Working Paper

Enhancing Patient Care Through Enhancing Employee Voice: Reflections on the Scanlon Plan at Boston's Beth Israel Medical Center

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#WPC0002

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Introduction

This working paper was produced from the transcript of a spring 2002 MIT Workplace Center seminar given by Mitchell T. Rabkin, M.D. and Laura Avakian, M.A. on March 13, 2002. Mitchell Rabkin is CEO Emeritus, Beth Israel Hospital; Institute Scholar, The Carl J. Shapiro Center for Education and Research at Harvard Medical School and Beth Israel Deaconess Medical Center; and Professor of Medicine, Harvard Medical School. Laura Avakian is Vice President for Human Resources, MIT and former Vice President of Human Resources, Beth Israel Hospital where, among other achievements, she worked closely with Dr. Rabkin to develop the Prepare/21 program. This working paper combines the comments made by both Ms. Avakian and Dr. Rabkin during the March 13th seminar, and includes questions from the audience and answers by the speakers.

Changing the Culture of the Workplace at Beth Israel: Mitchell T. Rabkin, M.D.

I want to draw on my 30 years as CEO of Beth Israel and describe our "PREPARE/21" initiative and other activities that helped to civilize the workplace at Boston's Beth Israel Hospital, a research-intensive major teaching hospital affiliated with Harvard Medical School.

In any job, from entry level to the top, there are two components of work. There's the prescribed component and a discretionary component. The prescribed component is when you tell the hospital photographer: "The Queen of England is coming to visit 9:30. I want you in the lobby all set up and ready to take the pictures by 9:00." But you don't tell the photographer where to point, when to click, and so forth – that's the discretionary component -- that is his or her professionalism. All work at all levels has a discretionary component. Where you start and what you do. In this sense, everybody is a professional at whatever level of the employment hierarchy each may happen to be. It implies that one should treat all people at all levels with respect since each is, in his or her own role, a professional and thus a colleague.

All work at all levels has a discretionary component ... In this sense, everybody is a professional...

P articipation
R esponsibility
E ducation
P roductivity
A ccountability
R ecognition
E xcellence

For instance, at employee appreciation days at Beth Israel executives and department heads would serve food in the cafeteria. As I was dishing out spaghetti at one of these, a physician came through the line with his tray and I said, "Hi, Jack." I saw this look on his face like, "Who the hell behind the counter is calling me by my first name?" But then all of a sudden he looked up and said, "Oh, oh, Mitch. What are you doing there?"

Prepare/21's Roots – The Scanlon Plan: Mitchell T. Rabkin and Laura Avakian

Beth Israel's "Prepare/21" program title meant preparing for the 21st Century. It is a derivative of the Scanlon Plan, named after Joseph Scanlon, who was a steelworker in Pittsburgh in the 1940s and later joined Douglass MacGregor on the MIT faculty. The whole program is based on Scanlon's belief that the people who do the work actually might know something about it. Scanlon thought employee's voices should be heard and that their voices should be informed, in order to place their own efforts in the context of the system in which their work is existing, and in the context of the mission of the organization in which they work.

Beth Israel was the first not-for-profit and the first service organization to implement the Scanlon Plan. Others earlier had been manufacturing businesses, most in the upper Midwest and generally fairly small. We uncovered Scanlon as a possibility when we were thinking about incentives and participative management in response to the introduction of the prospective payment system in the early '80s. For the first time ever, our trustees were saying to us, "You have never had layoffs before, but this may be the time. You may need to consider reductions in force and some very different ways of running the organization." As we tried tightening our belts, we worried about sacrificing anything important in the quality of care to the patient, and/or sacrificing something important in the quality of work life.

To learn what Scanlon was all about, several of us went to Zeeland, Michigan, to visit a Herman Miller furniture factory. We toured a plant with Max DePree, who was then the CEO, and Richard Ruch, who was the COO – and saw how they were welcomed by their factory employees as colleagues. Dick Ruch pointed out something impressive to me. He said: "There is not a single product we make that either in the design or in the production process has not been improved on the factory floor." These people knew what they were doing and why.

Case Example

An Employee Connected with the Mission: Mitchell T. Rabkin

When we were at the Herman Miller plant, we went out onto the loading dock where a burly, tattooed guy was busy crating up the desk. I said: "What's important about your job?" And he looked at me: "What's important about ***my*** job? You see that sucker?" --he's pointing to the desk. "Cherry wood, right?" "Yeah." "Drawers on the right-hand side, right?" I said: "Yes". He spoke: "Now suppose the guy in Kansas City who ordered this wanted birch – and he wanted the drawers on the left-hand side? Who do you think is going to pay for crating that sucker up and sending it back here to Zeeland, Michigan, eating into our profit? And where do you think that guy is going to buy his next desk? Not here. He's going to go down the road to Steelcase. Now the question is: are we going to be a furniture manufacturing company of 2,000 employees? OR, since they can make this same stuff in Korea -- same quality, same design -- for 30% less, are we going to be a furniture importing company with only 20 employees? That's what's important about ***my*** job."

That worker owned the business! He knew the mission; he also knew how his work was connected with the mission. And there was no question about it.

Implementing Scanlon at Beth Israel: Mitchell T. Rabkin and Laura Avakian

The principles of Scanlon resonated with us -- having employees own the organization, own the problems, being invested in finding resolutions to problems – theirs and those of the institution. It fit with the concepts that were so well in place at Beth Israel, with the idea that employees were valued, but we didn't have an active mechanism for making it happen. How do you really engage 4,000 people in solving problems? We took almost a year to ask the question. We went to every shift, weekends, nights, mornings, small groups, big groups, doctors, housekeepers, everyone, and said: "Do you think there's a compelling reason to change? And if you do, are you willing to come forward with ideas to help make the change? And if there are changes that are made, and they are good, do you think there is something in it for you?" And enough people said: "Yes, we think we see the reason we have to change. And we also

think that we have things to contribute and that there should be something in it for us if we do."

We then created an opportunity for people to elect a total of 75 people representing all walks of the hospital. Three subcommittees were formed to work out the three concepts of the Scanlon plan: identity, participation, and equity.

- Identity is who we are and where we are going -- the mission, history, and values of the hospital including our fiscal environment, how the individual is linked to the organization's success, and how we plan to manage change.
- Participation is how will we be involved, working together in teams and the quality measurements and improvements that would be used.
- Equity is how we would share the financial gains -- a fair return to the hospital and to the employees for the investment in the success of the hospital. Equity also involved how to treat everyone fairly.

We also created councils -- groups of employees – many of them elected from within their own employee units -- that met to work on problems within or across their units. The councils became the most effective way for problem identification and resolution. It turned out that most of the suggestions that really helped, were right in people's own front yards. "This is something I know something about and I can fix." It was an empowering process to see it, to do it, to get it resolved. What participation really means is that individuals have a way to contribute, and that often means doing it some way other than you would have thought yourself. No one knows the job as well as the person doing it!

What participation really means is that individuals have a way to contribute, and that often means doing it some way other than you would have thought yourself.

We also spent a lot of time on management training -- to train people to be participative managers, to elicit ideas, give appropriate responses, and to engage people. We developed formal recognition programs and team awards.

Prepare/21 was described in a book that was published in Spanish and in Haitian Creole as well as in English and given to everybody at Beth Israel. When we began to implement Prepare/21, we were determined to encourage suggestions and to respond to every suggestion. When something was not accepted, we documented why. When

something was accepted, we also documented what happened and estimated if there were dollar savings and put those into the budget. Every month we came out with a period performance report. We listed revenue, expense, actual budget, this period, year-to-date, variance, the reasons for the variance, good or bad. We would celebrate things that people were doing—their good ideas. All told the amount of gain sharing was very minimal -- it could be a check for three dollars and thirty-two cents, but it was more than the money! It was recognition that our employees had done something important. Believe it or not, when employees would see they got a check for 5 dollars and 41 cents, they weren't cynical about it. They would say: "Well, that's how much money we made and this is what's fair." Anything better than budget attributable to employee effort was shared 50:50 between the hospital and the employees. We also kept it so that anyone who made more than $50,000 a year didn't get more than calculated for that upper limit. So the CEO [Dr. Rabkin] got no more than someone at the $50,000 level. Everyone's P21 check was a bright purple with the words "Thank You" written across the check.

The hospital's basic philosophy was manifest during the first union drive at Beth Israel Hospital. Although the drive was unsuccessful, it wasn't because our consultant was a union buster. When Dr. Rabkin asked why so many vocal pro-union people seemed to aggregate in one particular department, he pointed out that the problem lay not in those workers but in the department manager. The manager was replaced and the result, a dramatic shift in employee satisfaction.

This consultant also pointed out: "Just because you are not unionized does not mean that you cannot have an appeals procedure for problems that are personal, one that would not subvert the right of a manager to manage, but for when any employee at whatever level thinks he or she is being treated unfairly in a personal way. In response, we came up with an appeals procedure that cascades upward and in which the employee can continue the appeal at every level. During the whole process, there is a monitor from human resources who is neutral, whose only commitment is to facilitate the process fairly for the appealing employee. If the individual continues the appeal upward, the case winds up with a group of five people whose judged recommendation goes to the CEO, whose decision is final. But what is of particular importance, of the five people, two are selected by the employee, although they obviously cannot choose a subordinate whom

they supervise or manage. Two are selected by management and the fifth person is chosen by the employee from a group of about 25 people that have been selected from volunteers at the beginning of the year to serve in that role. The volunteers represent the demography of the employees overall. In essence the employee picks three of the five.

The results demonstrate the effectiveness of this appeals process. If you say: "Who wins: the hospital or the employee?" Year after year it's been about 50/50. Having this process in place is very reassuring to employees. They know not only can they complain, but it can percolate upward, and that there is someone from HR who is committed to seeing that this gets resolved in a way that most will agree is quite fair.

Getting Commitment to the Mission of Beth Israel: Mitchell T. Rabkin

The task of creating a gratifying and fulfilling environment at work calls for leadership from the top down throughout the whole organization. Just as it is when one is teaching medicine -- you not only have to teach the content of medicine but you try to teach people ***how*** to be a doctor. That comes from watching doctors and hearing them deal with patients. So it is, too, that all of us dealing with our subordinates are serving as role models. Leadership is crucial in eliciting commitment throughout the whole organization. Commitment is needed to the mission, and each person must understand how his or her work actually relates to the fulfillment of that mission -- so that one's performance works toward the goal of that mission. Everyone's work, at any level of the employment hierarchy, must be understood and thoughtfully carried out in terms of the mission. And yet, leadership is not enough. In fact, leadership is unlikely if sound management at all levels does not underlie it. Sound management can create a vehicle that runs well, but leadership gives it the direction.

Respecting and treating everyone as a professional is important if you want people at all levels to be committed to the mission of the organization.

Respecting and treating everyone as a professional is important if you want people at all levels to be committed to the mission of the organization. One example made at Beth Israel that increased professionalism as well as commitment to the hospital's mission was in the structure of jobs on the medical floors. There are not only

nurses and nurses aids on each patient floor, but also housekeeping, dietary, and transportation personnel. It used to be that if you needed a transporter you called a central office and whichever transporter was available would respond. The same was true with the dietary housekeeping staff – they didn't necessarily have any particular station with which they were identified. Joyce Clifford, our Vice President, Nursing, changed that by locating them permanently on a particular nursing unit, so that they then had the chance to identify with the patients and with the nursing staff. The change was dramatic. All of a sudden the patients became ***their*** patients, not someone anonymous. What that engendered was a change… "If you think, that I'm going to let ***my*** patient lie in the corridor without a blanket in x-ray, where it's awful chilly, you are out of your head! Not ***my*** patient" and so on. The feeling of pride that developed, the identification with patients, and with the nursing staff, was illustrated by the fact that the transporters began brown bagging their lunches with the nursing staff in the conference room on the unit. It was a kind of equality and colleagueship that never had existed before.

Even with the people that we call professionals, the way that their role is defined can either support or denigrate their notion of professionalism. The difference between team nursing -- common in the United States -- and the primary nursing that Joyce Clifford at Beth Israel instituted illustrates this point. In team nursing, for "efficiency," different nurses do different tasks. One does the baths, another will check vital signs, another give out medications, and so on. Each nurse only worries about particular tasks. Consequently, no one nurse knows any patient overall. In primary nursing, a primary nurse will have 5 or 6 patients for whom she will write the nursing care plan. As patients are admitted, the physician writes orders for what needs to be done. The patient is interviewed by the primary nurse who also reviews what the doctor wrote, and then she determines the nursing care plan. She delivers that care, maybe with another nurse or another nursing aide. When the shift changes, she tells the nurse coming on what the nursing plan is, and that nurse then carries out the plan. The communication between the nurses on neighboring shifts as well as with the physicians is intensive.

Even with the people that we call professionals, the way that their role is defined can either support or denigrate their notion of professionalism.

As for "scutwork," -- emptying the bedpan or bathing or cleaning the patient, or changing the sheets is typically labeled "scutwork" and disdained in most hospitals, often delegated to little-trained staff, but Beth Israel's primary nurses don't view these activities negatively because while the nurse is giving the patient a bath, she or he will be talking with the patient, seeing how much the patient really understands about his or her illness, getting a sense of how well the patient or family might seem prepared to deal with the patient's illness upon discharge from the hospital, and so on. It is a time to get important information. For instance, this man's been in bed for seven days – while the nurse changes his sheets she or he gets a chance to check the condition of the patient's skin. Does he have any bedsores? If one views the menial tasks as something to be delegated to entry-level workers, one misses a lot of the closeness that makes for both better care and patient gratification. The primary nurse understands her professionalism in a far different way because of the way the job is characterized, than the nurse who is in team nursing. And her relationship with the patient's physician is collegial, as it should be, rather than subordinate.

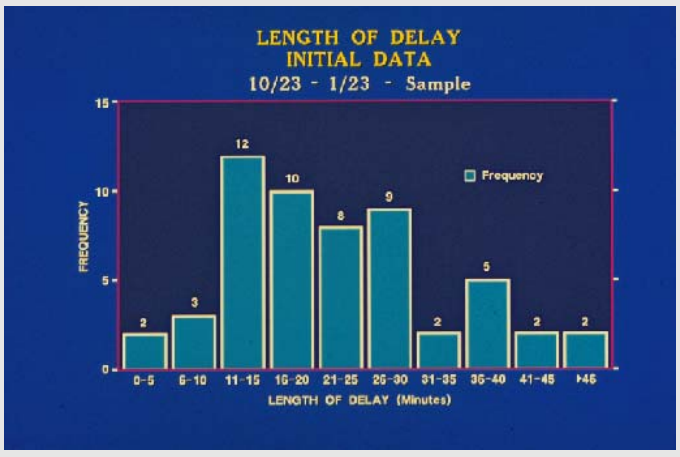
Case Example

Improving Hospital Efficiency: Mitchell T. Rabkin

The hospital had been experiencing significant delays in getting patients down from their rooms for CAT scans. These delays meant that a very expensive machine was not being used to its full potential. To reduce these delays, four groups of people needed to work together:

1. The CT technicians
2. The person in X-ray who called for the patient to come down
3. The transporter
4. The nurse who got the patient ready.

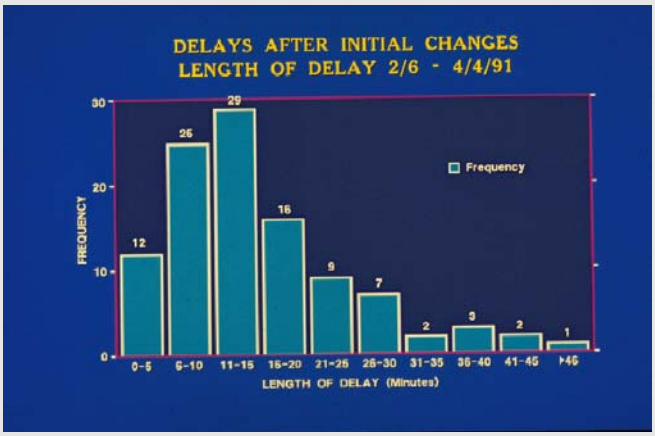
Under Prepare/21, all four groups got together to solve this problem. At the first meeting there were nurses in one corner of the room; the transporters in another; the CT technicians were in a third corner and the radiology secretaries in the fourth. We started by saying we had gotten reports of delays and asked is there a problem? Some thought there was and some thought there wasn't, but whatever, it was "someone else's fault." "Has anybody measured it?" we asked. " No." We suggested doing that, describing the utility of creating a histogram to document the extent, if any, of delay. The four groups



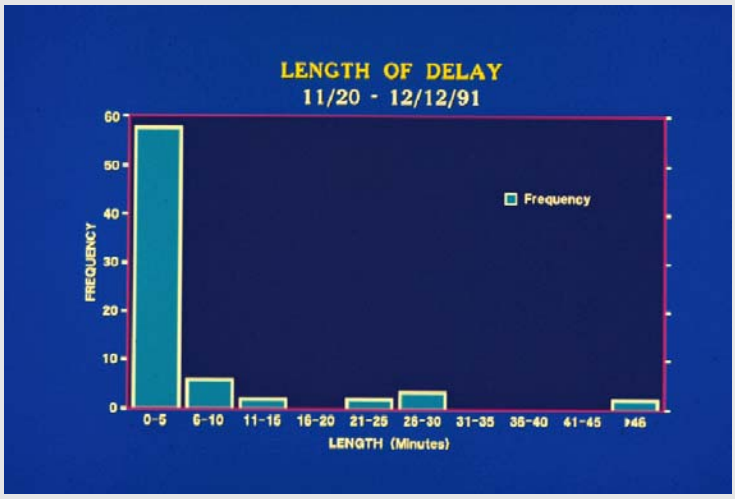
A couple of weeks later, they were horrified to see the histogram with the peak delay between 11 and 30 minutes. Then, by looking at the whole system and working out its

sequence of events, they began to see and work on the issues that might have made for delay.

At the next meeting, things were moving in the right direction.



The groups no longer separated into the four corners of the room. They kept working and were delighted with the next survey to find not only further improvement in the efficiency of the operation, but there was a new feeling of pride and teamwork among these four diverse groups, and a coalescence into one team dealing together with a problem they had uncovered and were resolving.



Conveying the Philosophy of Beth Israel: Mitchell T. Rabkin

It is obvious that workers who find the work environment gratifying, will more likely be more congenial at home, and likely be able to deal better with work-family tensions. But consider this: the workplace for many people is also family. Of course, it's typically secondary in importance to one's own family. While it's of great importance to work on the interface of work-family and the competing demands that the conditions and obligations of work make on the obligations and emotional components of the workers' family life, it is also important to appreciate that while our family concerns cannot be dropped during working hours, many people do spend almost as much time – sometimes even more – within their second family which is the workplace. Therefore, it's important to try to develop gratifying aspects of family at work along with the efficiency and throughput.

Our philosophy is that patients are people, and employers are people too.

For instance, I tried to speak at every new employee orientation. Not only so that the employees would get to know what the CEO looked like, but to convey the philosophy of the institution. I would generally start out by saying: "Welcome to Beth Israel. It's a major teaching hospital of Harvard, known around the world for the quality of care, for the research and teaching…" and so on and so forth "…but it's also known for being warmer and more personalized than many teaching hospitals." I'd continue by saying, "Why? Well, perhaps because we are a little smaller than some of the very big places like MGH or Johns Hopkins, but primarily it's because of our philosophy. And our philosophy is that patients are people, and employees are people too."

Dead silence would follow. Then I'd say, "Some of you are probably sitting there saying who is this guy telling us that patients are people? What kind of a nut is he?" And I would go on: "But in a group this size there must be some people who have been patients in a hospital. Let's have a show of hands." There would always be a few who'd raise their hand. Then I'd continue, "OK, don't tell me anything personal. Don't tell me the name of the hospital. Don't tell me why you were there. Just tell me, was it pleasant or not so pleasant?" As you can imagine, I'd typically get two sets of responses. For some, it was very pleasant: "I was so upset the night before my surgery I just couldn't

get to sleep. A nurse came in, sat down by the bed and put her hand on my arm. We talked for 20 minutes; it was so comforting." Or "It was terrible. The operation was OK, but I'd ask questions and get no response, 'Where am I going?' 'You'll find out.' 'What's this medicine?' 'Ask your doctor.'" I would point out: "Nobody said: '"My doctor knew more molecular biology than any doctor.' You just spoke about human relations, about whether people were kind and considerate and helpful and informative to you when you were a patient. The point is, every one of you is an expert. Whether you are sweeping the floor, or a cashier in the cafeteria, or the chief of neurosurgery, you're all expert in knowing whether people are warm and friendly and helpful or not. And in your job here at BI, whatever it may be, you will impact greatly on patients' and families' perceptions of the care and the nature of this place. If you walk down the corridor and see somebody who looks lost, you can walk up -- whatever your job is – and say, 'You look lost, can I help you?' And they walk off saying this is a pretty good hospital. Not because you told them where the bathroom was. Because you ARE the hospital. And their conclusion is: I had a problem, and somebody who IS the hospital came up voluntarily and said, can I help? And they did!! That's what I mean, patients and families are people."

I would go on: "Employees are people too. When people are sick they can be very demanding. And as soon as these patients get better and leave, others come in. So every day we're asked to put out more and more. I don't see how we can be expected to treat patients with warmth and concern and dignity, day after day after day, unless we, ourselves, feel that we are being treated with warmth and concern and dignity. So the philosophy here at BI is not: Understand the psychology of being a patient, understand the psychology of being a visitor, or the relative of a patient; but rather: understand the psychology of being human, and let's work together to make this the kind of place where, if you're going to be a patient, or a visitor it will be a good place to be. And if you're going to be an employee it will be a good place to be. Each one of you can contribute to

The point is, everybody is an expert… you are going to be able to impact greatly on patients and families perceptions of care and the nature of this place.

the richness of this institution. And in turn I think you'll find it a more gratifying place to be."

At Beth Israel we think of work-family in terms of appreciating the workplace as another family. We worked hard to make the workplace as nourishing, as emotionally gratifying, as educational and as reassuring of our personhood as employees as we would hope is accomplished within our families at home.

Questions and Answers

Question:

I worked at Beth Israel in the 1970s. I was involved in organizing the union there and the hospital ran a very forceful anti-union campaign that included illegal firings of union supporters, captive audience meetings, as well as things that I view more positively like the institution of the appeals procedure that you mentioned. There were four union elections and all four were defeated. Coming off of that whole experience, I wanted to ask: How do you view the role of unions in enhancing employee voice and what lessons do you draw from the experience at Beth Israel with unions? And do you have any regrets over the way you pursued the anti-union campaign?

How do you view the role of unions in enhancing employee voice and what lessons do you draw from the experience at Beth Israel with unions?

Answer: Mitchell T. Rabkin

I don't recall illegal firings. Basically, my thought is that one should try to run an organization where a union is not needed rather than simply being anti-union. I was very sympathetic with 1199 in New York City despite their tactics at some hospitals there because when I visited one or two of those hospitals, I saw that the workers were being treated as non-persons, and truly had no voice. But I would much prefer that the hospital be run in a way that the employees don't feel that they need the union because the union is in a sense, distracting. That is, if the employee is committed to the mission of patient care and identifies with the hospital, it seems to me that they will come across more effectively, both technically and humanly with patients, than if their prime commitment is with the union.

Answer: Laura Avakian

I started after those campaigns; but studied what had happened. I think Mitch is right – there was some lousy management going on in certain corners. We probably deserved some of what came at us, and hopefully learned some things from that. What I would say though is that many of the Scanlon companies that we looked at are unionized.

And there is no reason why a union can't become, if the relationships are at all collegial, a force for supporting and enhancing participative management concepts. In many ways it is a union's dream to have an organization that says: "We want to hear the voice of workers and we hope that you help make that happen." So I don't see that participative management and unionization run particularly counter. I do think that during a union drive when the union is of necessity trying to demonstrate that management isn't doing its job and management, of necessity, is also trying to say "Why do you need third party representation when we're here, for you?" -- those stances inevitably create a very conflicted situation. Employees can feel very torn about loyalty. My view is that's the nature of union organizing drives. Once unions are in place there are many examples of cooperative relationships with managements and unions.

Question:

How easy was it to bring the doctors into "Prepare/21"?

Several of us: Thomas Kochan, Susan Eaton, and myself (Robert B. McKersie) are doing a study of the partnership at Kaiser, and getting the doctors involved has been a big challenge. What lessons could you give for anybody else who is trying to get an organization-wide improvement effort going -- to get the doctors on board?

Answer: Mitchell T. Rabkin

Yes, it's difficult to get the doctors involved in part, because, particularly in an academic institution, the world in which many of them exist is really the world of their profession. Some will identify with community and they helped lead the way to PREPARE/21, but some others will not. Others you could pick up and put 'em down in Chicago or San Francisco, and they just go on as long as they have their lab, and the patients in their clinic, and so on. To that individual, location doesn't mean that much, and the institutional identification may be minimal. Many of them don't do much thinking about management or even leadership of their own laboratory. They may well not really understand what it is to manage an organization. I think it's a process of education... persistent education.

Answer: Laura Avakian

We found that when doctors were approached about things like sitting on a "Prepare/21" committee, the answer was "Heavens no!" But, when we said, "We have a group that is looking at the wait times for patients in this clinic, and your patient just complained to you last week about that. Are you interested in giving some suggestions on that process?" They were. If it related to the care of the patient, they're very interested.

They are not so interested in saving money, or in simply going to meetings to honor staff even though they like to see them celebrated, but their time is incredibly precious. And what moves them is when they know it's going to mean something better for their patient.

Question:

One of the things that we're trying to do in The MIT Workplace Center is to bring all these different groups with different interests together. We'll bring doctors, nurses, union representatives, community healthcare groups, and government groups together and given what's going on in healthcare, we sense that there is a hunkering down of each of these interests, trying to focus on their own particular short-term problems and I'd be interested in any suggestions or advice that you would have. How do we get the broader perspective? How do we get hospitals that are not unionized today to sit and really talk about different models of healthcare when union representatives are present? When there are government agencies represented, who sometimes are regulatory agencies that effect their class structure. We've got to bring these groups together, and yet there is not an environment or a context today that is conducive to this. Do you have any suggestions on how we might make some progress?

We've got to bring these groups together …How do we get the broader perspective?…

Answer: **Mitchell T. Rabkin**

Try to find people who will put on the institutional hat, rather than trying to feather their own nest -- and those are very rare people. In general, the doctors will be tending to talk about what will make their roles more easy and the union people about

what will make their roles more easy and so on. The challenge is to say, "Drop your own identities and now let's talk as if you were overseeing the whole thing. Try to engender that kind of thinking.

Answer: Laura Avakian

I think the one thing that all of those groups have in common is a recognition that the healthcare industry is really struggling these days. And, that at the end of the day, the one suffering is very likely the patient. That is a passionate concern of each of those constituencies. My advice is to think how you pose the question. What can you bring to the table that's going to help the rest of us understand how the whole dynamic needs to change if we're going to make healthcare better and affordable in this country? It's a huge societal problem, and to the degree that we only promote forums for people to talk about their self-interest we're not going to get very far.

Answer: Mitchell Rabkin

In the course of discussions of this sort sometimes you can perceive that someone's approach is from a narrow point of view. It's important in the course of the discussion to put that on the table. Say, "This is all fine for the particular sector you may represent, but let's broaden the perspective and think about all the other aspects and views of the issue. If those various aspects are not on the top of the table you know you'll never get there.

Question:

What enabled you to really sustain the momentum…?

I'm interested that you started this effort in the early '80's, and that it was going strong in '94/'95. What enabled you to really sustain the momentum, and what were the factors that at different times threatened to derail what you were doing?

Answer: Laura Avakian

One was just a commitment to stay the course. The original "P21" committee had 75 members and part of the value of having so many people is that they formed a good core of ambassadors. But a structural element that really did help sustain it was the

period performance report. Every month a document that came out that said the "P21" goals for this period were this, here's how we did. It had a lot of prongs and a lot of visibility, and we created these physical tools. We brought in a visiting committee that would come in about every 18 months with some very renowned people, people who really knew and understood good management. They would tell us what was working and what wasn't. And that would charge our batteries to go back into the fray and say: "We need to fix some of these things." It was a lot of nurturing and feeding. And also, I think it was changing and evolving so much that it never felt the same from one day to the next.

Question:

It seems that there were a lot of reasons why this should have continued and the organization seems to have become uninterested in it after the merger. What was missing? What would have kept it going?

Answer: Mitchell T. Rabkin

When the merger happened, Prepare/21 began to go into decline because we had a whole new set of colleagues who hadn't participated in its development. You cannot impose such a program on another institution flat out. It would take a process similar to that gone through at the start of P/21 at BI, and there were other issues demanding our attention, particularly that of cultural compatibility. Two institutions may have similar missions and mission statements, and our missions were similar -- good patient care, high technical quality, warmth, and so on…but interpreted somewhat differently as a result of the different histories of the two institutions. I think another basic issue is this: In your company you know how to get things done. You know who knows what, whom to trust and so on. And I know that in my company. Now, we merge and all of a sudden there are different managers, different subordinates, different locations, and different telephone numbers. It takes a long time to have that same kind of confidence of knowing who knows what and whom to trust and how to get things done. Mergers, I think, underemphasize "knowledge management" -- getting your knowledge of that sort across to my guys, and vice versa; and developing and incorporating the knowledge of what is new and what is developing out of the merger for both of us. And working to create that

awareness not only through written communications, but through those quasi-social situations set up by the institution where I meet you and we chat, and now I can pick up the phone and call you, and say: "Hey, what do you think?" Or: "Can you help me on this?" Whereas before, you were only a name, and maybe a telephone number, but essentially an unknown.

Question:

Was this part of the discussions in the pre-merger negotiations?

Answer: Mitchell T. Rabkin

No.

Question:

Would you, in retrospect, want to see these kinds of issues engaged in those negotiations?

Answer: Mitchell T. Rabkin

I'll be candid. In some respects, it was not a merger of equals. Deaconess had already tried to merge with New England Medical Center. Which was really a bizarre idea – two different medical schools and physically distant. From the point of view of Beth Israel hospital, we could have gone it alone, but there would be a real opportunity cost NOT to have made that merger. And, if we had insisted and acted as if it were a takeover and not a merger of equals, I don't think their board would have countenanced it, would have really understood it and it would have just taken too long and fallen apart.

The opportunity cost related to the business aggressiveness of Partners, the other major network in town. If we had not merged with Deaconess, likely it would have either been purchased by a for-profit hospital and out of the Harvard system completely. Or, probably more likely, been taken over by Partners, and probably decimated, and then the Joslin Clinic would have gone in that direction as well. So, instead of our having to contend - before the Brigham and the General got together - with two 300-pound gorillas, we were facing a 700-pound gorilla. If Partners had been able to incorporate the Deaconess and hence, the Joslin, we would have had a 1200 pound gorilla to wrestle

with. It would have been very difficult to compete, despite the high academic caliber of our institution just by virtue of the size. And it would not have been good for Harvard Medical School, since some of its excellence relates to the several outstanding yet independent teaching hospitals of which BI is a major component for teaching and research as well as patient care. I think that it would have been impractical for BI to go it alone. Besides, both BI and the Deaconess found strengths that complemented each other. And today we can say that the merger is a success, in terms of the movement from "we/they" to "us."

Answer: Laura Avakian

I think it would have been helpful to have had a lot of discussion about the cultures going into the merger. We would probably have faced the same issues, however, because the cultures of both organizations were very strong. . The Deaconess had its own traditions and its way of doing things, as did the BI. We worked very hard at the merger to say: "We won't superimpose one on the other." Even though, I think, each organization wanted to. The reality is that we agreed, probably, 99% down the line, in terms of what the values were, how patients should be treated, and how staff should be engaged. But we didn't have the structures in place to make operating decisions about the new organization, and we didn't know each other well enough to know whom to engage and in what way. Also, we were so conscious of the lopsided nature of the merger – B.I. was twice the size of the Deaconess, in terms of numbers of people. So, while B.I. was bending over backwards not to be the acquirer, everyone at the Deaconess felt acquired no matter what. We were concerned about consistent leadership and financial liability, and we really had to reinvent everything about the organization. The patient scheduling system, the financial system, the billing system, the employee record-keeping system, the payroll, the job classifications, the benefits…every single thing had to be rebuilt. . It would have been a luxury to have discussions about culture and how we wanted to run the place. We were just trying to keep it going and to get the paychecks out every Friday.

Answer: Mitchell T. Rabkin

In an ideal world, due diligence should not only deal with the finances of two organizations that are merging, but with the way things are done and the history of the two. You say, "this is part of the package. This is the way we do it and this is the way we are going to do it, because two organizations will use the same words with markedly different meanings.