Special Report

Can Your Group Make Decisions?

Latham
Consulting Group

Make Decisions, Resolve Conflict, Move Forward

Can Your Group Make Decisions?

The Meeting

Time: 7:35 P.M.

Place: Medical Group, P.A. - office conference room

Activity: Monthly Board Meeting

President: *"The next item we need to discuss is a non-compete clause for our employment contracts."*

Physician 1*: "Didn't we discuss that last month? I thought we reached a decision."*

Physician 2: *"Yes, I thought we decided to put one in."*

Administrator: *"No, we talked about it, but never reached a decision."*

Physician 3: *"Well, I think we should have one - and it should apply to everyone."*

Physician 4: *"I don't want it to apply to me."*

Physician 1: *"I thought we agreed to do this. Why do we always discuss the same things over and over again?"*

Physician 2: *"We've beat this to death – let's move on."*

wlatham@lathamconsulting.com

Group Governance

Sound vaguely familiar? The scene or subject may be different, but the result is the same - no decision is made, and the issue is tabled until the next meeting.

Group decision-making, or the lack of it, is a significant challenge facing all group medical practices. In today's increasingly competitive environment, a medical group's ability to make sound, timely decisions is critical.

Like it or not, medical groups today are much like traditional business enterprises, with one major difference - most traditional businesses have one person at the top, an ultimate decision maker. Medical groups, however, often have a number of "bosses," with each partner or shareholder wanting full participation in every decision.

Although full participation sounds good in theory, it can result in paralysis. It is nearly impossible to gain consensus on the broad array of decisions facing any group.

The individual nature of the physician also complicates the issue. For example, physicians:

- Are trained as individuals, and the performance of their medically-related functions are normally done as an individual.
- Have difficulty dealing with the confrontations in a group environment.
- Have different goals. Some are willing to sacrifice for the growth of the firm, while others want to arrange the functioning of the firm around their personal goals.
- Have different time horizons. Younger physicians are looking at the long-term prospects for the group, while senior physicians may be focusing on retirement.

wlatham@lathamconsulting.com

- Have different viewpoints. Some physicians look at the practice of medicine with a business orientation, while others are appalled at the thought of equating business and medicine.

These characteristics present no problem for the sole practitioner. For physicians in group practice, however, these characteristics increase the difficulty of making decisions. Physician groups attempt to cope with these problems by using one of the following decision-making models:

1. ***Consensus:*** Under this model, consensus of the group is required before any decision is acted upon. Such a system usually results in "tyranny of the minority," and the group is prevented from moving ahead on any front in any significant way. Most groups of three to twenty physicians operate this way.
2. ***Autocratic:*** At the other end of the spectrum, some groups have a senior physician who makes all the decisions for the group. This physician may have formed the group, and his/her partners relinquish their "rights" as a condition of association. This "benevolent dictatorship" model may work well for a number of years, and may only result in a problem when the senior physician leaves the group.
3. ***Democratic:*** To cope with the problems under the Consensus model, some groups are moving to a "majority vote wins" method of making decision. For each issue requiring a decision, the group votes and then moves in the direction with the most support. Some decisions may, however, require consensus. Over time, this will become the preferred decision-making model for groups of three to twenty physicians.
4. ***Representative:*** Under this model, groups have recognized that problems are too complex or need to be acted on too quickly to be made by the entire group. A representative group of physicians are selected by the group and charged with making the group's decisions. If the group does not like their representatives' performance, they can vote them out on a periodic basis. Some issues may require a vote or consensus by the entire group. This model normally is used by groups with twenty or more physicians.

How can groups improve their decision-making capability?

The first step is to recognize that the "Democratic" and "Representative" models are preferable to the "Consensus" model, and, over time, to the "Autocratic" model. Then the group must identify the responsibilities and authority of each of its leadership functions (e.g., its board of directors, executive committee, group president). Finally, the group must stick with the new system until it seems like second nature.

Normally, a group will change its decision-making process only after some express extreme dissatisfaction. It is often difficult for the physicians to identify the problem's source. Frequently, the Administrator must assist the physicians with the problem and its solution.

Let's review an example of how one group made such changes. In this group, both the Administrator and group president recognized the group's inability to make decisions. No action was taken unless consensus was obtained. The president and Administrator decided that a combination of the Democratic and Representative models would be appropriate for their group.

To begin the process, they summarized some of the major issues that the group faced but did not resolve during the year. They reviewed the minutes of their board meetings, noted the issue, the number of meetings in which it was discussed, and any action taken. They found little progress had been made on significant issues.

This information was presented at the next board meeting. The president took a strong role in the meeting, pointing out the risks of leaving this basic issue unresolved. He then suggested that the group explore alternative decision-making methods.

After much discussion, the group agreed to consider a change. After the board meeting, the president and Administrator developed a proposed leadership system by defining the responsibility and authority of the Board of Directors (see Exhibit 1, below); Executive Committee (see Exhibit 2); and president (see Exhibit 3).

They also:

- Developed a formalized meeting schedule for the board and executive committee.

- Proposed that all decisions, except those specifically identified in the definition of authority, would be voted on by the members of the group.
- Agreed that the group president would control the pace of the executive committee and board meetings.

This information was presented to the entire board. After much discussion, and some modification of the items needing consensus, the plan was adopted.

Several other changes in the way the group operated were made:

1. *Executive Committee Meetings:* At these meetings, the President was given the responsibility to:
    a. Help establish a consensus of the executive committee before presenting issues to the board.
    b. Outline the issue and the decisions needed if consensus could not be reached by the executive committee.
2. *Board Meetings:* To improve their board meetings, the group initiated the following rules:
    a. Each meeting will have an agenda developed by the executive committee.
    b. The president will control the pace of the meeting using a modified "Roberts Rules of Order." His role will be pushing the members towards making motions, clarifying the motions, monitoring the discussion of the motions, and calling for a vote.
    c. Major points of discussion will be recorded on a flipchart to prevent the rehashing of a issue.
    d. The group will separate its policies into a separate policy book to avoid lengthy searches through the minutes book.

As you might expect, the first months under this new system were stressful for the physicians and the Administrator. Although some of the physicians complained about how "formal" and "controlled" the organization had become, the majority recognized the benefits of the new system. Their

meeting time was reduced; more effective decisions were made on a timely basis; and the executive committee could handle a substantial amount of the group's more mundane business.

In the group medical practice environment, tension is natural because of the conflict between group and individual goals. However, tension does not need to result in decision making paralysis. The key to success in group environments is to select the proper decision-making method and to define the responsibilities and authority of the decision-making entities.

wlatham@lathamconsulting.com

Exhibit 1 – Board of Directors

MEMBERSHIP:

- All full partner members
- Other physicians (nonvoting)
- Administrator (ex-officio)
- Others may attend as invited

TERM:

Members will serve as long as their contractual arrangements with the practice are in effect.

RESPONSIBILITIES:

The Board is responsible for making decisions regarding the major operations of the practice. The Board sets policy for the group, performs long-range planning, and makes certain operating decisions regarding contracts and expenditures.

The Board monitors the overall performance of the practice.

AUTHORITY:

- Approves new physician positions within the group practice.
- Approves all contracts.
- Authorizes hiring of physicians.
- Approves all expenditures over $15,000.

MEETINGS:

The Board will meet the third Thursday evening of each month.

wlatham@lathamconsulting.com

Exhibit 2 – Executive Committee

MEMBERSHIP:

- President
- Vice President
- One additional Physician
- Administrator (ex-officio)

TERM:

One year.

RESPONSIBILITIES:

This Committee is responsible for making the day-to-day decisions for the group, and reporting to the full board.

AUTHORITY:

This Committee has the following authority:

- $15,000 approval limit on expenditures.
- Make salary/benefit recommendations to the Board.
- Approves new administrative positions.
- Approves modifications to personnel policies.

The Committee may not enter into contracts on behalf of the group, but must present them to the Board for approval.

MEETINGS:

The Executive Committee will meet each Tuesday morning at 7:00 AM.

wlatham@lathamconsulting.com

Exhibit 3 – President

ELECTION:

The President is elected in December of each year by a majority of the voting Board members.

TERM:

One year.

RESPONSIBILITIES:

- Handle the ceremonial role for the group with external parties.
- Direct the Board in policy formation.
- Lead the physician recruitment effort.
- Set agenda and run meetings of Executive Committee and Board.
- Monitor performance of Administrative function.
- Conducts performance review of Administrator.
- Create committees and appoint Chairpersons.
- Make day-to-day decisions within limits of authority.

AUTHORITY:

$5,000 approval limit on expenditures.

As you might expect, our knowledge in this area is based on the fact that Latham Consulting Group has substantial experience in assisting medical groups with improving their governance through our **Governance Services**.

If we can provide assistance or answer any questions you might have, please contact us at 704/365-8889 or e-mail us at wlatham@lathamconsulting.com.