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Partnership Is a State of Mind—Not a Piece of Paper

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INSIDE: REALIZING E-PRESCRIBING BENEFITS

Partnership Is a State of Mind—Not a Piece of Paper

Enculturation at Kaiser Permanente Orange County

BY RICHARD PITTS, D.O.

With the cost to replace a physician in a medical group approaching $300,000, medical groups are looking for solutions to avoid this expense.[1] One way to decrease physician attrition may be enculturation of new physicians. But what is enculturation? Although it isn't yet listed in the dictionary, enculturation is a word heard commonly in discussions today. Words that come close to the common usage meaning of enculturation include "orientation" and "indoctrination." Unlike orientation and indoctrination, enculturation seems to best be explained as a conscious attempt to shape thinking individuals while helping them to develop a shared vision of common goals and ways to get things done within an organization. "Partnership is a state of mind—not a piece of paper" is but one piece of the Permanente genome that Kaiser Permanente Orange County (KP-OC) attempts to insert into the new physician on arrival at KP-OC. This article seeks to share with the larger group practice community the rationale, development, and results of KP-OC's efforts to enculturate its new physicians.

THIS ARTICLE SEEKS TO SHARE WITH THE LARGER GROUP PRACTICE COMMUNITY THE RATIONALE, DEVELOPMENT, AND RESULTS OF KP-OC'S EFFORTS TO ENCULTURATE ITS NEW PHYSICIANS.

Introduction

In 1999, Kenneth Bell, M.D., associate area medical director of KP-OC area, mused that the entering new physicians needed more than a nuts-and-bolts orientation to become bonded to the Southern California Permanente Medical Group (SCPMG). The question was how to accomplish this task. Historically after a three-year trial period to become a partner, less than one percent of SCPMG physicians left once they became a partner. Physicians who left before achieving partnership did so for one of three reasons: technical issues, relocation out of the area, or cultural mismatch issues. The rate of physicians leaving due to cultural issues was from five to ten times higher during the three-year trial period than after a physician became a partner.

Is there a way to decrease the departure of physicians from the medical group early in their career due to cultural issues? What is the benefit to the organization if the organization invested time and energy to enculturate a new physician? Can an environment be created where new physicians would be able to become more fully involved at an earlier point in their career, that is, early and full engagement as a prospective partner? Is there a way to improve physician satisfaction? Why should a medical group care about whether or not a physician is happy? This article suggests answers to these important questions, as well as providing some of the results of the KP-OC enculturation program.

Environment

Kaiser Permanente is composed of two entities: The Kaiser Foundation Health Plans (KFHP) and a Permanente Medical Group in each region. Currently there are nine regions where KP offers a health care program: Mid-Atlantic, Ohio, Georgia, Colorado, Southern California, Northern California, Oregon, Washington State, and Hawaii. These nine regions combined serve approximately 8.2 million members. In each region, a Permanente Medical Group is partnered with the health plan to provide integrated health care. In eight of the regions, the Permanente medical groups are each a separate corporation with physician shareholders. In Southern California, the Permanente Medical Group is organized as a partnership of approximately 4,500 physicians called the Southern California Permanente Medical Group or simply SCPMG. There are many sub-divisions of the Southern California Region of KP. One of those medical service areas is KP-OC. KP-OC has approximately 400 physician partners serving approximately 340,000 health plan members. KP-OC is one of the fastest growing medical service areas in the KP program.

Besides the area medical director's intuition, what are some other motivations for having an enculturation program? As noted above, the price to replace a physician in a medical group can approach $300,000 per physician in direct and indirect costs. Also, patient satisfaction relates directly to physician satisfaction. Physician satisfaction relates to being tightly bonded to the medical group to which he or she belongs. Hence,

Summarization of Program Evaluation 2001-2002

	Helpful %	Not Helpful %
To what extent did the program contribute to your understanding of Kaiser Permanente?	100	0
To what extent did the program help you identify with the Permanente Medical Group?	100	0
To what extent did the program contribute to your understanding of the Kaiser Permanente culture?	95	5
To what extent did the program enhance your understanding of partnership in a general sense?	95	5
To what extent did the program help you understand your responsibilities in the medical group beyond simply providing medical care?	95	5
To what extent did the program make your first year in Orange County more enjoyable?	90	10
To what extent did the program help you with the transition into a large group culture?	90	10
To what extent did the program help you to plan your career with Permanente?	100	0
To what extent did the program help you to understand that this is your practice?	95	5
To what extent did the program help you to make connections within the Orange County Service area?	90	10
To what extent did the program help you to understand the process of change within a large organization?	90	10
To what extent did the program help you to understand how to implement change within Kaiser Permanente?	85	15
To what extent did the program help you to understand expectations to become a partner in Permanente?	95	5
To what extent did the program help you to understand what it takes to become a partner in Permanente?	90	10
To what extent did you enjoy the small group discussions?	90	10

satisfaction among all three—medical group, physician, and patient—is highly interdependent.[2,3] Perhaps an enculturation program could decrease departures due to cultural issues.

Orientation vs. Enculturation

So, what is the difference between orientation and enculturation? How questions are formulated regarding the differences between orientation and enculturation is one way to ferret out the distinction between them. Questions about orientation tend to be "I" type questions, while enculturation inquiries tend to be questions about the organization. Table 1 demonstrates this pattern with examples of typical questions.

Problem-Solving, Theory, and Development

The natural laws of the universe as suggested in systems theory mandate the constant presence of DNA in a living system as the living system expands, sustains, and repairs itself. In other words, no living system can survive without DNA. Various authors [4,5,6,7] point out that the natural laws of the universe as postulated in systems theory apply to human-made systems. Living system theorists suggest that business organizations are in fact living systems with criteria to stay alive and reproduce, not unlike those for any living creature. Social, religious, military, and business organizations generally have a formal way of enculturating new members with the goal of inserting their specific cultural issues (DNA) into new members. Without a formal program, organizations run the risk of a "default" culture as opposed to a "designed" culture. In general, default cultures are characterized by negativity. In fact, a common but not necessarily complimentary term in use within the KP

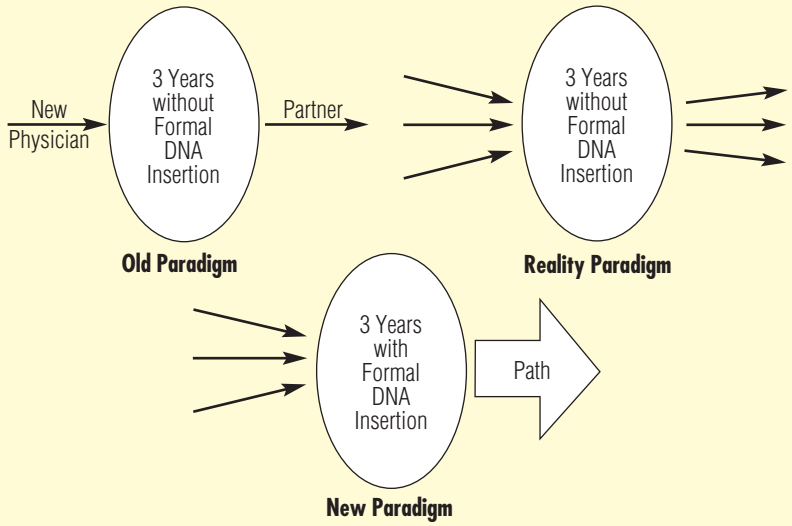
TABLE 1

Orientation vs. Enculturation

Orientation	Enculturation
■ Where am I?	■ Where did organization come from?
■ Where do I go?	■ Where is organization going?
■ What am I supposed to do?	■ What is the mission of the organization?
■ How do I use the computer?	■ How is change achieved in the organization?
■ How do I get paid?	

FIGURE 1

Kaiser Enculturation Paradigms



organization is "Kaiserized," referring to the default culture, and perhaps suggesting a cynical point of view.

A careful and thorough review of the orientation program as it existed in 1999 was completed. From a systems theory point of view, the information for day-to-day operations was well covered. However, there was little DNA about the KP organization available for the new physician. This research found that there was a defacto viewpoint that the physicians entering KP were homogeneous. The anticipated result of the old orientation program was that new physicians would pass through the three-year trial period and emerge as partners holding similar viewpoints and expectations (see Figure 1, Old Paradigm). The reality was that the physicians were heterogeneous and upon emerging from the three-year trial period often would be heading in different directions (Reality Paradigm). What was needed was the recognition that entering physicians were heterogeneous, and that new physicians needed to be instilled with the DNA of KP during the initial phase of their trial period. The goal was to have the newly minted physician partners emerge from the three-year trial period not as robots functioning exactly the same, but rather as Permanente partners all following a similar path that allowed for some differences (New Paradigm).

Task

Developing the program was a formidable task—the "genetic code" of the organization was spread out in many different documents, and other strands of DNA were embedded in people's thoughts. The task was to develop a program with KP genetic information, such as the following:

- New physicians are in a position of leadership from day one
- Everything speaks of the culture—behavior, dress, habits
- Understand the dynamics of change
- Embrace change
- New physicians can affect change
- Modeling behavior is one of the most powerful ways to change others
- Understand the difference between leadership and management
- Physicians should act as partners as quickly as possibly
- Principles of Permanente medicine
- Embrace 360-degree evaluation
- Provide new physicians with an introduction to needed "Skills for the Future"[8]
- Embrace the concept of partnership
- Other elements as noted in the agenda

Application: Finding Your Path to a Successful Permanente Partnership

In 1999, preliminary work was completed in anticipation of a program that would complement as opposed to replace the existing "nuts-and-bolts" orientation. The idea behind the program was to immediately start the enculturation process to ensure an active culture at KP-OC, as opposed to a default

culture. The result of the intensive review of the existing orientation program was the development of a program to "bond" or "glue" new physicians to the organization. Consistent with the concept that "everything speaks," the name of the program—Finding Your Path to a Successful Permanente Partnership—was deliberately chosen to reflect the need for active participation by the new physician, as opposed to a passive matriculation into partnership. See page 16 for highlights from the current agenda of the program.

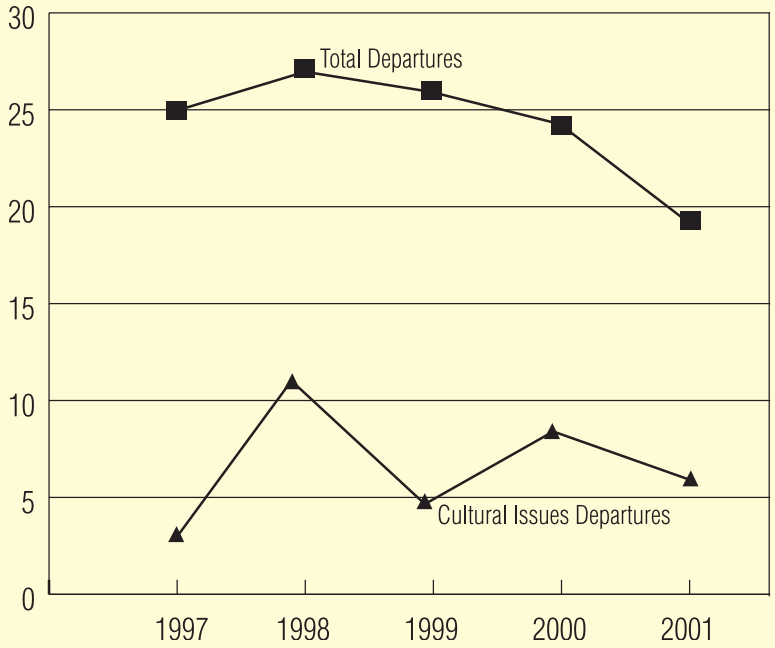
In addition to this program, which runs roughly every other week for nine months, there is a retreat at the end of the program, consisting of a Friday night and an all-day Saturday retreat which includes spouses and significant others. The theme for the weekend is set at a Friday evening social event with entertainment. Saturday's agenda is set to touch on gut issues for the new physicians and spouses. Generally, this session includes senior leaders from KFHP and SCPMG. Also included is a detailed explanation of partnership benefits and retirement issues, which busy physicians often poorly understand. Post-program surveys confirmed that the benefits and retirement presentation was highly valued and had high correlation with perceived value of staying with the medical group. Another highlight of the retreat was a small group exercise (SGE) where physicians and spouses discuss the "significance of KP in the culture at large." This activity was highly interactive with spouses as well as physicians acting as facilitators.

As Finding Your Path to a Successful Permanente Partnership has matured, almost all topics presented include a SGE with a report-out session to the larger group immediately following (getting presenters to develop a short didactic session with a SGE can be a challenging task for the program coordinator, so we developed presenter instructions). The SGE serves several purposes: (1) The SGE helps physicians to develop group interaction skills that are rarely if ever taught in medical school and residency training programs,[9] (2) personal bonds are formed between group members that otherwise may not have developed, and (3) with initial written instruction on facilitation, facilitation skills are honed as each new physician takes a turn at leading a small group. Additional information on physician retention[10] has been incorporated into the program.

WITHOUT A FORMAL PROGRAM, ORGANIZATIONS RUN THE RISK OF A "DEFAULT" CULTURE AS OPPOSED TO A "DESIGNED" CULTURE.

FIGURE 2

Percentage of Physicians Leaving Due to Cultural Issues



Results

What about the issue of physician retention? How has the program affected KP-OC's ability to retain physicians? Figure 2, which shows the number of physicians who leave or are asked to leave before reaching partnership, suggests that it may be too early to answer this question.

On page 12 are shows the results of the 2001-2002 post-program survey. The percentages suggest that there was an overwhelmingly positive response to the program in all categories. The lowest category was dealing with change, where 85 percent indicated that the program was helpful. More attention to this topic is planned for next year's program.

Is there other tangible evidence of program success? There are many instances of physicians in their three-year trial period who have completed significant projects in their respective departments—projects that have the mark of thinking as a partner. These physicians have returned to the program to share their experiences

Highlights from "Finding Your Path to a Successful Permanente Partnership"

This document is an attempt to provide you with a path towards partnership. It should not be viewed as a complete solution to achieving partnership. However, it may provide important information in achieving partnership in SCPMG. What are some important questions that you should think deeply about in your work towards partnership? Some are:

- What are the expected norms for a Permanente physician?
- How do you stay on a path of personal development and stay out of the personal repair shop?
- What should be the demonstrated competencies of a pre-partner?

Becoming a Partner: What Is Expected?

Sidney Garfield, M.D., was the founder of The Permanente Medical Group. …The following is an address by Sidney Garfield, M.D., to the Permanente Medical Group Executive Committee, August 14, 1974 (found by Steve Gifford, historian):

"Most important of all, I think you ought to build up your competitive position in this medical world by innovating and opening up to change. …You know institutions tend to become static; they build walls around themselves to protect themselves from change and eventually die. You should fight that by opening up your thinking and your ideas, and work for change. Improvement of service is very important for the competition you face in the future.…Put your money into more and better service to the people. That is where it is needed."

What should be the demonstrated competencies of a partner?

The following points are a compilation of ideas from SCPMG partners:

- Putting group success above your own and your specialty
- Working to help your colleagues
- Volunteering for non-clinical functions
- A deep caring about people and an ability to communicate
- A philosophical orientation to clinical practice that would permit them to participate meaningfully within a large group
- Possessing the requisite interpersonal skills that would allow them to communicate effectively with our members, and our colleagues
- Clinical excellence
- Dedication to customer service
- Flexibility
- Teamplayer
- Commitment to the medical group
- Know when, where, and how to vent frustrations
- Recognize your behavior serves as a role model for the staff
- Ability to bring positive regard to the group regardless of venue
- Raise issues for improvement in appropriate settings
- Self-awareness
- Ability to provide and receive constructive criticism
- Develop balance in work/personal life
- Share talents with group-leadership, research, and clinical expertise
- Willingness to mentor and be role model for pre-partners
- Value the partnership
- Dedicated to providing highest quality care, unimpeded by personal desires, to each and every patient
- Dedicated to continued learning, both in professional education and personal development
- Able to enhance our partnership unencumbered by ego
- Able to balance his professional and personal life, enriching of both environments
- Creative and innovative, and possesses an ability to effectively push our partnership toward new goals and achievements
- Self-critical and honest with strengths and shortcomings of oneself and of our partnership, and willing to change
- Insightful, able to find beauty and value where it's not apparent
- Enjoys life and is able to maximize the positives and minimize negatives

with the new physicians. They shared their victories of fostering change and adding value to their departments and to their individual practices. In one instance, a close relationship developed between the area medical director and a new physician during the enculturation meetings. This relationship may have assisted with developing a dialogue between the area medical director and the new physician regarding the change initiative which the new physician was attempting to complete.

Insights

Some physicians indicated that in a large group it is easy to develop the feeling of isolation. Participants indicated that coming together on a regular basis in the first year can help to counter feelings of isolation. Also, the sharing of what is going right or wrong in a physician's day-to-day practice helps to provide a point of reference for the new physician in the group.

The first meeting of the program has changed from two hours to four hours. This longer initial meeting time is used to hook the participants on the idea that this program can contribute to the success of a physician in the three-year trial period. Near the end of the nine-month Path program, the second group to go through the program started to refer to themselves as the entering class and have even talked about having reunion meetings. After the first few meetings of 2002, the current new physicians have already started to think and speak of themselves as the "new class" suggesting a higher level of bonding with each other and hopefully with the larger medical group. Although lacking the test of statistical significance with respect to causation, the longer initial meeting may have contributed to the formation of a group identity earlier in the program than with the

first two enculturation "classes."

A more formal measurement program is now under way with a pre- and post-program evaluation, which will facilitate a more accurate assessment of the participants.

In Summary

As present day issues come up, active discussion needs to be carefully managed by the program director to help the new physicians see how the KP DNA applies to the issues at hand. The program needs the commitment of a program director skilled in leading small and large group discussions. He or she needs to be highly literate with the resource materials available on the organization.[11,12] The medical director needs to be involved on a regular basis asking sentient questions to instill a sense of connection with the new physicians. Some sample questions asked in this program follow: What is going right and what is going wrong since you arrived? What can we do to help make your transition into the group easier?

PARTICIPANTS INDICATED THAT COMING TOGETHER ON A REGULAR BASIS IN THE FIRST YEAR CAN HELP TO COUNTER FEELINGS OF ISOLATION.

What makes the program successful? In the final analysis, hard work on the part of the program director is essential. This is not a program that can be put on autopilot. Why have an enculturation program? There are many reasons to have a "cultural" orientation (enculturation) in addition to a "nuts-and-bolts" orientation. Critical to the success of any organization is the easy distribution of information and achievement of common goals. Entering and understanding a large group culture can be a daunting task. Also the larger the group, the greater is the risk of a schism developing within the group when there isn't a common genetic code.[13]

The idea behind the Path program is to inoculate new physicians with the genetic code of the organization, information that may be needed during their decades-long career at Permanente. In addition to the cultural aspects, having interaction in a two-hour meeting every other week for nine months creates cross-department linkages that may last during the career of the physicians. Keeping in mind the following three thoughts helps to focus the view of the program: First and foremost, instill a sense of leadership in the new physicians from the very beginning. Second, instill the culture of KP and SCPMG. Third, help the new physicians understand the process of change at the personal, local, and organizational level.

Acknowledgements

This article is dedicated to Ken Bell, M.D., FACOG, who recently retired from the Southern California Permanente Medical Group after 33 years and over 4,000 obstetrical deliveries. He is the quintessential leader, who has the foresight to see what needs to be done, the intelligence to pick the right people to do it, and the wisdom to stay out of their way and let them get the job done. Also deserving of honorable mention is Patti Moorhead, administrative assistant. Patti's attention to detail and planning is essential to the success of this program. Others who have contributed to this project in various ways: Ruth Maurer, Ph.D., Ray Thron, Ph.D., and James McGettigan, Ph.D., Walden University faculty; Tad Funahashi, M.D., and Marc Klau, M.D., assistant area medical directors, KP-OC; Ed Ellison, M.D., current area medical director, KP-OC; Oliver Goldsmith, M.D., medical director of SCPMG; and Andrew H. Card, Sr., life mentor.

Suggested Reading List

Estimates of Costs of Primary Care Physician Turnover
By S.B. Buchbinder, M. Wilson, C. Melick, and N. Powe
The American Journal of Managed Care, November 1999. 5(11): 1431-1438

Physician Satisfaction Revisited
By C. Dunstone and H. Reames
Social Science and Medicine, 2001. 52: 825-837

General Systems Theory Beginning with Wholes
By B.G. Hansen
Taylor and Francis: Washington, D.C., 1995

Historical Review of the Southern California Permanente Medical Group
By R. Kay
SCPMG: Los Angeles, 1979

Ten Evidence–Based Practices for Successful Physician Retention
By H. King and C. Speckart
Permanente Journal, Summer 2002. 6(3): 52-54.

Physician-Patient Satisfaction: Equity in the Heal
By W.F. Koehler and M.D. Fottler
Medical Care Review, Winter 1992. 49(4): 455-484.

Skills for the Future
By R. Pitts
Southern Californian Physician, November 2000: 48

Lessons in Open Systems Theory: Learning from Kaiser Permanente-Georgia
By R. Pitts
Group Practice Journal, March 2001. 51(3): 44-46

The Fifth Discipline
By P.M. Senge
Doubleday: New York, 1990

The Dance of Change
By P.M. Senge et al
Doubleday: New York, 1999

Can Physicians Manage the Quality and Costs of Health Care: The Story of the Permanente Medical Groups
By J. Smillie
McGraw-Hill: New York, 1991

References

1. S.B. Buchbinder, M. Wilson, C. Melick, and N. Powe. 1999. Estimates of Costs of Primary Care Physician Turnover. *The American Journal of Managed Care*, November 1999. 5 (11): 1431-1438 .
2. W.F. Koehler and M.D. Fottler. 1992. Physician-Patient Satisfaction: Equity in the Heal. *Medical Care Review*. Winter 1992. 49(4): 455-84.
3. C. Dunstone and H. Reames. 2001. Physician Satisfaction Revisited. *Social Science and Medicine*. 52: 825-837.
4. B.G. Hansen. 1995. *General Systems Theory Beginning with Wholes*. Taylor and Francis: Washington, D.C.
5. R. Pitts. 2001. Lessons in Open Systems Theory: Learning from Kaiser Permanente-Georgia. *Group Practice Journal*. 50(3): 44-46.
6. P.M. Senge. 1990. *The Fifth Discipline*. Doubleday: New York.
7. P.M. Senge, et al. 1999. *The Dance of Change*. Doubleday: New York.
8. R. Pitts. 2000. Skills for the Future. *Southern Californian Physician*, November 2000: 48.
9. Ibid.
10. H. King, and C. Speckart. 2002. Ten Evidence–Based Practices for Successful Physician Retention. *Permanente Journal*, Summer 2002. 6(3): 52-54.
11. J. Smillie. 1991. *Can Physicians Manage the Quality and Costs of Health Care: The Story of the Permanente Medical Groups*. McGraw-Hill: New York.
12. R. Kay. 1979. *Historical Review of the Southern California Permanente Medical Group*. SCPMG: Los Angeles.
13. P.M. Senge. 1990. Op cit. P.M. Senge et al. 1999. Op cit.

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