_____

Marrying Research and Intervention in the Health Care Industry

A Discussion with Lotte Bailyn, Ann Bookman, Mona Harrington

**Lotte Bailyn, Ph.D.
MIT Workplace
Center**

Lotte Bailyn is a Professor of Management (in the Organization Studies Group) at MIT's Sloan School of Management and Co-Director of the MIT Workplace Center. In her work she has set out the hypothesis that by challenging the assumptions in which current work practices are embedded, it is possible to meet the goals of both business productivity and employees' family and community concerns, and to do so in ways that are equitable for men and women. Her most recent book, *Beyond Work-Family Balance: Advancing Gender Equity and Workplace Performance* with Rhona Rapoport, Joyce K. Fletcher, and Bettye H. Pruitt (Jossey Bass, 2002) chronicles a decade of experience working with organizations that supports this hypothesis, while also showing how difficult it is to challenge workplace assumptions.

**Ann Bookman, Ph.D.
MIT Workplace
Center**

Ann Bookman is Executive Director of the MIT Workplace Center. She is a social anthropologist who has authored a number of publications in the areas of women's work, work and family issues, unionization, and child and family policy. Her new book, *Starting in Our Own Backyards: How Working Families Can Build Community and Survive the New Economy* (Routledge, 2004), extends the discourse on work-family integration to include issues of community involvement and civil society. Bookman has held a variety of teaching, research, and administrative positions and has also worked in government, as a presidential appointee during the first term of the Clinton administration, as Policy and Research Director of the Women's Bureau at the U.S. Department of Labor, and as Executive Director of the bipartisan Commission on Family and Medical Leave. She is co-editor of *Women and the Politics of Empowerment.*

Mona Harrington is the Program Director of the MIT Workplace Center. She is a political scientist and writer who examines connections between American political culture and social policy. Her recent work focuses on the policy implications of profound changes—personal, political, economic, social—produced by the transformed roles of American women. Her latest book, *Care and Equality: Inventing a New Family Politics* (Routledge, 2000) calls for a national conversation about new ways to connect families, care, women, and work. With the Public Conversations Project of Watertown MA, she organized a year-long series of public dialogues on these questions.

Mona Harrington, Ph.D.
MIT Workplace Center

_____

In 2001, the MIT Workplace Center interviewed over 40 leaders in the Massachusetts healthcare industry. They found that although many of the industry's most pressing problems, including staffing shortages and long, inflexible work hours, have a direct impact on both patient care and workers' personal lives, work-family issues remain largely invisible in this industry.

To probe further into work-family issues in healthcare, MIT Workplace Center researchers have used a "research and intervention" approach called Collaborative Interactive Action Research (CIAR)[1], This methodology involves documenting the connections between workforce problems and problems facing workers at home and working collaboratively with workers, managers, and other stakeholders in specific healthcare workplaces to identify work-family problems and create alternative structures and supports through work redesign or other appropriate initiatives.

MIT Workplace Center Co-Director Lotte Bailyn is applying the CIAR methodology to surgical wards at a Boston hospital. She is following nurses to understand their lives, particularly how their work schedules intersect with their personal lives. Nurses on these wards have great flexibility about the kind of schedules – full-time or part-time; 8 hour shifts or 12 hour shifts – that they want to work, but very little control over what days or shifts they will be assigned to.

A second project, headed by MIT Workplace Center Executive Director Ann Bookman and Program Director Mona Harrington, involves research on the operation of two teams of health care professionals at a large multi-specialty medical practice organization in Boston. Bookman and Harrington have conducted individual interviews with members of the Geriatric Care team and Palliative Care team, as well as with some family members of those teams. They are doing work observations of team members -- some at nursing home sites and some in patients' homes. Additional interviews are being conducted with nursing home staff and patients' families. Research so far indicates possible work-family interventions in three areas:

- The interface between the teams and nursing home staff members - addressing work hours, flexible arrangements, and stress.
- Work organization and integration of services, between the teams and staff based in outpatient centers -- addressing flexible work arrangements, work load, and stress.
- Work-family conflicts of patients' family members engaged in decision-making and direct care -- addressing flexible arrangements and integration of the needs of patients, institutional caregiving staffs, patients' family caregivers, and employers of family caregivers.

Recently, we sat in on a conversation among the researchers. Here's what they had to say about their projects, and in particular, the CIAR methodology.

---

[1] Rapoport, R., Bailyn, L., Fletcher, J.K., & Pruitt, B.H. (2002). *Beyond Work-Family Balance: Advancing Gender Equity and Workplace Performance*. San Francisco, CA: Jossey Bass.

Lotte Bailyn: Collaborative Interactive Action Research is unlike both the usual vision of research and the usual vision of intervention. CIAR brings research and intervention so closely together, that the research becomes intervention, and the intervention yields data that can then be analyzed. Its goal above all else is to help create changes at the work site by collaborating with people there to redesign work so that both work goals and employees lives can benefit. In our projects, we've found that CIAR can improve the lives of employees as well as the work unit itself which is a big surprise, because people usually think of these as trade-offs.

> **"CIAR (Collaborative Interactive Action Research) brings research and intervention so closely together, that the research becomes intervention, and the intervention yields data that can then be analyzed. Its goal above all else is to help create changes at the work site by collaborating with people there".**
>
> **- Lotte Bailyn**

A goal of our current project at the surgical units is to make the lives of nurses a little better. Nurses have a lot of flexibility in whether they work part time or full time, but don't have much control over when they work. That makes it difficult for them to manage their personal time. To get to that issue, we're working on a joint collaborative intervention involving self-scheduling. We're hoping that as a result, work-family conflict will be reduced for nurses, and care for patients will be improved since the nurse manager will be freed from scheduling tasks and will have more time to spend on improving the quality of care.

We're at the implementation stage now. Often, when intervention is introduced at the workplace, it falls off when the researchers leave. The ones that endure fit into the goals of the organization. In this case the nurse manager has the goal of improving patient care, but hasn't been able to do it because she spends so much of her time on scheduling tasks.

This agenda emerged from a lot of observation of the nurses, some analysis of those data, feeding that back to them, then working with them. We went a different route to begin with, but that didn't work. It's a very interactive process

ANN BOOKMAN: When the MIT Workplace Center decided to do collaborative interactive research projects in healthcare, we started by conducting a series of informational interviews with leaders in our local healthcare industry. One of the things we found was that there was resistance to the idea that you could organize your work to do it well, while at the same time have a fully actualized personal and family life. In healthcare, that is not a concept that is really talked about or accepted. Although there are HR departments in various health care institutions that have particular work-family policies, such as leave or flexible scheduling, the ideas that we are trying to bring in - the dual agenda and work redesign - require a whole new way of thinking for people in health care. That's a context that shapes how the collaboration unfolds and what types of interventions are appropriate.

> **"One of the things we found was that there was resistance to the idea that you could organize your work to do it well, while at the same time have a fully actualized personal and family life. In healthcare, that is not a concept that is really talked about or accepted."**
>
> **- Ann Bookman**

MONA HARRINGTON: Within healthcare there is a very strong cultural focus and professional focus on patient care. This fosters an ethic of self-sacrifice among workers. Therefore they almost consider it inappropriate to take into account their needs when deciding how the work should be done.

One of the interesting things we find in working with the geriatric and palliative care teams is that their collaborative nature gives them extraordinary potential to put together their work and family lives. They all understand the work that is being done. Therefore, they can cover for each other. The team structure allows for a fair amount of flexibility. Also, all of the mutual understanding seems to be a way of helping the team members live with the stress that is a constant part of their work as they deal with geriatric patients and dying patients in particular. This kind of team structure we can see is a very interesting and useful model for dealing with work-family. However, it hasn't been constructed for that purpose. It has been constructed for the purpose of efficiency, so is always in danger of having work loaded onto various team members.

> **"One of the interesting things we find in working with the geriatric teams is that their collaborative nature gives them extraordinary potential to put together their work and family lives. They all understand the work that is being done. Therefore, they can cover for each other. The team structure allows for a fair amount of flexibility. Also, all of the mutual understanding seems to be a way of helping the team members live with the stress that is a constant part of their work as they deal with geriatric patients, and dying patients in particular".**
>
> **- Mona Harrington**

What we will be successful doing, if it succeeds, is bringing this dimension of concern about protection of personal and family lives of the team members into the automatic thinking that goes on in the organization of the group. We're at a point in which the group is attempting to expand its services, which raises the potential of excessive work for the team members. Our aim in gathering information is to understand and report what is happening, but also in the course of asking questions, to keep the team members conscious of the effect their work has on their lives.

ANN BOOKMAN: Something interesting that emerged early on in this project was that many of the team members had previously worked in the outpatient centers of this large medical organization. One of the reasons that they left the centers and joined a team was because of the stress and constant pressure of having very short patient visits -- 15 minutes basically. Even though they did not explain their moves this way, we think the team environment has allowed them to have much more control over their time, both at work with patients, and in their lives outside of work. However, they are not immune to overall pressures in the healthcare system. So, this team structure in some ways is creating an oasis in an otherwise very pressure-filled environment. And, as Mona said before, it's constantly being threatened. So, as they try to expand their services, immediately these pressures from the healthcare system overall, and all the healthcare institutions that they are connected to, begin to impinge on them.

LOTTE BAILYN: In our previous settings we used one-on-one interviews, which, as Mona indicated, is already an intervention because it begins to change people's thinking. When we bring people together and feed back what we've learned, they begin to get a shared understanding. But, in the healthcare setting it is very difficult to do individual interviews because of people's schedules. Rather, you talk to them as you're observing them, and it's even more difficult to bring them together. This makes collaboration more complicated. My meetings have usually been with two or three nurses one day, and two or three others another day. Because of this, I don't think we

have been as successful in creating shared new understandings, as you can when you really bring people together.

The first group of nurses told us self-scheduling would be a good idea. We then checked with the next group to make sure that they thought self-scheduling would be a good idea, too. We were able to give them a questionnaire, so we do have individual responses about what they thought would help them and what they thought might be a problem. The nurse manager sees what is going on, and interestingly enough is playing a key role as a researcher in terms of monitoring. We had the wrong forms at the beginning. I made these forms from what I knew, but it didn't fit the situation and she immediately changed them. She is playing a very significant researcher role.

It's a very fluid model. In these projects, expertise goes back and forth among the employees, the managers, and the researchers. The term, "fluid expertise," is how we describe this interaction – a form of mutual inquiry. In some ways, healthcare is a good environment to do this kind of research because companies that know the language and the concepts of work-life tend to connect it to family policies, rather than to the design of work. In healthcare, people don't have these preconceptions.

> **"It's a very fluid model. In these projects, expertise goes back and forth among the employees, the managers, and the researchers. The term, "fluid expertise," is how we describe a mutual inquiry. In some ways, healthcare is a good environment to do this kind of research because companies that know the language and the concepts of work-life tend to connect it to public policy. In healthcare, people don't have these preconceptions".**
>
> **- Lotte Bailyn**

ANN BOOKMAN: In our project, the teams are only the starting point for understanding the very complicated delivery system of geriatric care. The way that our project has been organized is to start with interviews and work observations of the team members. It also includes two other very important components, both of which are in progress. One is some interviews and observations in the nursing homes where the teams work; interviewing staff there. Another component is that we are interviewing the families that have recently used these extended care facilities. What we have found is that, with the very short length of stay in acute care hospitals and the Medicare-regulated deadlines for stay in rehab facilities, patients are quickly being pushed back into their homes for a lot of their ongoing care. That obviously puts a great deal of pressure on the family members. So, the work and family issues of the family caregiver is another important piece of our project. We are trying to look at and understand the relationship between all of the different clinicians who are involved in caring for these patients as well as the family caregivers.

In the literature, this type of team is called a "dispersed team," the members are not all in one place. In this case, they are dispersed in a number of nursing homes. They also do their work sometimes in hospitals, sometimes in the patients' homes, and they come together for a fairly regular set of meetings a couple of times a month. However, they maintain a lot of virtual contact using phones, pagers and email. This contact produces a set of connections that are quite alive even though they do not all work in the same place. We see this as part of the satisfaction they take in their work and also a way to relieve stress. They turn to each other when there is a particular difficulty or a particular problem that is beyond the experience of an individual team member – it's their own version of "fluid expertise."

MONA HARRINGTON: Once the patients are home the connection is a bit harder to maintain, but there is a fair amount of knowledge that is retained on the part of the team members about particular patients and their families. Many tend to be, as the clinicians call them, "frequent

fliers." Geriatric care often requires repetitive care of some kind. Therefore, the contact with the patients' families is vital for the clinicians taking care of the patient. They tend to be known and information about them is fairly well maintained. It is almost as if the patients' families are extended members of the team in ways that we haven't completely tracked, but it is vital and it's going to be a subject of ours.

ANN BOOKMAN: An example of that concerns the transfer of medical information. Usually medical records are kept on an institutional basis, so a patient will have one medical record in the hospital, one in the extended care facility, and one held by their primary care physician that is used when they come home and become an outpatient again. The family member acts as an integrative medical record. They are the ones who have been with the patient in all of these different settings and they are the ones who remember specifics about the patient – about allergies to medication, for instance. Finding ways to integrate medical information is a hot subject in healthcare. These records don't travel from one healthcare setting to another, and it's a big issue in patient safety and the quality of patient care. Before this gets figured out from an IT perspective, the family members are the only source for an integrated cross-institutional medical record.

One of the things we've been learning through this project is the importance of relationship building. In the past when I have done projects that don't use the CIAR method, I may meet a subject once and do an interview, and it will hopefully be an enjoyable interaction, but then I never see them again. I use material from that interview as data that I analyze along with other data I have collected. With this kind of project, there is the need to create long-term relationships where there is some trust.   In terms of the fluid expertise that Lotte was talking about, the team members don't fully understand the way we construct the dual agenda for work and family, and we don't always understand what they are saying, so there is a mutual back-and-forth trying to understand each others' framework and language. And that back and forth constitutes an important source of data itself.

The ability to ultimately construct a new type of work organization that is going to better support the work and better support people's personal and family lives is a direct outcome of the quality of relationships that are built. That's a very big part of the work and is another thing that differentiates this type of work from traditional research.

> **"One of the things we have been learning through this project is the importance of relationship building. With a project that uses the CIAR method, there is the need to create long-term relationships where there is some trust. In terms of the fluid expertise that Lotte was talking about- the team members don't fully understand the way we construct the dual agenda for work and family, and we don't always understand what they are saying, so there is a mutual back-and- forth trying to understand each others' framework and language… The ability to ultimately construct a new type of work organization - one that is going to better support the work and better support people's personal and family lives - is a direct outcome of the quality of relationships that are built".**
>
> **- Ann Bookman**

MONA HARRINGTON: In healthcare everyone involved is very used to having researchers around. Researchers are crawling all over hospitals and every kind of healthcare institution, but they are focusing on medicine, patient care, patient safety -- on issues of that kind. It is very rare for somebody to go into these institutions focusing on the workforce. All of the expectations are that we are there to examine something that has to do with the care of patients. It seems quite surprising to people that we are interested in how the organization of work varies, and that changes in work organization can really make a positive difference in both work and family life.

For more information about the authors and the MIT Workplace Center, please visit, http://web.mit.edu/workplacecenter/.

For more detailed information on the Collaborative Interactive Action Research (CIAR) methodology information, see Rapoport, R., Bailyn, L., Fletcher, J.K, & Pruitt, B.H. (2002). *Beyond Work-Family Balance: Advancing Gender Equity and Workplace Performance*. SanFrancisco, CA: Jossey Bass.

Study Examines the Careers of Physicians
An Interview with Forrest Briscoe

Forrest Briscoe, Ph.D.
Pennsylvania State University

Forrest Briscoe is an Assistant Professor in the Department of Labor Studies and Industrial Relations at The Pennsylvania State University. He received his PhD at MIT's Sloan School of Management and was a Research Assistant with the MIT Workplace Center. He also holds a Bachelor's degree from Harvard University. His current interests concern the diversity of careers and organizational settings experienced by professional workers, including their ability to balance work with family. His dissertation examines these issues among physicians.

The changes occurring in the healthcare system and in the composition of the physician workforce are having a significant impact on the career paths and professional fulfillment of Massachusetts doctors. Forrest Briscoe, Assistant Professor of Labor Studies and Industrial Relations at Pennsylvania State University, initially began examining these impacts last year as part of his doctoral work at MIT's Sloan School of Management.   Briscoe has focused his research at a large multi-site medical group in Boston, where he has conducted multiple interviews with practicing physicians who are involved with a variety of career activities. Interestingly, his findings suggest that despite their traditional bias against such large organizations that constrain autonomy, many doctors appear to value working in larger organizational settings because of the better hours and more predictable schedules available there.

Briscoe notes that at the same time that large healthcare organizations have become more common, the workforce itself has changed. The greater number of women and dual-earner families in the workforce have created a need for workplace flexibility.

Briscoe found that the conditions in the workplace have also freed up physicians to vary their professional activities. "There are new kinds of career flexibility that have become available in big organizations that weren't available in private practice," says Briscoe. Among the physicians he studied, some practiced part time, and some were involved with non-patient-related duties, such as research or administration. "One even had a start-up company (?) going. They really did a variety of different things other than just seeing their regular patients in the office," Briscoe says.

Workplace flexibility was an unintended result when large healthcare organizations came to dominate the medical landscape. "What allows them to have these different career options are

actually a series of organizational systems, like patient-centered care teams, special physicians to handle hospitalization, and electronic medical records, which all help physicians to have time for other work or non-work activities outside of patient care. These systems weren't created to help doctors out with their careers, they were created to improve the efficiency of the delivery of healthcare or maybe improve the quality of healthcare," Briscoe says. Now, however, healthcare administrators tout the flexibility their organizations offer their staff. "If you talk to a leader in one of these organizations they will say that one of the most important advantage they have right now is they can offer career flexibility and attract good doctors," Briscoe says.

Briscoe is also completing a representative survey of doctors across the state, co-sponsored by the Massachusetts Medical Society. Data from this survey will allow him to generalize the findings of his thesis research by systematically comparing career and work options across different organizational settings (large medical groups, small private practices, hospitals, etc). A possible intervention in this project is helping one division of a large medical organization in evaluating and improving the implementation of part-time and flexible scheduling arrangements for physicians.

For more information, please contact Forrest Briscoe at fbriscoe@psu.edu.