Organization, Department/Service or Agency (e.g., decisions made, new policies, etc.). ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(106-108)
15. Writing new or modifying existing standards of medical care practice. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(109-111)
16. Ensuring that standards of care are written and disseminated. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(112-114)
17. Writing new or modifying existing administrative or business (versus medical care) policies for the Medical Staff (e.g. informed consent issues; ways to establish E.R. call list, etc.). ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(115-117)
18. Ensuring administrative or business policies for the Medical Staff are written and disseminated. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(118-120)

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	RESPONSIBILITY			FREQUENCY			IMPORTANCE TO OVERALL EFFECTIVENESS OF ORGANIZATION				
	YES	NO	N/A	SOFTLY	DISCUSSIONALLY	FORMALLY	NOT FREQUENTLY	NOT FREQUENTLY	VERY IMPORTANT		NOT IMPORTANT
19. Preparing or modifying existing administrative policies for non-physician health professionals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Record 5 (1-3)
20. Chairing Medical Staff Committees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4-6)
21. Attending Medical Staff Committees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(7-9)
22. Chairing Administrative Committees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(10-12)
23. Attending Administrative Committees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(13-15)
24. Chairing Board Committees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(16-18)
25. Attending Board Committees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(19-21)
26. Preparing agenda items for Medical Staff or Physicians' meetings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(22-24)
27. Preparing agenda items for meetings with the Administrative or Business Staff or with the Administration of the Organization (e.g., business manager or CEO.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(25-27)
28. Preparing agenda items for meetings with the Governing Body. ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(28-30)
29. Deciding on research activities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(31-33)
<b>B. OUTSIDE THE ORGANIZATION, DEPARTMENT/SERVICE, OR AGENCY</b>											
30. Monitoring and reporting on changes in the social environment (e.g. high concentration of elderly in service area), in the economic environment (e.g. local unemployment rate), or in the political environment (e.g. cuts in health care delivery service), in order to identify issues to be acted upon by the Organization, Department/Service or Group...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(34-36)
31. Lobbying Regulatory Agencies (e.g., HSA's, State Licensing Authority) or Legislative Bodies (e.g., Federal Government, State Legislature).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(37-39)
32. Coordinating with other Health Care Organizations (e.g. about patient care issues, shared services).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(40-42)
33. Promoting your Organization, Department/Service or Agency (e.g. to local industries or to the general public).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(43-45)
34. Representing (being a spokesperson for) your Organization, Department/Service or Agency to other Medical or Health Care Organizations (e.g. local Medical Society).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(46-48)
35. Representing (being a spokesperson for) your Organization, Department/Service or Agency to the general public (e.g., speak to local groups, meet the press, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(49-51)
36. Representing your Organization or Agency to third party payors. .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(52-54)
<b>C. QUALITY ASSURANCE</b>											
37. Designing new or modifying existing programs that compare physicians' behavior to established standards of care in the Organization, Department/Service or Agency.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(55-57)
38. Ensuring that a system for review and evaluation of the credentials of new physicians being admitted to the Organization or Agency exists.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(58-60)
39. Ensuring that a system for review and evaluation of Medical Staff competency exists (e.g. identifying the impaired physician).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(61-63)
40. Ensuring that a system for review and evaluation of Medical Staff competency operates effectively.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(64-66)

	RESPONSIBILITY			FREQUENCY			IMPORTANCE TO OVERALL EFFECTIVENESS OF ORGANIZATION			
	YES	NO	N/A	RARELY	PERIODICALLY	VERY FREQUENTLY	NOT VERY IMPORTANT	MODERATELY IMPORTANT	VERY IMPORTANT	
41. Monitoring or reviewing the system for evaluating the competency of non-physician health professionals. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(67-69)
42. Ensuring accreditation with JCAH, AAAHC, or other accrediting bodies. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(70-72)
<b>D. EDUCATIONAL ACTIVITIES</b>										
43. Designing Continuing Education (CE) programs for physicians. ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(73-75)
44. Designing CE programs for non-physicians. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(76-78)
45. Designing general (non-clinical) education programs (e.g., management courses). ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(79-81)
46. Teaching CE programs to physicians, including house staff if applicable. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(82-84)
47. Teaching CE programs to non-physician health care professionals, clients and/or their families. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(85-87)
48. Evaluating education programs. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(88-90)
<b>E. DATA MANAGEMENT</b>										
49. Ensuring systems designed to obtain data necessary to evaluate medical care are developed. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(91-93)
50. Ensuring systems designed to obtain data necessary for general management decisions are developed (e.g., management information system). ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(94-96)
51. Monitoring and reporting on data from systems designed to obtain information about medical care. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(97-99)
52. Monitoring and reporting on data from systems designed to obtain data for management decisions. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(100-102)
53. Ensuring that data relevant to medical care issues are used appropriately. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(103-105)
54. Ensuring that data relevant to management issues are used appropriately. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(106-108)
<b>F. FINANCIAL MANAGEMENT</b>										
55. Designing ways to improve efficiency of professional departments within your Organization or Agency. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(109-111)
56. Developing the budget or part of the budget for the Organization, Department/Service or Agency. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(112-114)
57. Reviewing the budget or part of the budget for the Organization, Department/Service or Agency. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(115-117)
58. Reviewing the financial performance of the Organization, Department/Service or Agency (e.g. management data exclusive of the budget). ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(118-120)
<b>G. RISK MANAGEMENT</b>										
59. Does your Organization or Agency have a risk management program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer questions 60 & 61. If not, skip to question 62.										Record 6 (1)
60. Designing new or modifying existing risk management functions. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2-4)
61. Monitoring and/or managing existing risk management functions and or programs. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(5-7)

RESPONSIBILITY			FREQUENCY			IMPORTANCE TO OVER-ALL EFFECTIVENESS OF ORGANIZATION		
1-5	1-2	1-3	DAILY	WEEKLY	MONTHLY	NOT VERY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT

**H. GENERAL MANAGEMENT**

- 62. Identifying the need for outside consulting services.          (8-10)
- 63. Obtaining/buying consulting services for the Organization.          (11-13)
- 64. Supervising capital construction projects as needed          (14-16)

**I. RESOURCE MANAGEMENT**

- 65. Designing incentive programs to increase physician productivity.          (17-19)
- 66. Ensuring that a physician recruiting program operates as needed.          (20-22)
- 67. Deciding scope of practice for non-salaried physicians.          (23-25)
- 68. Designing contracts for physicians.          (26-28)
- 69. Designing contracts for non-physicians.          (29-31)
- 70. Designing wage/benefit schedule for physicians.          (32-34)
- 71. Designing wage/benefit schedule for non-physicians.          (35-37)
- 72. Hiring physicians.          (38-40)
- 73. Hiring non-physician health care personnel.          (41-43)
- 74. Deciding expectations of salaried or contract physicians (e.g., writing a job description).          (44-46)
- 75. Deciding organizational expectations of non-physicians.          (47-49)
- 76. Supervising physicians (e.g. for appropriateness of hospitalization use).          (50-52)
- 77. Supervising non-physicians.          (53-55)
- 78. Ensuring a grievance procedure for physicians is followed.          (56-58)
- 79. Ensuring a grievance procedure for non-physicians is followed.          (59-61)
- 80. Negotiating with unions.          (62-64)
- 81. Advising and/or counseling physicians on personal issues.          (65-67)
- 82. Advising and/or counseling physicians on career or professional issues.          (68-70)
- 83. Advising and/or counseling non-physician health care personnel.          (71-73)
- 84. Mediating conflict among physicians.          (74-76)
- 85. Mediating conflict among physicians and non-physician health care personnel.          (77-79)
- 86. Mediating conflict among physicians and Administration or Governing Body.          (80-82)
- 87. Mediating conflict among non-physician health care employees.          (83-85)
- 88. Please add any tasks that you perform not listed \_\_\_\_\_ (86-88)
- \_\_\_\_\_ (89-91)
- \_\_\_\_\_ (92-94)
- \_\_\_\_\_ (95-97)
- \_\_\_\_\_ (98-100)
- \_\_\_\_\_ (101-103)
- \_\_\_\_\_ (104-106)
- \_\_\_\_\_ (107-109)

APPENDIX B

THE SURVEY INSTRUMENT: DESCRIPTIVE STATISTICS

## PART ONE

## INDIVIDUAL INFORMATION

1. Sex
 

Male 96%	Female 4%
----------	-----------
2. Mean Age 53 years
3. Clinical specialty
 

Family Practice 14.3%	Radiology 1.8%
Internal Medicine 29.1%	Preventive Medicine 3.4%
General Surgery 7%	Physical Med. & Rehab. 2.6%
Psychiatry 5.2%	Urology 1%
Pediatrics 12%	Pathology 1.2%
OB/GYN 5.6%	Otolaryngology 1%
Orthopedics 1.4%	Emergency Medicine 1.6%
Anesthesiology 1.8%	Other 10.8% *
4. Are you board certified in your area of specialization?
 

Yes 79.4%	No 20.6%
-----------	----------
- 5a. Is membership on your medical staff or Independent Practice Association (IPA) a requirement for your position?
 

Yes 69.7%	No 13.5%	Not applicable 16.8%
-----------	----------	----------------------
- 5b. If yes, what is your status?
 

Active 90.2%	Provisional .5%	
Courtesy 4.1%	Consultant .5%	
Inactive .8%	Other 3.9% **	
6. Mark the answer(s) that describes your training in management or administration.
 

None 17.2%	Graduate courses in a university based
Undergraduate degree in Mngmt. or Admin. .4%	mngmt. or bus.program 19.1%
Masters in Public Health 7.1%	Continuing ed. in mgmt. (e.g. AAMD seminars) 77.8%
Masters in Bus. Adm. 2.1%	Other 1.3% ***
Masters in Health Adm. 2.1%	
7. Before assuming your current position, please list:
 

Years in medical practice: Average 16.7

Years in paid management position: Average 5.4

\* For "other" specialties see Appendix C, p. 272

\*\* For "other" category see Appendix C, p. 272

\*\*\* For "other" management training see Appendix C, p. 273



Years in other paid professional work relating to your  
current management position: Average 2.9  
Years in armed services: Average 4.9

8. Mark which of the following work experiences you have had:

Internship/residency 99.4%  
Medical Practice 95.4%  
Voluntary Management experience (e.g., chief of service; chair of standing committee; board member) 81.8%  
Paid management experience 63%  
Other paid professional work (e.g. Public Health Service; government programs) 19.4%  
Armed Services 65.2%  
Business experience (e.g. entrepreneurial activities, real estate, investments, etc.) 35.2%  
Academic Position .6%  
None of the above .2%  
Other .4% \*

9. Mark how helpful the following experiences have been in preparing you for your current position.

Clinical experience of Internship/Residency:

Very helpful: 33.1%      Not very helpful: 20.7%  
Somewhat helpful: 29.3%      Not at all helpful: 15.5%

Organizational or supervisory experience of

Internship/Residency (e.g., Chief Resident)  
Very helpful: 25.5%      Not very helpful: 19.3%  
Somewhat helpful: 34.3%      Not at all helpful: 11.6%

Clinical aspects of Medical Practice

Very helpful: 44.8%      Not very helpful: 12.7%  
Somewhat helpful: 37.8%      Not at all helpful: 2%

Managerial aspects of medical practice

Very helpful: 47.2%      Not very helpful: 10.6%  
Somewhat helpful: 33.9%      Not at all helpful: 1.8%

Voluntary management experience

Very helpful: 43.2%      Not very helpful: 6.6%  
Somewhat helpful: 32.3%      Not at all helpful: 4%

Paid management experience (other than practice)

Very helpful: 44.4%      Not very helpful: 4.4%  
Somewhat helpful: 10.8%      Not at all helpful: 10%

\* For list of "other" experiences see Appendix C, p. 273

## Other paid organizational work

Very helpful: 7.8%                      Not very helpful: 10.8%  
Somewhat helpful: 15.1%                Not at all helpful: 13.1%

## On the job training

Very helpful: 58%                        Not very helpful: 3.2%  
Somewhat helpful: 17.5%                Not at all helpful: 2.6%

## Armed Services

Very helpful: 19.3%                      Not very helpful: 18.1%  
Somewhat helpful: 20.3%                Not at all helpful: 18.5%

## Business experience

Very helpful: 12.5%                      Not very helpful: 11%  
Somewhat helpful: 25.7%                Not at all helpful: 10.8%

## Formal education as noted on Question 6

Very helpful: 40.2%                      Not very helpful: 3.2%  
Somewhat helpful: 20.5%                Not at all helpful: 7%  
Other \*

10. How many years have you held your current position?

Average: 5.4 years

11. How many people preceded you in your current position?

Average: 1.6

12. Were you working for this Organization, Department/Service or Agency before you assumed your current position?

Yes 53.5%                                  No 46.5%

13. Please mark the method used to select you for your current position.

Elected (e.g. by Medical Staff, Executive Committee of Medical Staff, and/or Administration of Organization or Agency). 13.2%

Selected (e.g. by Medical Staff, Executive Committee of Medical Staff, Administrator, Dean, CEO, or search process) 78.9%

Assigned (e.g. with military) 5.1%

Founder or son of founder 1%

Other 1.8% \*\*

14. Do you now hold any paid administrative or management position in ADDITION to your current job?

Yes 15.5%                                  No 84.5%

\* For List of "other" helpful experiences see Appendix C, p. 274

\*\* For "other" methods see Appendix C, p. 274

15. Is your position considered full or part time?  
 full time (35 hours a week or more) 70%  
 part time 30%
16. Do you have a written contract or memorandum of understanding  
 with your Organization or Agency?  
 Yes 64.2% No 35.8%
- 17a. Is there a written job description for your position?  
 Yes 77.3% No 22.7%
- 17b. If yes, by whom was it written? Mark as many as apply.
- Self: 56.3%
  - Medical Director: 15.4%
  - CEO: 41.1%
  - Vice Pres. of Professional or Medical Affairs: 8.1%
  - Vice President of Organization: 6.8%
  - Medical staff (or Exec. Committee of Medical Staff): 16.5%
  - Service or Department Chief: 1.8%
  - Personnel Director of Organization: 9.9%
  - External Consultants: 4.7%
  - Dean: 1%
  - Board of Trustees: 20.2%
  - Administrator: .8%
  - Dept. Armed Services: 2.4%
  - Other: 5.8% \*
- 18a. Is there a formal evaluation of your job performance?  
 Yes 57.3% No 42.7%
- 18b. If yes, who evaluates your performance?
- Self: 9.1%
  - Medical Director: 10.9%
  - CEO: 48.1%
  - Vice Pres. of Professional or Medical Affairs: 7.7%
  - Vice Pres. of Organization: 10.9%
  - Medical Staff (or Exec. Committee  
 of Medical Staff): 11.9%
  - Service or Department Chief: 4.6%
  - Personnel Director of Organization: 1.1%
  - External Consultants: 1.8%
  - Dean: 1.4%
  - Board of Trustees: 20.4%
  - Other: 12.6% \*\*

\* For "others" who wrote job description see Appendix C,  
 p. 275

\*\* For "others" who evaluate performance see Appendix C,  
 p. 275

18c. If yes, how often does the evaluation occur?.

Annually: 87.2%	Every two years: 1.4%
Occasionally: .3%	Other: 11% *

19. Do you maintain a private medical practice?

Yes 43.6%	No 56.4%
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20. If yes, since assuming your current position, has the time spent in your practice:

Substantially increased: 4.1%
Somewhat increased: 4.6%
Not changed: 19.9%
Somewhat decreased: 25.3%
Substantially decreased: 46.1%

21. Do you feel your primary professional committment is:

to your private medical practice: 19.2%
to your management/administrative responsibilities: 79.6%
to other professional duties: 1.1%

#### JOB SATISFACTION

22. Please mark the answer that best describes how you feel about your position.

Very dissatisfied: 6.1%	Somewhat satisfied: 28.1%
Somewhat dissatisfied 7.9%	Very satisfied: 57.9%

\* For "other" category see Appendix C, p. 276

## PART TWO

## ORGANIZATIONAL CHARACTERISTICS

## 1. Title

Chief Executive officer 12%  
 Vice President of Medical or Professional Affairs 12.8%  
 Medical Director of an Organization 34.5%  
 Director of Medical Affairs 8.2%  
 Medical Director of a Service, Department or Program 10%  
 Assistant Medical Director 2%  
 Clinical Director of Dept., Service or Program 2.2%  
 Chairman or Chief of Dept. or Services 7.2%  
 Director of Medical Education 2.2%  
 Chief of Staff 3.4%  
 Other 5.4% \*

## 2. Type of organization

General Hospital (University based) 6.8%  
 General Hospital (non-University based) 37.8%  
 Specialty Hospital (University based) 2.2%  
 Specialty Hospital (non-University based) 6.6%  
     Long-term Care Hospital .8%  
 Single Specialty Group Practice 2.2%  
 Single Specialty Group Practice with over 50% asso-  
     ciated with a health plan .2%  
 Single Specialty Group Practice with less than  
     50% associated with a health plan 0%  
 Multi-Specialty Group Practice 7%  
 Multi-specialty Group Practice with over 50% asso-  
     ciated with a health plan 2.8%  
 Multi-specialty Group Practice with less than  
     50% associated with a health plan 5%  
 Staff (or Group) Model Prepaid Health Plan (PPHP) 6.4%  
 Independent Practice Association (IPA) .8%  
 Nursing Home (or extended care facility) .8%  
 Industrial Organization 2.2%  
 Pharmaceutical Company 1%  
 Government agency 4%  
 Military 3.8%  
 Community Health Center .8%  
 Other 8.6%\*\*

\* For list of "other" titles, see Appendix C, p. 277

\*\* For list of "other" organizational types see  
 Appendix C, p. 278

## 3. Ownership

For Profit 25.7%	State Government 4.4%
Non Profit, Non Govt. 54.6%	Local Government 4.6%
Non Profit Govt. sponsored 3%	Other .8%*
Federal Government 6.8%	

## 4. Which of the following positions does your Organization or Agency have?

Medical Director 84.1%	Director of Medical Educa- tion 41.5%
Chief of the Medical Staff 64.4%	

## 5. Does your Organization or Agency have or is it affiliated with a residency program?

Yes 56.4%	No 43.6%
-----------	----------

## REPORTING/COMMUNICATION ARRANGEMENTS

## 6. To whom do you FORMALLY report in the Organization or Agency?

Governing body as a whole 36.1%	Executive Committee of Medical staff 12.6%
Few selected members of the governing body 15.6%	Medical Staff 8.3%
Chief Executive Officer 49.8%	Chief of Staff 6.8%
Dean or Chancellor 3.6%	Chief of Service or Dept. Chair 3.2%
Medical Director 10%	Vice President in Org. 12.4%
Executive of Parent Org. 4.5%	Other 8.9% **
Vice President of Med- ical Affairs or other Vice President in Org. 12.4%	

7a. In addition to the above, are you INFORMALLY accountable to anyone else in the Organization or Agency?

Yes 53.8%	No 46.2%
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## 7b. If yes, to whom?

Medical Staff 43.2%	Pres. of Organization 16.7%
Board of Trustees 38.5%	Chair of Dept. or Serv. 6.4%
Exec. Comm. of Med. Staff 31.2%	Other 16.7% ***
CEO 24.4%	

\* For list of "other" types of ownership see Appendix C, p. 273

\*\* For list of "other" reporting/communication arrangements see Appendix C, p. 279

\*\*\* For list of "others" informally accountable see Appendix C, p. 280

8. How would you describe the position you hold within your Organization or Agency?

Line 45%	Mostly Line 25.6%
Staff 8.5%	Mostly Staff 19.9%

9. Do you think your position should be:

Line 49.7%	Mostly Line 29.2%
Staff 5.9%	Mostly Staff 15.1%

10. How much formal authority do you feel you have in your Organization or Agency?

A great deal 57.2%	Very little 8.4%
Some 32.6%	Almost none 1.8%

11. How much influence do you feel you have in your organization or agency?

A great deal 72.5%	Very little 2.4%
Some 24.9%	Almost none .2%

12a. Do you generally attend Governing Board meetings?

Yes 72.6%	No 27.4%
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12b. Are you a member of the Governing Board?

Yes 36.9%	No 63.1%
-----------	----------

12c. Do you have a vote on the Governing Board?

Yes 29.9%	No 70.1%
-----------	----------

13. Which of the following formal or informal mechanism does your Organization, Agency or Group use to ensure communication between the Medical Staff Organization or physicians, and the Administration or Business Staff?

#### MECHANISMS

Regularly scheduled staff meetings	90.4%
Regularly scheduled management/decision making Policy Committee meetings	67.1%
Regularly scheduled breakfast, lunch or dinner meetings	34.4%
Assigned agenda time for reports, updates, announcements in Committee meetings	48.7%
Cross representation on Committees	64.2%
Informal on the job meetings	68.1%
Informal off the job meetings	31.3%
Off site retreats	39.7%

Staff Memoranda 68.1%  
 Administrative directives/guidelines 67.5%  
 Files of communications, messages, memos, etc. 49.7%  
 Bulletin boards 41.5%  
 Newsletters 60.1%  
 Other 2.4% \*

IF YOUR ORGANIZATION IS A HOSPITAL, ANSWER QUESTIONS 14 THROUGH 22  
 IF NOT, SKIP TO QUESTION 23

14a. Does your hospital have a national or regional affiliation

Yes 41.2%                  No 58.8%

14b. If Yes, specify

Catholic Hospitals 74.2%  
 Military 24.2% \*\*

15. How many physicians are there on your Medical Staff?  
 Average 375.3

16. How many full time physicians are employed by your Organization?  
 Average 40.1

17. How many full time contract physicians are there in your  
 Organization? Average 19.8

18. What was the (approximate) number of in-patient days in  
 1982? Average 98916.7

19. How many licensed beds are there in your Organization?  
 Average 424.3

20. How many ICU beds are there in your Organization?  
 Average 31.7

21. Does your Organization participate in a Prepaid Health Plan  
 (PPHP)?  
 Yes 22.1%                  No 77.9%

22. Does your organization participate in a Preferred Provider  
 Organization (PPO) or an Exclusive Provider Organization  
 (EPO)?

Yes 14.4%                  No 85.6%

\* For list of "other" communication mechanisms see Appendix  
 C, p. 280

\*\* For list of "other" affiliations see Appendix C, p. 281



IF YOUR ORGANIZATION IS A GROUP PRACTICE ANSWER QUESTIONS  
23 THROUGH 27. IF NOT, SKIP TO QUESTION 28

23a. Does your group provide any prepaid health care

Yes 52.3%                      No 47.7%

23b. If Yes, approximately what % of your group's annual revenue  
is derived from Prepaid Health Care arrangement? 45.6%

24. How many full time physicians are there in your Group?  
Average 91.8

25. How many part time physicians are there in your Group?  
Average 18.6

26. What is the total number of full time non-physician employees  
in your Group? Average 651

27. Does your Group participate in a Preferred Provider Organiza-  
tion (PPO) or Exclusive Provider Organization (EPO)?

Yes 16.2%                      No 83.8%

IF YOUR ORGANIZATION IS ANY TYPE OF A PREPAID HEALTH PLAN, ANSWER  
QUESTIONS 28 and 29. IF NOT, SKIP TO 30

28a. Does your Organization have a national or regional affilia-  
tion

Yes 42.7%                      No 57.3%

28b. If Yes, specify\*

29. How many enrollees does your Organization have?  
Average 357,432

IF YOUR ORGANIZATION IS A STAFF MODEL PREPAID HEALTH PLAN ANSWER  
QUESTIONS 30 THROUGH 32

30. How many full time physicians are there in your facility?  
Average 61.4

31. How many part time physicians are there in your facility?  
Average 14.5

\* For list of specific national or regional affiliations, see  
Appendix C, p. 282

32. How many non physician full time employees are there in your facility? Average 435.3

IF YOUR ORGANIZATION IS AN IPA MODEL PREPAID HEALTH PLAN ANSWER QUESTION 33

33. How many physicians participate in the IPA? Average 101.8

IF YOUR ORGANIZATION, DEPARTMENT/SERVICE OR GROUP DOES NOT FALL INTO ANY OF THE ABOVE CATEGORIES, ANSWER QUESTIONS 34 THROUGH 36

34. How many full time physicians work in your Organization, Department/Service or Agency? Average 207.6

35. How many part time physicians work in your Organization, Department/Service or Agency? Average 65.8

36. How many non physician full time employees are there in your Organization, Department/Service or Agency? Average 2664.8

## PART THREE

1. Approximately what percentage of your time do you think is devoted to management activities?

Hours per week Average 34.9      Percentage Average 68.6%

2. Are you financially compensated for management activities?

Yes 92.5%  
No 6.7%  
Sometimes .8%

3. What was the established annual salary for your position in 1982? Average \$80,560.9

4. What was the total amount you received in bonuses from your Organization or Agency for your management role in 1982? Average \$5627.8

5. What was the total share of profits or dividends you received from your Organization or Agency relating to your management role in 1982? Average \$2540.2

6. What was the annual dollar amount of pension and retirement pay contributed by your Organization or Agency in 1982? Average \$8741.8

7. Does the Organization or Agency pay the Premium for your malpractice insurance?

Yes 74.1%      No 25.9%

8. Did your Organization or Agency pay the Premium or provide:

Health Insurance 95.5%	Disability Insurance 80%
Life Insurance 87.6%	Other 12.6%*

9. How many WEEKS of paid vacation were you authorized to receive in 1982? Average 3.5

10. How many DAYS of paid professional or educational leave were you authorized to receive in 1982? Average 9.1

\* For list of "other" type of insurance see Appendix C,  
p. 283

11a. Please mark all other compensations or benefits you received from your Organization or Agency in 1982:

Travel and expenses to Professional Conferences or Conventions: 89.9%  
 Membership dues for Professional Organizations: 74.5%  
 Additional Health Care Benefits: 53.7%  
 Other private educational expenses: 41.6%  
 Additional Life Insurance: 31.1%  
 Entertainment expenses: 30.9%  
 Car: 22.4%  
 Car including maintenance, insurance and/or gas: 20.6%  
 Additional time off: 15.9%  
 Membership dues for other than professional Organizations: 14.5%  
 Other: 6.9%\*  
 Stock options: 6.5%

11b. What do you estimate the dollar value to be of additional benefits marked above? Average \$9185.10

12. When you assumed your current job, your total financial compensation:

44.2% of respondents reported an increase by an average of \$18,579.60 representing 25.8% of total compensation.

21.2% of respondents reported a decrease by an average of \$24,311.8 representing 28.6% of total compensation.

34.6% of respondents reported no change in their income.

However, it is important to note that more respondents reported an increase in their income than a decrease. Therefore the mean (average) compensation increase is \$4,825 representing an average of 8.3% of total compensation.

\* For list of "other" compensations see Appendix C, p. 283

## TASK LIST

## A. INSIDE THE ORGANIZATION, DEPARTMENT/SERVICE OR AGENCY

1. Preparing new or modifying existing bylaws.  
Yes 65.3% No 19.9% N/A 14.8%
2. Preparing new or modifying existing policies and/or procedures.  
Yes 93.6% No 4.7% N/A 1.6%
3. Preparing goals and objectives for the Organization, Department/Service or Agency  
Yes 87.7% No 8.8% N/A 3.5%
4. Designing or reviewing new programs.  
Yes 91.4% No 6.6% N/A 2.1%
5. Deciding which programs and medical services your Organization, Department/Service or Agency offers.  
Yes 80.5% No 15% N/A 4.5%
6. Deciding size of programs and medical services.  
Yes 72.5% No 18.3% N/A 9.2%
7. Deciding patient care equipment needs.  
Yes 70.5% No 19.1% N/A 10.4%
8. Deciding the number and type of physicians that practice in your Organization, Department/Service or Agency.  
Yes 69% No 20.6% N/A 10.4%
9. Writing new or modifying existing criteria for the responsibilities of physicians.  
Yes 72% No 18.8% N/A 9.2%
10. Writing new or modifying existing criteria for the privileges of physicians.  
Yes 55.6% No 28.6% N/A 15.8%
11. Deciding on pricing for services.  
Yes 34% No 46.1% N/A 19.9%
12. Monitoring and reporting on issues of interest (and/or concern) of Medical Staff to Administration or Business Staff.  
Yes 87.6% No 5.8% N/A 6.6%
13. Monitoring and reporting on issues of interest (and/or concern) of Administration or Business Staff to the Medical Staff.  
Yes 84.3% No 7.6% N/A 8%

14. Communicating information to the Medical Staff and the Governing Body of the Organization, Department/Service or Agency (e.g., decisions made, new policies, etc.)  
Yes 88.3% No 6.1% N/A 5.5%
15. Writing new or modifying existing standards of Medical care practice.  
Yes 60.1% No 27.7% N/A 12.2%
16. Ensuring that standards of care are written and disseminated.  
Yes 69.7% No 20.8% N/A 9.5%
17. Writing new or modifying existing administrative or business (versus medical care) policies for the Medical Staff (e.g. informed consent issues; ways to establish E.R. call list).  
Yes 65.4% No 23.5% N/A 11.1%
18. Ensuring administrative or business policies for the Medical Staff are written and disseminated.  
Yes 64.9% No 23% N/A 12.1%
19. Preparing or modifying existing administrative policies for non physician health professionals.  
Yes 52.1% No 35.4% N/A 12.5%
20. Chairing Medical Staff Committees.  
Yes 51.2% No 36% N/A 12.8%
21. Attending Medical Staff Committees.  
Yes 83.7% No 8.2% N/A 8%
22. Chairing Administrative Committees.  
Yes 50.1% No 36.4% N/A 13.5%
23. Attending Administrative Committees.  
Yes 80.9% No 12.3% N/A 6.8%
24. Chairing Board Committees.  
Yes 18.1% No 52.6% N/A 29.3%
25. Attending Board Committees.  
Yes 66% No 18.3% N/A 15.6%
26. Preparing agenda items for Medical Staff or Physicians' Meetings.  
Yes 77.7% No 15.1% N/A 7.2%
27. Preparing agenda items for meetings with the Administrative or Business Staff or with the Administration of the Organization (e.g., Business Manager or CEO.)  
Yes 63.9% No 24.8% N/A 11.3%

28. Preparing agenda items for meetings with the Governing Body.  
Yes 47.4% No 31.3% N/A 21.3%
29. Deciding on research activities.  
Yes 38.8% No 34.7% N/A 26.5%

#### B. OUTSIDE THE ORGANIZATION

30. Monitoring and reporting on changes in the social environment (e.g. high concentration of elderly in service area), in the economic environment (e.g. local unemployment rate), or in the political environment (e.g. cuts in health care delivery service), in order to identify issues to be acted upon by the Organization, Department/Service or Agency.  
Yes 53% No 31.9% N/A 15.1%
31. Lobbying Regulatory Agencies (e.g., HSA's, State Licensing Authority) or Legislative Bodies (e.g., Federal Government, State Legislature).  
Yes 26.5% No 51.1% N/A 22.4%
32. Coordinating with other health Care Organizations (e.g. about patient care issues, shared services),  
Yes 60.7% No 27% N/A 12.3%
33. Promoting your Organization, Department/Service or Agency. (e.g. to local industries or to the general public).  
Yes 66.3% No 24.5% N/A 9.2%
34. Representing (being a spokesperson for) your Organization, Department/Service or Agency to other Medical or Health Care Organizations (e.g. local Medical Society),  
Yes 74.7% No 18.1% N/A 7.1%
35. Representing your Organization, Department/Service or Agency to the general public (e.g., speak to local groups, meet the press, etc.).  
Yes 69.1% No 22.3% N/A 8.6%
36. Representing your Organization to third party payors.  
Yes 31.2% No 47.7% N/A 21.1%

#### C. QUALITY ASSURANCE

37. Designing new or modifying existing programs that compare physicians' behavior to established standards of care in the  
Yes 74.5% No 16.6% N/A 8.8%
38. Ensuring that a system for review and evaluation of the credentials of new physicians being admitted to the Organization or Agency exists.  
Yes 76.2% No 14.1% N/A 9.8%

39. Ensuring that a system for review and evaluation of Medical Staff competency exists (e.g. identifying the impaired physician).  
Yes 77.6% No 14.7% N/A 7.8%
40. Ensuring that a system for review and evaluation of Medical Staff competency operates effectively.  
Yes 76.6% No 14.5% N/A 9%
41. Monitoring or reviewing the system for evaluating the competency of non-physician health professionals.  
Yes 60% No 29.2% N/A 10.9%
42. Ensuring accreditation with JCAH, AAAHC, or other accrediting bodies.  
Yes 72.2% No 14% N/A 13.8%

#### D. EDUCATIONAL ACTIVITIES

43. Designing Continuing Education (CE) programs for physicians  
Yes 47.1% No 37.6% N/A 15.3%
44. Designing CE programs for non-physicians.  
Yes 27.1% No 53.2% N/A 19.7%
45. Designing general (non-clinical) educational programs (e.g., management courses).  
Yes 15.3% No 62.6% N/A 22.1%
46. Teaching CE programs to physicians, (including house staff if applicable).  
Yes 44.8% No 35.8% N/A 19.4%
47. Teaching CE programs to non-physician health care professionals. (clients and their families).  
Yes 30.7% No 48.6% N/A 20.8%
48. Evaluating education programs.  
Yes 54.4% No 30.5% N/A 15.1%

#### E. DATA MANAGEMENT

49. Ensuring systems designed to obtain data necessary to evaluate medical care are developed.  
Yes 58.7% No 30.4% N/A 10.9%
50. Ensuring systems designed to obtain data necessary for general management decisions are developed (e.g., management information system).  
Yes 41.5% No 43.5% N/A 15%



51. Monitoring and reporting on data from systems designed to obtain information about medical care.  
Yes 64.1% No 25.5% N/A 10.5%
52. Monitoring and reporting on data from systems designed to obtain data for management decisions.  
Yes 45.2% No 40.9% N/A 14%
53. Ensuring that data relevant to medical care issues are used appropriately.  
Yes 74.6% No 16.3% N/A 9.1%
54. Ensuring that data relevant to management issues are used appropriately.  
Yes 48.9% No 38.1% N/A 13%

#### F. FINANCIAL MANAGEMENT

55. Designing ways to improve efficiency of professional departments within your Organization or Agency.  
Yes 60.2% No 27.3% N/A 12.5%
56. Developing the budget or a part of the budget for the Organization, Department/Service or Agency.  
Yes 70.5% No 21.3% N/A 8.2%
57. Reviewing the budget or a part of the budget for the Organization, Departments/Service or Agency.  
Yes 75.8% No 16.8% N/A 7.4%
58. Reviewing the financial performance of the Organization, Department/Service or Agency (e.g. management data exclusive of the budget).  
Yes 62.4% No 27.3% N/A 10.3%

#### G. RISK MANAGEMENT

59. Does your Organization or Agency have a risk management program function?

Yes 66.9% No 33.1%

If yes, answer next two questions:

60. Designing new or modifying existing risk management functions.  
Yes 53.1% No 39.5% N/A 7.4%
61. Monitoring and managing existing risk management functions and/or programs.  
Yes 59.7% No 32.6% N/A 7.7%

## H GENERAL MANAGEMENT

62. Identifying the need for outside consulting services.  
Yes 60.6% No 30.6% N/A 8.7%
63. Obtaining/buying consulting services for the Organization.  
Yes 42.2% No 43.0% N/A 14.8%
64. Supervising capital construction projects as needed.  
Yes 25.2% No 52.8% N/A 22.1%

## I HUMAN RESOURCE MANAGEMENT

65. Designing incentive programs to increase physician productivity.  
Yes 41.6% No 37.7% N/A 20.7%
66. Ensuring that a physician recruiting program operates as needed.  
Yes 63.9% No 20.2% N/A 15.9%
67. Deciding scope of practice for non-salaried physicians.  
Yes 35% No 37.5% N/A 27.5%
68. Designing contracts for physicians.  
Yes 46.3% No 36.3% N/A 17.4%
69. Designing contracts for non-physicians.  
Yes 18.3% No 55.9% N/A 25.9%
70. Designing wage/benefit schedule for physicians.  
Yes 38.9% No 38.5% N/A 22.6%
71. Designing wage/benefit schedule for non-physicians.  
Yes 19.8% No 55.1% N/A 25.1%
72. Hiring physicians.  
Yes 64.3% No 21.8% N/A 13.9%
73. Hiring non-physician health care personnel.  
Yes 37.6% No 45.6% N/A 16.8%
74. Deciding expectations of salaried or contract physicians (e.g., writing a job description).  
Yes 57.9% No 27.4% N/A 14.7%
75. Deciding organizational expectations of non-physicians.  
Yes 39.6% No 43.6% N/A 16.8%
76. Supervising physicians (e.g. for appropriateness of hospitalization use).  
Yes 65.8% No 23.6% N/A 10.7%

77. Supervising non-physicians.  
Yes 53.5% No 34.5% N/A 12%
78. Ensuring a grievance procedure for physicians is followed.  
Yes 67.6% No 19.7% N/A 12.7%
79. Ensuring a grievance procedure for non-physicians is followed.  
Yes 35.5% No 45% N/A 19.5%
80. Negotiating with unions.  
Yes 8% No 56.9% N/A 35.2%
81. Advising and/or counselling physicians on personal issues.  
Yes 65.2% No 24.3% N/A 10.4%
82. Advising and/or counselling physicians on career or professional issues.  
Yes 65.1% No 23.3% N/A 11.6%
83. Advising and/or counselling non-physician health care personnel.  
Yes 46.5% No 39.5% N/A 14%
84. Mediating conflict among physicians.  
Yes 78.6% No 12.4% N/A 9%
85. Mediating conflict among physicians and non-physicians health care personnel.  
Yes 77.8% No 13.8% N/A 8.4%
86. Mediating conflict among physicians and Administration or Governing Body.  
Yes 73% No 16.4% N/A 10.7%
87. Mediating conflict among non-physician health care employees.  
Yes 37.6% No 45.4% N/A 17%
88. Please add any task that you perform that are not listed \*

\* For list of additional tasks see Appendix C, p. 284

APPENDIX C  
LISTS OF "OTHERS" FROM SURVEY

LIST OF "OTHER" SPECIALTIES  
QUESTION 3 PART ONE

---

Nephrology	Immunoematology
Aerospace Medicine	Endocrinology
Industrial Medicine	Public Health
Plastic Surgery	Cardiology
Cardiac Surgery	Insurance Medicine
Dermatology	Radiation Oncology
Neurosurgery	Medical Genetics
Rheumatology	Medical Oncology
Adolescent Medicine	Head and Neck Surgery
Neurology	Alcoholism
Allergy	Child Psychology
Thoracic Surgery	Occupational Medicine
Legal Medicine	Pharmacological Research
Pediatric Surgery	Ophthalmology
Pulmonary Medicine	

---

LIST OF "OTHER" CATEGORIES OF STATUS ON MEDICAL STAFF  
QUESTION 5b PART ONE

---

Emeritus  
No admission privileges  
Partner  
Member of medical group  
HMO medical director  
In addition to active, senior meritorious  
Administrative  
Honorary  
Associate

---

LIST OF "OTHER" MANAGEMENT TRAINING  
QUESTION 6 PART ONE

---

University based courses at undergraduate level  
M.S. in Community Health  
Masters in Management  
Fellowships or preceptorships of various types  
State government training courses  
Advanced training at corporate management workshop  
Federal executive management short course  
Paid consultants  
Broad reading  
Grew up in business family  
Military management courses

---

LIST OF "OTHER" WORK EXPERIENCES  
QUESTION 8 PART ONE

---

Medical film maker  
Disability management  
Medical missionary  
Consulting  
School board member  
Research on medical computer system  
Academic experience  
Medical director of small multi-specialty group  
Founder of group

---

LIST OF "OTHER" EXPERIENCES FOUND HELPFUL  
QUESTION 9 PART ONE

---

Self-directed study  
Teaching residents and boy scouts  
Continuing education  
Applied research  
Bureaucratic experience in state hospital  
Consulting  
City Planning Commission

---

"OTHER" METHODS OF SELECTION  
QUESTION 13 PART ONE

---

Promoted from within  
State testing  
Interviewed for clinical position but offered  
administrative position  
Negotiated  
Elected civilian contract  
Within military  
Appointed by Governing Board

---

LIST OF "OTHERS" WHO WROTE JOB DESCRIPTION  
QUESTION 17b PART ONE

---

State personnel board  
Partnership board  
Board of governors  
National corporate headquarters  
Search committee  
Director of plans and resources  
Executive director of organization  
Assistant chancellor  
Attorney for commissioner  
Previous program director  
Previous CEO  
President of division  
AHA guidelines  
Medical staff rules and regulations  
Bylaws inclusion  
Management company contract  
An amalgam of many samples  
Do not know

---

LIST OF "OTHERS" WHO EVALUATE PERFORMANCE  
QUESTION 18b PART ONE

---

Board of management  
Board of health  
Partnership board  
Agency director  
Deputy health commissioner  
Executive director of hospital  
Chief of staff  
Chancellor  
Senior general officer  
District administrator of HRS - State bureaucrat  
Director of plans and resources  
Assistant vice president for ambulatory services  
Chief of department  
Peer review committee with outside consultant  
Frequent meetings with administration and administration committee  
Military hierarchy - Dept. of armed services  
Accreditation such as AACME  
Provision in medical staff bylaw to discharge me for  
Informal-unorganized

---



"OTHER" FREQUENCY OF EVALUATION  
QUESTION 18c PART ONE

---

Informally  
Semi-annually  
Every two years informally, every six years formally  
Quarterly  
Every fourteen months  
Every six months  
Every five years  
Every three years  
Never

---

LIST OF "OTHER" TITLES  
QUESTION 1 PART TWO

---

Associate Dean for Clinical Affairs  
Assistant Health Commissioner  
Executive Director Medical Staff  
Chief of Professional Services  
Assistant Administrator for Professional Affairs  
Associate Medical Director, Family Practice Residency  
Program  
Executive Head of Regional Blood Services  
Consultant  
Chairman of Corporation Profit Sharing and Pension  
Plans  
Chair utilization Committee  
Director of Quality Assurance and/or Risk Management  
Serve as both Medical Director and Director of Medical  
Education  
Both Vice President and Medical Director  
Hospital Commanding Officer, Director Base Medical  
Service  
Medical Member Air Force Physician Evaluation Board  
Senior Medical Evaluation Officer  
Chief Medical Readiness United States Air Force  
Chief Operating Officer

---

LIST OF "OTHER" ORGANIZATIONS  
QUESTION 2 PART TWO

---

Foundation for Medical Care  
 Management Corporation  
 Retirement Community  
 Emergency Medicine Contract Service Group  
 Evaluation Health Care Delivery Service  
 Medical Association  
 County Public Health Department  
 State Institution for Mentally Retarded  
 Hospital Based Health Center  
 Telecommunications Company  
 Regional Blood Services/Blood Center  
 Combination non-University general hospital, multi-  
     specialty group practice with less than 50%  
     associated with prepaid health plan and research  
     foundation  
 Regional Human Services Center  
 Non-profit medical education foundation  
 State operated intermediate care facility  
 JCAH  
 State run comprehensive health benefits plan  
 Residency Programs  
 Forprofit health care organization owned by  
     insurance company  
 Hospital malpractice insurance company  
 Health Plan Division of insurance company  
 Paramedical training program under medical association  
 Insurance company  
 Corporation that includes six hospitals and two groups  
 Multi-institutional health system  
 Private organization that designs, implements, manages  
     and evaluates health care delivery services  
 Research center

---

LIST OF "OTHER" TYPES OF OWNERSHIP  
QUESTION 3 PART TWO

---

Non-profit district hospital  
 Partnership  
 Joint township district  
 "EDS" federal corporation  
 Mutual company  
 Hospital authority

---

LIST OF "OTHER" FORMAL REPORTING/COMMUNICATION  
ARRANGEMENTS  
QUESTION 6 PART TWO

---

Agency Director  
General Manager  
Administrator of Organization  
Vice President of Administration  
Assistant Administrator  
Associate Administrator  
Assistant Vice President Ambulatory Services  
President of University  
Medical School Hierarchy  
Military Hierarchy  
No one  
Corporate Medical Director  
Regional Vice President  
Comptroller  
Medical Society  
Private Contractors  
DME  
Non Medical Middle Manager  
Health Officer  
Chief of Professional Services  
Trustee of Profit Sharing and Pension Plans  
Chief of Police and Mayor

---

LIST OF "OTHERS" TO WHOM MEMBERS  
ARE INFORMALLY ACCOUNTABLE  
QUESTION 7b PART TWO

---

Partnership  
Peers and Co-Workers  
Management Board  
Board of Commissioners  
Executive Committee  
Board of Visitors  
Hospital Authority  
Executive of Parent Organization  
Director of the State Department (local)  
Medical Director of Health Sector  
Superintendent  
Medical Director  
Chief of Staff  
Medical Affairs Director  
Someone in Military Hierarchy  
Sisters that own hospital  
Commissioner of Health  
Quality Assurance Manager  
President of Foundation  
Manager of Employee Relations

---

LIST OF "OTHER" COMMUNICATION MECHANISMS  
QUESTION 13 PART TWO

---

Medical Director meetings  
On site seminars  
Weekly grand rounds  
Circulate board minutes  
Policy manuals and protocols  
Closed circuit TV  
Regulations  
One on one telephone calls  
Marketing brochures  
Staff assistance visits

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LIST OF "OTHER" NATIONAL OR REGIONAL AFFILIATIONS  
FOR (HOSPITALS)

QUESTION 14b PART TWO<sup>1</sup>

---

Appalachian Regional Hospitals  
Federal Government System  
State Government Hospital System  
Adventist Health System  
Alexian Brothers of America, Inc.  
American Medical International  
Charter Medical Corporation  
Evangelical Hospital Association  
Hospital Corporation of America  
Kaiser Foundation Hospitals  
Lutheran Hospitals  
Methodist Hospital  
National Medical Enterprises  
Presbyterian St. Lukes Medical Center  
Psychiatric Hospitals of America  
Raleigh Hills Hospital  
Samaritan Health Services  
Shriners Children's Hospital  
State Wide Multi-institutional organization  
United Health Services, Inc.  
Universal Health Services, Inc.

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1

Abbreviations were omitted when they were unknown and/or did not correspond with any of the organizations listed in the American Hospital Association Guide to the Health Care Field.

LIST OF OTHER NATIONAL OR REGIONAL  
AFFILIATIONS FOR PREPAID HEALTH PLANS  
QUESTION 28b PART TWO

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Military  
Blue Cross/Blue Shield  
FHP Inc.  
National BA  
Health America  
Union ACTWU  
Kaiser  
INA  
HMO of Pennsylvania  
Life Extension Institute, Comprehensive HS  
Prudential Heal Care Plan, Inc.  
Prucare  
GHAA  
Federal Government

---

LIST OF "OTHER" TYPE OF INSURANCE  
PROVIDED BY ORGANIZATION  
QUESTION 8 PART THREE

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Workmens Compensation  
Liability Insurance  
Travel Insurance  
Accident Insurance  
Supplement umbrella Malpractice and Liability  
Life and Dental Insurance Spouse and Dependents  
Military Benefits

---

LIST OF "OTHER" COMPENSATION OR BENEFITS  
QUESTION 11a PART THREE

---

Tax sheltered annuity  
Professional study time  
Educational stipend  
Savings plan  
Deferred payment plan  
Sick leave  
\$50,000 annuity  
Housing  
Meals  
Profit sharing  
Deferred compensation and pension  
Gas credit card  
Reimbursement for getting up professional corporation  
Sabbatical leave  
Commissary and other military privileges  
University tuition  
Free parking  
Use of condominium  
Consultations with other benefits  
Moving expenses  
Low interest loans  
Great amount of freedom  
Vacations redeemed for cash  
Portion off office rent  
Office, secretaries  
Incentive plan  
Supplemental malpractice

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## LIST OF "OTHER" TASKS

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### Miscellaneous Policy Management Activities

Set the philosophical tone of the group.  
Establish and maintain corporate culture.

### Miscellaneous Program Management Activities

Medical advisor, consultant or director of various specific programs or services not listed, (e.g., director of poison control information center).  
Develop and coordinate various programs not listed (e.g., safety programs; industrial hygiene programs; toxicology programs; industrial epidemiology programs; industrial relations programs).  
Monitoring of local occupational health hazards.  
Negotiating sale of dialysis service to nephrologists.  
Review flight programs for aero-medical significance

### Miscellaneous Resource Management Activities

Supervise specific departments, divisions or services not listed, (e.g., medical records department, anesthesiology department, respiration therapy).  
Work with satellite/branch clinic. Investigate potential of new satellite/branch sites.  
Deal with investment issues; e.g. retirement benefits.  
Terminate physicians and other health care personnel when necessary.  
Negotiate contracts for physician services.  
Contract for hospital, SNF, surgery center, at a favorable rate.

### Clinical Activities

Caring for other physician's patients in emergency.  
Visiting other physicians' patients when they do not visit in prescribed time.  
Signing telephone orders for other physicians.  
Occasional medical provider - 20 hours + per week in clinic plus responsibility for hospital's (federal) patients and after hours calls.  
Emergency room physician 24 hours per month.  
Employee health supervision  
Executive Physical Evaluation, e.g., pre-employment and reclassification/physical examination.

## List of "other" tasks (continued)

## Specific Military Activities

Flying four hours a month.  
Ensure state of wartime medical readiness.  
Responsible for: public health; OSHA compliance - safety in maintenance shops; exercise of a disciplinary system over employees and members (patients).  
Reviewing medical examinations for entry into USAF flying training or continued flying status.  
Reviewing aircraft accident reports.  
Staff assistance visits to medical facilities.  
Attend social functions.  
Duty as medical officer of the day.  
Write letters of commendation.  
Administer punishment under the uniform code of military justice.

## Educational Activities

Direct residency training program.  
Supervise curriculum of program.  
Responsible for undergraduate and /or graduate medical education.  
Review and screen all requests for admission to medical school.  
Monitoring non-physician health care personnel with respect to education, certification.  
Author medical column for union newspaper.

## General Marketing Activities

Direct participation in marketing pre-paid plans to prospective employers and employees.  
Market programs to client hospitals.

## List of "other" tasks (continued)

## Quality Assurance and/or Risk Management Activities

Liability Control.  
 Safety review (products).  
 Review malpractice suits against hospitals and physicians.  
 Assist defense counsel on malpractice cases.  
 Collect data on causes of suits.  
 Handle all legal contact with corporation attorneys.  
 List of "other" tasks (continued)  
 Lecture on prevention of malpractice suits.  
 Develop and assure systems to protect patient confidentiality.  
 Primary responsibility for federal regulations review.

## Research Activities

Design and conduct clinical research.  
 Insure proper investigation and respond to product complaints.  
 Search for new product ideas or market trends.  
 Publish original articles and books.  
 Seek grants.  
 Coordinate and direct worldwide clinical trials and research candidates of new pharmaceuticals.

## Miscellaneous Administrative Activities

"Approval/Veto" decision making for some of the tasks in A,C,D,F, specifically in the areas of "design", "prepare" and "write".  
 Academic chair functions of appointment, promotion, and tenure.  
 Acting as CEO in his absence.  
 Evaluate other agencies.  
 Investigate other agencies.  
 Completing Role/Compensation surveys.

## List of "other" tasks (continued)

## Miscellaneous Committee or Board Activities

Chair or attend various committees not specifically listed on Task List.  
Serving on boards of directors, policy making bodies, or task forces.  
Act as medical consultant to lay governing board of retirement community and ensure availability of medical care.

## Liaison Management Activities

Advocacy for the community and the patients.  
Mediate between patients and physicians.  
Attempt to sense developing problem and to correct the situation before serious rifts develop.  
Act as liaison between various committees, with community, with other organizations and/or between organization and physicians.

## Miscellaneous

Trainer in group dynamics, group process, etc.  
Application of organizational development principles to public health agency.  
Responsible for lease space as landlord.