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IN TRANSIT: FROM PHYSICIAN TO MANAGER

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MORGAN W. MCCALL, JR.
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ABSTRACT

In Transit: From Physician to Manager

by

Morgan W. McCall, Jr.
and
Judith A. Clair

University of Southern California

Physicians are finding themselves in increasing numbers in significant managerial roles. Successful transition from a role as individual professional to a managerial role is neither automatic nor easy. Physician-managers were interviewed about their experiences in changing careers. Six critical transitions were identified, three involving psychological adjustments and three requiring development of new skills. A framework was developed, relating career events that trigger transitions, the transitions, and the obstacles that can hinder or block successful transitions. It was suggested that the challenges physicians encounter in management are similar to those faced by other professional groups, and that the chances of successful transition can be improved by individual and organizational actions.

In Transit:

From Physician to Manager[1]

"Who are <u>you</u>?" said the Caterpillar.

This was not an encouraging opening for a conversation. Alice replied, rather shyly, "I - I hardly know, Sir, just at present - at least I know who I <u>was</u> when I got up this morning, but I think I must have been changed several times since then."[2]

The last decade saw convulsions in health care. Among the fundamental changes was the emergence of medicine as big business, complete with takeovers, acquisitions, and corporate ownership. While the days of the independent, house-calling physician were long gone, the era of the salaried physician embedded in a corporate bureaucracy marked a stunning change for both the physicians and the corporations that hired them. Managers of these awkward behemoths faced more challenges than just the inevitable turbulence of a "new" industry. In the midst of a health care revolution driven by technological miracles on one hand and intolerable costs on the other, corporate managers (often developed in the insurance industry) found themselves out of their element and performed correspondingly.[3] Caught between the pointing fingers of government and corporate clients who were concerned about costs, of physicians who were concerned about quality of care and preservation of the profession, and of patients who were concerned about quality, freedom of choice, and cost, health care organizations searched for options. Among them was to move physicians into significant managerial roles.[4] From an organizational

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[2]The opening quotation is from <u>Alice in Wonderland</u> (Carroll, 1960, 67).

[3]Examples of the managerial challenges in the new health care "battleground" see "Can you Afford to Get Sick?" (Newsweek, January 30, 1989) or "The Failed Revolution in Health Care-- The Role of Management" by Regina Herzlinger (<u>Harvard Business Review</u>, 1989).

[4]For an example, see "Can Insurers Nurse their HMOs Back to Health?" (<u>Business Week</u>, January 16, 1989).

point of view the physician-as-manager seems to be a good fit. Who better to oversee health care than someone intimately familiar with it? Who better to lead physicians than one of their own, who speaks their language and understands the issues? Who better to make strategic decisions regarding quality of patient care and responsible cost containment?

The corporate need for physician managers coincided with a greater willingness among physicians to accept managerial roles. With increasing numbers of physicians on salary and with increasingly regulated reimbursement for specified procedures, the disparity in remuneration between clinical practice and managing was narrowed or even reversed. Changes in practice, leading some physicians to see eight to ten patients per hour, led to burn out and disillusionment-- and to increasing numbers electing a managerial alternative.

At first glance it appears that physicians are especially suited for the managerial world. Many of the skills and abilities expected of an effective physician seem directly transferable to a managerial setting. Diagnosis requires analytical ability. Responsibility for patient care-- sometimes life and death-- requires extreme self confidence and comfort with command. Dealing with patients and families in distress requires interpersonal sensitivity. Yet, like other kinds of professionals, physicians are finding that the transition from one profession to another is sometimes rockier than they expected it to be.[5] There is a significant gap between a theoretically ideal fit and the realities of managerial life. Both the organizations that promoted them and the physicians who ended up as managers frequently have been disappointed.

Organizations, for example, sometimes find that clinical dedication in a physician can become strategic myopia in a physician manager-- especially in investment decisions that pit individual patient care against institutional objectives.

Physicians sometimes find that a move into management is more than they had bargained for. Some physicians, for example, enter management believing they can continue their clinical practice or

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[5]See "Why Physician Managers Fail" (McCall & Clair, 1989).

medical research and manage at the same time. Sooner or later they discovered that being effective at both was impossible, and that learning to manage effectively was more difficult than it first appeared. When physician managers failed, it was rarely because they lacked clinical skill.[6] Instead, they discovered that the skills that served them well in clinical practice were only a small part of what they needed to know to succeed in management-- in fact, some of the clinical habits and skills could even get in the way. What they discovered was, in essence, that the move into management was no less than a change in careers. After many years of investment in becoming a physician and learning all the skills and values required to succeed as a doctor,[7] they now faced learning the skills and values needed to succeed at something totally different. One way to understand the change from physician to manager is to view it as a series of transitions that reflect the fundamental differences between success at technical/professional jobs and success in managerial roles. Focusing on transitions puts attention on the differences between the two careers, on the new skills that must be learned, and on how one goes about learning the new. Specifically, by transitions we mean the kinds of changes in an individual's skills, values, knowledge, or other attributes required to move <u>from</u> effectiveness in one profession (in this case, medicine) <u>to</u> effectiveness in another (management).

In summary, physicians are finding themselves in increasing numbers in significant managerial roles. Unfortunately, successful transition from a role as an individual professional to a managerial role is neither automatic nor easy. If we can better understand the kinds of changes required to successfully make the transition, we can perhaps do a better job of selecting and developing people for these critical roles.

THE RESEARCH

It would be relatively easy to document the differences between medical practice and managerial

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[6]For insights into physician manager failures and challenges see McCall & Clair (1989) and Ottensmeyer & Key (1988). But the process is not unique to physicians-- executives rarely derail for lack of technical knowledge (McCall & Lombardo, 1983). Research on scientists and engineers also documents the difficulties they face in learning to manage, few of which have anything to do with their professional or technical accomplishments (McCall, 1983; Raelin, 1986; Von Glinow, 1988).

[7]More than most other professions, becoming a physician requires an unusually lengthy period of training and intense socialization. Giving it up for a career in management is that much more wrenching a loss.

jobs.[8] No doubt the list would be both long and intimidating, and each difference could represent a transition that should be made. But a long list of objective differences begs several important questions, including which changes are most crucial and which are the most difficult. Of all the possible tribulations, which ones really precipitate the gnashing of teeth and pulling of hair? Perhaps in the subjective experience of physicians who became managers were clues that could help us sort out the underlying dynamics of radical, individual change.

To explore the role of the physician manager, we interviewed fourteen physicians who had become managers (and one non-physician who had become a hospital administrator)[9] about a variety of topics, including their careers, why they became managers, what and how they learned about managing, and the problems they dealt with in their managerial jobs.[10] Questions on each of these topics generated information relevant to the transition from physician to manager, but this paper deals primarily with their answers to the specific question, "What do you consider to be the major transitions you have been through in your career? What made them difficult? What helped you get through them?" We defined a transition as the movement "from" something "to" something else, emphasizing that what the "something" was was entirely up to them. It could be subjective or objective, a feeling or a fact, a skill or an attitude. We asked the physicians to be as specific as possible in describing changes they had gone through in making the shift from doctor to manager.

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[8]To get an idea of what some of the differences are, see Kurtz (1988) or Ottensmeyer & Key (1988).

[9]The fifteen people interviewed included 14 physicians and 1 hospital administrator who was not an M.D. All but one of the physicians held managerial positions at the time of the interview. Titles represented included Medical Director (4), Associate Medical Director (1), Chief of Staff (2), Associate Dean (2), Department Head (1), Director (1), and Chief Executive Officer (1). Organizations represented included four hospitals (private, community, public, and university), two national managed-care organizations, three group practices, and a medical school.

[10]For a report on some of the other results, including why physician managers sometimes fail, see McCall & Clair (1989).

A content analysis of their descriptions produce six themes that seemed to capture the physicians' experiences as they moved, or tried to move, into managerial jobs.[11] Three of the transitions seemed to involve substantial psychological or social adjustment, while the other three involved the development of new skills or abilities. The six transitions were...

Psychological Adjustments

1. From hard-earned independence as a clinician to dependence as a manager;

2. From identity as a physician focused on individual patient care to identity as a manager focused on the institution; and

3. From naivete about organizational dynamics to acceptance of organizational realities as part of managerial life;

New Skills or Abilities

4. From command and control in a clinical setting to persuasion and ambiguity in a managerial role;

5. From comfortable relationships with professional colleagues to authority-based, boss-subordinate relationships with former colleagues; and

6. From competence in medicine to competence in business.

It was our sense that few if any of the physician managers we interviewed had successfully completed all of these transitions. Which of the transitions people were struggling with and how far along they were depended on their prior managerial experiences and the demands of their current managerial position. It appears, however, that over time all physician managers will have to face these issues. For some of them certain transitions will not be difficult, but they can't be avoided altogether if a managerial career is pursued very far up the hierarchy. In an increasingly difficult organizational environment like health care, a manager's inability to resolve the issues in a transition eventually leads to a crisis. Sooner or later either the physician seeks reassignment (for example by returning to clinical

[11]Approximately twenty-six major transitions were described by the physicians in the sample, and many of these contained multiple parts. The two authors independently sorted their responses into themes, then compared the results. On the one hand, many of the transitions could be described as job changes, such as the first supervisory job or promotion from one level to another. More meaningful to us were the kinds of things they had to cope with in making the transitions, and it was these elements rather than the jobs themselves that finally emerged from our analysis.

practice as at least one person in our sample did) or the organization takes action to remove the physician from management (as happened to another).

THE SIX TRANSITIONS

Psychological Adjustments

From Independence to Dependence. Physicians and other highly trained professionals make a substantial investment in their chosen career. Physicians in particular spend a long period of time in student and apprentice roles, achieving professional independence only after an extended socialization process. When this independence is finally won, the sweet feel of mastery and control is heady stuff. Further, it is noble stuff. More than just the Hippocratic oath, becoming an independent M.D. carries with it a strong set of values about the sanctity of the doctor-patient relationship, the primacy of quality care, and the physician's right (duty) to make decisions for the good of the individual patient.

Early in the process of becoming a manager, the very heart of this independence is threatened. The physician (who, as one physician manager said, "[is] very independent and like[s] a lot of rope"), finds himself once again dependent on superior authority for setting goals, evaluating performance, and determining rewards. Having metamorphosed once, resumed subordination is not inherently attractive even if the "boss" is also a physician. Eventually that boss in the organizational hierarchy will not be a physician, and the dependence becomes based completely on hierarchical rather than expert authority. It is seldom well received.

A typical reaction to the return of dependence was captured by a physician manager working for a non-physician boss:

> Once you've played God, it's hard (or impossible) not to feel good about yourself. Then a lay guy tries to tell you how to do your job.[12]

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[12]Unless otherwise noted, all quotes came from participants in the study and were reconstructed from interview notes. In some cases they have been altered slightly to protect confidentiality.

Like the proverbial fish in water, the average manager lives this dependency as a natural habitat. But for the professional, used to a certain level of autonomy and discretion by virtue of special expertise, this water is decidedly tainted. Former accomplishments and special status based on medical success count substantially less in the managerial sphere.

This transition, then, is more than a simple return to subordination-- it is no less than accepting as legitimate a dependency relationship based on organizational hierarchy rather than on medical expertise, degrees, or technical knowledge. While this transition can begin early in an organizational career, its true impact is not apparent until the physician reports directly to a lay manager. As one physician manager discovered when he reported to a regional vice president for the insurance company that owned his HMO, even a bad physician-boss shares some basic values and a view of the world understandable to a physician. Dealing with a "lay" boss-- even a good one-- demands a different orientation.

From Identity as a Physician to Identity as a Manager. "I'm a doctor" to "I am a manager" is, in a nutshell, the transition in identity. Physician managers describe physicians as fiercely independent, acting in their patients' or their own interests, and only tangentially a part of the particular institution in which they are embedded. As one put it, "Doctors are looking at personal agendas rather than department agendas." Another physician manager noted with frustration that "it's hard to understand why physicians are so hard headed-- why they do things for themselves and not for the group (or even the patient)." Those who manage physicians (in this case physicians too!) reflect in their complaints the identity issue. From their perspective, a physician's identity is tied up in personal professional agendas, or in individual patients. It is difficult to get physicians to make sacrifices for the good of the institution.

In contrast, the heart of the manager's job lies in building the unit or institution, and managerial effectiveness requires increasing identification with organizational goals and systems rather than personal or professional ones. Concomitantly, achieving managerial goals increasingly requires long time frames and interaction with external bodies (such as boards and legislatures).

As the institutional demands of leadership increase, it is increasingly difficult to commit the time

and energy required to meet those demands and, at the same time, maintain the professional intensity of the physician. In fact, the tough side of this transition is that effectiveness increasingly depends upon institutional commitment and time spent on institutional objectives, yet this is psychologically and physically at the expense of clinical practice. As many told us, they "feel fear because they are giving up their lives as a doctor." Thinking of one's self as a manager first, and learning to identify with and embrace the goals and challenge of management, is no small accomplishment.

From Naive to Pragmatic. Few dynamics affect the professional entering management as much as the startling shift in the nature of rationality. For a professional, and especially for a clinician, the world has one kind of order, based on fact, linearity, and logic. An engineer can analyze pressure points on a bridge and predict within specified parameters where and under what circumstance it might give way. A physician can diagnose on the basis of symptoms and tests, and, once diagnosed, most diseases will follow a predictable path. Treatments are, within limits, predictable in their effects.

But the world of management and organizations seems to have a different basis for its rationality.[13] One of the first shocks any new manager faces is that logic and rationality, as defined in other professions, are not the same in management.[14] Finding a technically satisfactory solution, for example, is sometimes the easiest part of a managerial job--getting people to accept and act on the "right" answer is the real challenge. In the managerial hierarchy, technical expertise is sometimes only a minor driving force in what happens. Many physicians and other professionals enter management profoundly naive about what it takes to make things happen in a complex organization. It is a jolt that facts alone don't always triumph, that people don't automatically rally around logic, that power and position and differing perspectives all influence outcomes.

In response to this jolt, some new managers begin a transition from their naive view to a cynical one. When rationality as previously known doesn't hold in this new world, some conclude cynically that

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[13]One of the best treatments of the perception and the reality of management is Chapter 1 of Len Sayles, Leadership (1979).

[14]See the sections on early work and first supervisory experiences in McCall et al (1988).

there is no rationality. "It's all politics," "It's who you know not what you know," "you've got to play the game" are the kinds of statements reflecting this psychological movement. This is a very dangerous intermediate stage in the overall transition. Cynical reactions, while perfectly understandable, define problems as irrational, unapproachable, unsolvable. Thus the manager is left with an unassailably self-righteous position upon which he or she cannot-- or need not-- act. As one put it, "I didn't want it or need it [management] as a job and there was power in that."

In an organizational world of conflicting interests and power differentials, to ignore or disdain "politics" is to resign from organizational leadership. To view "people problems" with disgust is to abandon the very heart of management. The transition is not complete until the physician can move from the naive through (or past) cynical into a pragmatic approach to how organizations work.[15] As long as there are hierarchies, power differences, and different views of the world, people will disagree and work to have their views prevail ("politics"). To the pragmatist, politics simply is. It is another issue to be dealt with, another thing, like ambiguity, to learn to manage effectively. People can be a real problem-- so that means learning new sets of skills for dealing effectively with people. Unlike the cynic, who dismisses the apparently non-rational, the pragmatist tackles it as another problem to be solved. Larger goals require mastery of these skills, and the pragmatic manager learns to "do whatever it takes" to make the organization work.[16]

This movement from one rationality to another can be very difficult for the professional. In our interviews, for example, many clashes with "lay" managers centered on what physicians believed were moral and ethical value issues. In many cases, however, the real dilemma lay in pragmatic organizational choices which simply looked different from the two perspectives. One example, given by a senior medical executive, showed the dramatic differences in perspective even among physician managers at different hierarchical levels. It involved a dispute over the purchase of a million dollar piece of equipment-- an

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[15]This process as it plays out with physician managers is not unlike Strauss' (1959) model of individual reaction to change: Movement from indifference to violent rejection to prideful acceptance.

[16]McCall & Kaplan (1990).

extremely sophisticated, high technology apparatus that would save a relatively small number of lives and would put the organization on the cutting edge of care in a particular field. The lower level manager, based largely on his physician's values for a single life, saw the equipment as essential for patient care and the reputation of the specialty area. For him, not allocating the funds was indicative of fundamentally misplaced values in the administration. The senior manager, viewing the situation from the institutional perspective of limited resources and many needs, believed the million dollars could be used to significantly upgrade emergency preparedness, potentially saving hundreds of lives. The issue was perspective, not abandonment of values.

Developing New Skills

From Command to Persuasion. Accepting a boss's authority (the transition of dependence) is not the only issue of control faced by the physician in management. The physician manager's own ability to control situations seems to change in two unsettling ways. First, most physicians are used to calling all the shots in patient care, and decidedly unused to having their authority to do so questioned. As managers, they discover quickly that their "subordinates" (who are often physicians) are not always looking for direction and sometimes don't respond well to orders. The new requirement, as the doctors themselves describe it, is to learn to influence, persuade, and convince. As one physician manager described it,

> Doctors only talk to God. [They] prescribe. [They] dictate. This works in the doctor-patient relationship because the patient wants direction. In organizations, members are not necessarily looking for directives. [We] need to get executives comfortable with using persuasion ... to get physician managers to work with others in a fashion that they aren't always captain of the ship.

This control issue involves development of the skills necessary to influence (rather than order) others and to be effective in spite of the ambiguity of managerial jobs. Used to working with patients, physicians expect quick feedback (a treatment works or it doesn't; a patient gets better or not) and tangible results. The contrast they find in managing others is stark. Because achieving change through others may take a long time, gratification, if any, is delayed. Feedback on how well one manages others

is slow to emerge and often misleading; rewards are not immediate. It is a world of ambiguity in which the impact of decisions may be slow to emerge, and credit is often diffused.

The control transition, then, requires learning patience, the skills of negotiation and persuasion, to act comfortably in spite of ambiguity and long time frames, and to accomplish things through others rather than hands-on.

From a Physician-Peer to Managing Diverse Relationships. Most successful managers, regardless of technical background, eventually end up promoted over their former peers (or even bosses). Handling this situation is inherently difficult because interacting as a peer is dramatically different than interacting as a boss who influences another person's evaluation, objectives, salary, and even employment.[17] For physicians who become managers the normal difficulty of this situation is apparently exacerbated by the loss of peer support. The association with the peer group-- other physicians-- is more central for physicians because it has professional as well as collegial implications.[18] In addition, promotion over one's peers is both less common among, and viewed with greater skepticism by, physicians. Professionals in general and physicians in particular seem to have little respect for authority based on hierarchy, being far more impressed by professional credentials and accomplishments.[19]

Physician managers were often surprised at the magnitude of the change in their relationship with their former peers. After accepting a serious managerial role, some were viewed by their former colleagues as having "sold out" or abandoned the values of the profession.[20] The impact of finding themselves in the out-group was reflected by one physician manager who said his peers considered him "second class". Another reported that his former peers "think I'm goofing off."

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[17]The experience of senior executives who were promoted over peers or bosses is documented in Hutchison, Homes, & McCall (1987).

[18]Kerr, Von Glinow, & Schreisheim (1977) describe the core values and identifications of professionals.

[19]See Kerr et al (1977), Rubin (1988), or Von Glinow (1988).

[20]This can turn to scorn or disdain, with devastating results for the organization. See Herzlinger (1989).

Adding to the this hurt and loss are the difficulties associated with relationships that the physician manager now finds central. Depending on the nature of the job, these may include the "natural enemies" of physicians, nurses and administrators. Even when the physician manager still deals primarily with physicians, there is often a totally new perspective from the managerial side. As one frustrated physician manager of physicians discovered ironically, it is "hard to work with physicians. [They] are very difficult to manage." Another found that "When I tried to use authority, no one took me seriously."

Even family life can be affected by the move into management because the social network and status in the community are often tied to the role of physician. As one physician manager recounted, when people found out he was manager invitations tapered off and his wife was treated differently in organizations she belonged to. Another physician said that deciding to accept a managerial role almost led to a divorce, his wife was so upset.

The transition in relationships, then, entails a change from in-group to out-group, a fundamental change in the relationship to a central professional peer group, and the initiation of new central relationships. It hinges on the development of a host of interpersonal skills relevant to these changed situations. Like other managers who are promoted over peers, physician managers must learn to deal effectively with the changed relationship with their now-subordinates (in essence learning to <u>manage</u> professionals as opposed to <u>being</u> a professional), as well as develop the skills needed to deal with other kinds of people (e.g., non-physicians) who are now central to managerial success.

From Competence as a Physician to Competence as a Manager.

> "I had no training. I had no idea of what the personnel policies were."
>
> "I moved from taking care of patients with specific diseases...to being lost."
>
> "I couldn't speak 'business'."

Another painful transition was precipitated by the return to ignorance faced by many physicians as they took on increased responsibilities in managerial roles. It was one thing to be conversant with microsurgery, magnetic resonance imagers, ventricular assist devices, and biotech miracle drugs, but the

arcane language and complex content of medicine didn't help much in the equally arcane and complex world of business. They found themselves confronted with undreamed-of esoterica-- cost of capital, return on equity, spreadsheets, E.E.O.C. legislation, tax law, market segmentation, customer service, labor shortages, cost containment, union work rules. Not only were the language and concepts baffling, most of the crucial players with whom they had to work already knew the rules. As one medical general manager observed, not understanding finance and accounting made him helpless in influencing crucial organizational decisions.

If the content of business weren't difficult enough, the process of getting things done added yet another dimension to the managerial Twilight Zone. Instead of making decisions within a limited domain of professional expertise, physician managers found themselves forced to make decisions on things they didn't fully understand and about which they had insufficient information.

The magnitude of these changes was, for many physicians, enormous. Before they were expected to be an expert in medicine and know diseases and treatments; now they were expected to be experts in business, knowing people and budgets. From fighting for and spending money as part of a cost center, they were propelled into controlling costs and earning revenue as part of a business unit or profit center. From relying on specialists when they were ill-informed, they were now expected to adjudicate disagreements among experts in a vast array of areas well outside their expertise.

At the core of this transition is competence. Psychologists have long known that a feeling of personal competence is central to individual self-esteem and self image.[21] It is no small matter to move voluntarily from mastery to ignorance, essentially starting over to learn a new set of skills. Yet this is exactly what a move into management asks from a physician. And, to the extent that taking on a new profession results in giving up mastery of the old-- through decreased time spent in practice or gradual obsolescence-- the challenge of learning is compounded by significant personal loss.

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[21]Bass, 1981, reviews some of this research as it relates to leadership.

OBSTACLES TO TRANSITION

As we have seen, physicians who move into management face significant transitions which, under the best of circumstances, would be difficult to achieve. It would seem that failing to make the any of the transitions would hurt both the physician and the organization: Being unable to adjust to working in a hierarchically driven context, failing to identify with the managerial role, inability to accept the realities of organizational life, failing to learn how to exert influence in ways other than command, inability to handle changed and diverse relationships with a variety of people, and failing to learn the language and content of business.

It is crucial, then, to understand what helps physicians make the necessary transitions and what gets in the way. We asked the physician managers about these issues, and, not surprisingly, they tended to focus on how their organizations helped or (more often) hindered them in making changes. From the interviews, our richest data base is on how organizations contribute to the difficulties faced by physician managers. However, reading between the lines, capitalizing on the candor of a few, and drawing our own conclusions, leads us to believe that there are three major forces in addition to the organization's failings that hinder physicians in making the necessary transitions. They are 1) the physician manager's own defenses, especially denial, which get in the way of dealing with realities; 2) the unsuitability, for motivational or ability reasons, of some physicians for a managerial role, reflecting an error in selection; and 3) the physician manager's inability to build a new support system to replace the loss of physician peers. Apparently both the individual physicians and their employing organizations can contribute to making transitions more difficult.

No One Else to Blame

It's a well established psychological fact that people have difficulty accepting or admitting their shortcomings, frailties, and failures.[22] It is also well-established that people sometimes have trouble

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[22]An interesting example of this unrealistic self-appraisal was a survey of Americans' expectations about heaven and hell. 77% believe there is a heaven; 76% think they'll end up there. 58% believe there is a hell; only 6% think they'll end up there (Newsweek, March 27, 1989, 53).

dealing with significant losses-- it is hard to let go of either people or situations that have meant a lot to us.[23] Physicians are not immune to these basic processes. On the contrary, physicians may have a harder time with both of them because other people are more likely to defer to or be intimidated by a physician, further restricting available feedback and challenges to the physician's behavior.

Both inability to accept shortcomings and inability to accept loss result in denial, which translates into behaviors such as acting as if nothing has changed, downplaying the significance of the change, refusing to accept the new situation (and, in some cases, fighting anyone or anything that tries to force change), or continuing habitual behavior in the face of contradictory information. Each of the six transitions represents a loss to the physician manager. Whether it is a loss of freedom, control, important relationships, mastery, identity, or naivete, it can be significant and elicit counterproductive responses. Denying a transition can be compounded by perceived inadequacy when feedback is available. Thus both processes may work together to create a serious block to change. Failing to recognize the need for change, or persisting in behaviors that were useful in the old situation but are inappropriate to the new one, seriously hinders making a needed transition.[24] When such responses persist over time or exacerbate an already prickly situation, the organization may respond by removing the physician manager.[25]

Poor Choice in the First Place

Psychological defenses are not the only reason physicians fail to make needed transitions-- some are simply not suited to become managers. They may not want to manage, or they may not be willing to make the investment required to manage well. One physician manager was quite candid about it, saying, "I have an aversion to administrative-type activities. I have others represent me. I want to be involved in my research." Still others may not have the skills required, even if they try very hard. Regardless of the underlying reason for the failure, the organization has made a selection error, choosing the wrong

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[23]Bridges (1980), Kubler-Ross (1969), Viorst (1986).

[24]Bridges (1980), Kubler-Ross (1969), Viorst (1986).

[25]McCall & Clair (1990).

individual for a managerial role. Physicians become managers for a variety of reasons, including gradual increases in responsibility within a narrow specialty area, reputation as a clinician or researcher, shortage of viable candidates, desire to get out of practice, and as a result of a takeover or buy-out.[26] Neither the presence of needed managerial skills nor the ability to learn those skills is assured by any of these mechanisms, and the needed motivation for change is not assured by most of them. To the degree that the six transitions require both skills and motivation to change, poor selection plays a major role in eventual failure.

Loss of Support at a Crucial Time

A third reason for difficulty with transitions is the loss of a primary support group and the failure to replace it with another. Physicians seem to associate primarily with other physicians, both at work and socially. Physicians we interviewed confirmed this, suggesting that it was a logical result of the time they spend together, professional identity, and common interests. As we described earlier, however, becoming a manager fundamentally changes the relationship between the manager and the former peers. To the degree that physician managers spend time exclusively with other physicians, this change can eliminate the major source of personal support at precisely the time it is most needed-- to help with a major transition. Because the change in the nature of relationships with peers is often a surprise, the impact of loss of support is confounded by the personal loss.

Lousy Design, Poor Preparation

Finally, but in physician managers' minds most significantly, the organizations that employ them contribute to the difficulty of transition. The physician managers we interviewed described a litany of mistakes their organizations made, including failing to set clear objectives or specify the responsibilities of the job; failing to provide adequate or timely feedback; failing to train or otherwise prepare the professional for the role; neglecting to provide experiences for physicians to develop needed managerial skills; assigning new physician managers to bosses unable to coach or mentor; surrounding the physician

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[26]McCall & Clair (1990).

manager with troubled or incompetent staff; and failing to reward or recognize exceptional performance. The general pattern of responses suggested that health care organizations were uncertain of how to use physicians in managerial roles, how to structure the managerial roles in terms of reporting relationships and responsibilities, and how to prepare their professionals for the demands of the roles. Combined with the errors of selection described earlier, it appears that the organization is a substantial obstacle to successful transitions.

TOWARD AN UNDERSTANDING OF TRANSITION

This exploratory study provides a framework for understanding the transitions required in moving from a full-time physician to an effective full-time manager. At least three clusters of variables need to be considered: the events that trigger transitions, the transitions themselves, and the obstacles that prevent or retard progress. The postulated relationships among these clusters is displayed in Figure 1.

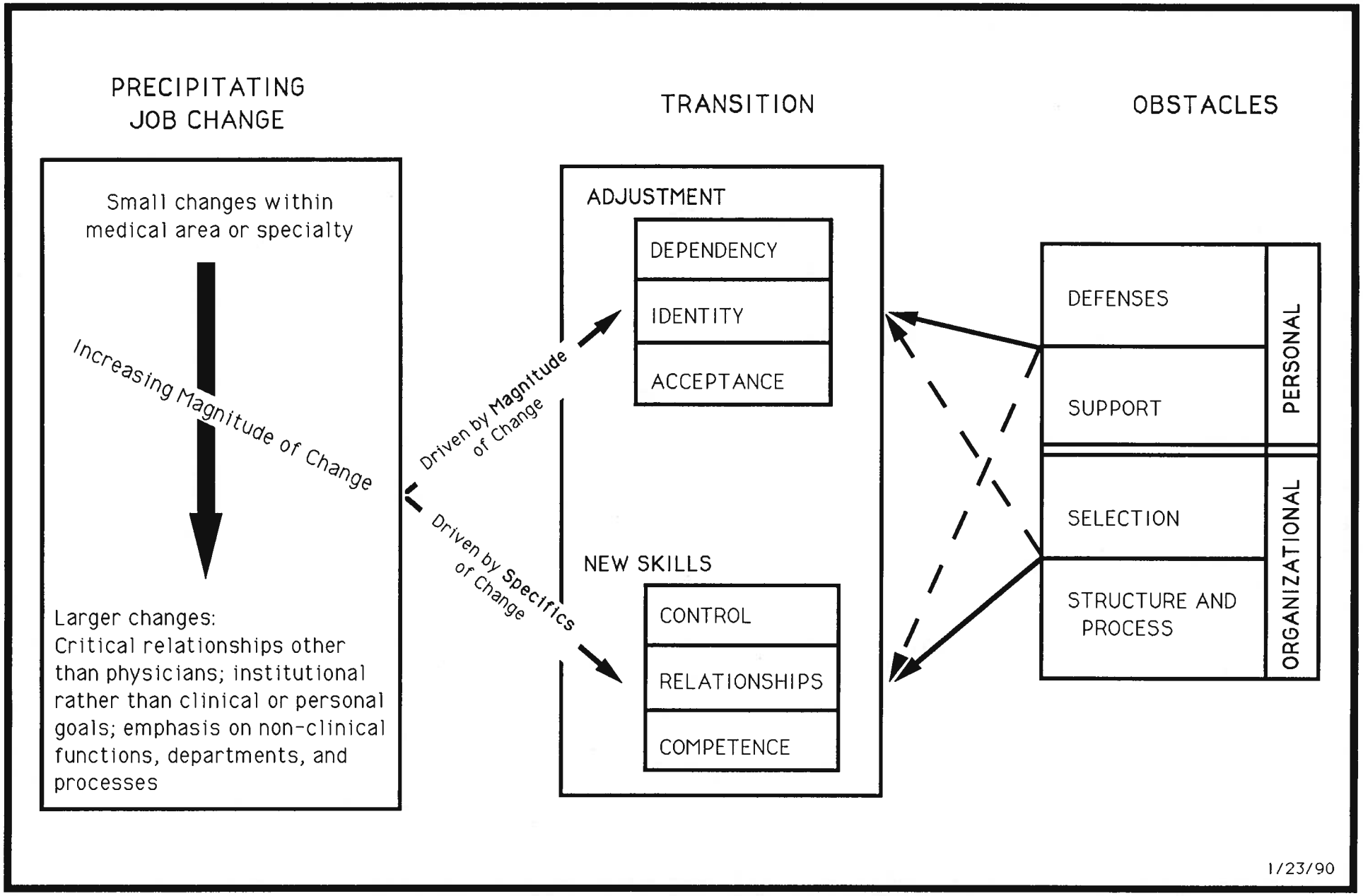
INSERT FIGURE 1 ABOUT HERE

For these physician managers the events that triggered transitions were almost all related to job changes. The most frequently mentioned were 1) the first professional role after medical school, where as a resident or fellow they wound up playing some kind of leadership role; 2) the first managerial position, which for many of them involved taking on a little bit of managerial responsibility in addition to their primary role as a physician; 3) significant job changes, usually promotions but sometimes lateral moves, that substantially increased managerial demands (involving such things as managing managers or people other than physicians, responsibility for different functions or departments, and being in charge of increasingly large units or institutions); and 4) evolutionary processes, in which transitions were slowly pushed along by gradual increases in responsibility rather than by a single trigger event.

We postulate that the specific transitions faced and the pressure to complete them depend largely on the degree of change required in moving from one job to another. On one end of the continuum are managerial jobs involving few major changes, such as supervising a small group in a narrow medical

FIGURE 1

A Framework for Understanding Transitions



specialty. While a physician assumes some supervisory and managerial responsibility, such "low change" jobs involve continued focus within patient care or medical specialty, working with bosses and subordinates who are also physicians, and taking little responsibility for revenue production, budgeting, community relationships, marketing, and other functions foreign to the physician. These kinds of managerial jobs may create stress and difficulty, but we hypothesize they are unlikely to serve as major triggers for any of the serious transitions. In fact, these kinds of jobs may make later transitions more difficult by reinforcing the illusion that managing is a secondary activity that can be handled with minimum investment while continuing one's clinical or research commitments.

At the other end of the continuum are major job shifts that demand significant changes: dealing with non-physician bosses and subordinates, alien functions and disciplines (for example, food service, maintenance, contracts), and institutional responsibilities (e.g., strategic planning, finance). These, we hypothesize, are the major triggers for transitions-- transitions that must be accomplished successfully (and sometimes quite quickly) if the physician manager is to succeed.

The idea that significant growth is triggered by significant changes in job demands accompanied by high pressure was documented in studies of high level corporate executives[27] and is consistent with the experiences of the physicians in this study. We hypothesize that those physician managers whose careers consisted of a slow accumulation of modest increases in managerial demands had encountered fewer of the transitions and made less progress in those they did face. Thus we suggest that transitions are driven by 1) the **magnitude** of change in managerial job demands, with increasing demands creating more pressure for change, and 2) the **specific demands** made on the individual to handle new situations, such as different kinds of key people, different functional or technical areas, or different strategic perspectives.

The second element of the framework is the transitions themselves. Of the six we have described, three are primarily centered around personal psychological adjustment to change (dependency, identity,

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[27]McCall et al (1988).

and acceptance), and three involve the development of significant new skills (control, relationships, and competence). We do not believe that the six transitions are independent of one another, although they may be. It is entirely possible, for example, to go through a crisis of dependency and identity at the same time or at different times. It is likely, however, that the three transitions involving psychological change are more similar to each other than they are to the transitions involving skill development, and vice versa. In that respect, the learning processes involved are likely quite different, and people are likely to differ in their ability to achieve one kind of change or another.

We hypothesize that the transitions requiring psychological adjustment are more dependent on the overall magnitude of a job change (from physician to manager or from physician-supervisor to higher level manager or executive) than they are on the specifics of it. The skill-based transitions, while clearly affected by the magnitude of a change, may be driven more by the specific elements within the job change (for example when bosses and subordinates are not physicians, the "relationships" transition is likely to emerge as central).

Finally, the third cluster of variables involves the obstacles to successfully achieving a transition. Two of these are primarily personal, in the sense that they are largely under the control of the individual of the physician: psychological defenses and lack of supportive relationships outside of the former physician peer group. The other two obstacles are largely controlled by the organization: the ways people are selected for managerial roles and the ways managerial jobs are designed and how people are prepared for them.

This framework suggests that physicians are similar to other professionals when it comes to taking on managerial roles. The factors that trigger a need for change, the transitions that face them, and the obstacles to success seem relevant regardless of the particular professional specialty. It is likely, then, that the same organizational initiatives useful for moving other professionals or technical specialists into general management (for example, engineers or accountants) should work for physicians as well. Organizations employing physician managers might profit from paying more attention to their selection processes and to job design and managerial development. Criteria used for selecting physicians for

managerial jobs should reflect managerial (as opposed to professional) skills and attributes, and should tap potential to develop the skills and attributes needed for higher level managerial jobs. Selection might also be improved by helping physicians make realistic choices for themselves by providing job previews, feedback, and options for those who do not succeed or decide they prefer life as a professional.

Physicians could be better prepared for significant managerial roles through systematic use of on the job experience and other developmental opportunities, in much the same way that high potential candidates are developed in better-managed corporations.[28] Managerial jobs destined for physicians might be designed so that the scope of responsibilities, objectives, and goals are realistic and clear (many of the physician managers we spoke with felt their jobs were ill-defined or that expectations were unrealistic), and structured so that organizational support is available to help new incumbents as they take charge (for example, coaching from an experienced boss, training programs, or needed learning resources).

Becoming an effective manager is no easy task. Even for individuals whose entire careers build logically toward general management, developing the intimidating array of skills and attributes is a daunting task. Professionals who have already progressed down one career path face the added burden of starting over on a new career. In the case of physicians moving into management, both the physicians themselves and their organizations can make a substantial difference by recognizing the kinds of transitions that must be made and by taking steps to successfully make them. It is not magic.

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[28]Kotter (1988), McCall, et al (1988).

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