

# Being Friends or Being in a Fight Club: Organizing Work Amidst Conflicts

How Politics, Egos, and Tensions among Physicians  
disrupted Vital Work in a Cardiac Department

**Sriteja Reddy Wudaru**

Wageningen University & Research

**Andrea Prencipe**

Luiss University

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# Introduction

In Jupiter, a leading international hospital in Southern India, around 20 cardiac physicians share two “Catheterization Laboratories” to perform interventional cardiac procedures for patients. Jupiter’s management has designed a schedule that allocates the labs in 1- or 2-hour slots to different physicians at different times on different days. Additionally, they have also appointed a coordinator to ensure the physicians respect the schedule and to manage any discrepancies that may arise. Because only 2 labs are present, a physician can perform a procedure only if another physician already using a lab hands it over on time. But these hand-offs never go according to the plan because of a few reasons.

Jupiter implements a unique *fee-for-service* business model. It does not pay physicians a fixed salary; instead they earn a fee for seeing patients in their “out-patient” offices, and a share in the amount earned through interventional procedures. To balance procedures and out-patient office, physicians often put their patients in the lab and go back to their out-patient offices. The lab remains blocked and other physicians cannot use it. This derails everyone’s schedule within and beyond CCL. Physicians also plan their procedures in ways that benefit them without any concern towards others’ work. Additionally, the interpersonal competition amongst physicians has put pressure on them to appear superior to their peers. They try to highlight their own skills or defame or trash-talk about others.

As more and more physicians engage in such behaviors, even those who joined the hospital recently think this is legitimate and acceptable behavior. There is also a lack of loyalty towards and identity with the hospital as physicians work in other organizations too. As they can leave taking their patients with them, Jupiter’s top management is reluctant to impose sanctions on the physicians for not following the rules. As a result, frequent tensions occur amongst physicians who often resort to arguing and even fistfights. The coordinator often tries to resolve these conflicts through various tactics but no concrete solution seems to be possible.

We now introduce the organization and the main actors involved in Part A. Then we elaborate on the nature of interventional procedures and how they are supposed to be performed in Jupiter. In Part B, we provide examples and explanation of how work is disrupted in the hospital and how conflicts ensue. We also shed light on how the coordinator tries to resolve these issues before concluding with a few questions to be discussed in the classroom.

## Part A: Setting the scene

*“It had become so bad that there were fistfights.  
I was also one of those involved in that.”  
– One of the physicians, P11.*

### *Jupiter’s History*

Founded in 1983, Jupiter is a chain of multi-specialty hospitals mainly operating in India but also with a presence in Asian and African countries. The first corporate healthcare provider in India, its presence today encompasses over 70 hospitals, 75 dental hospitals, 3000+ pharmacies, 170 primary care and diagnostic clinics, as well as 148 telemedicine units across 13 countries. They also boast 15 medical schools and research centers on stem-cell and genetic research, among others. Jupiter’s organizational culture is rooted in providing the best patient care. The level of service, combined with the affordability, has not only made Jupiter one of the preferred hospitals in India but patients from around 140 countries come to India to get treatment of one form or the other at Jupiter. This affordability did not come at a cost to quality either. Jupiter boasts over 152,000 cardiac surgeries with a 99.6% success rate thus being considered the best heart surgery hospital in India by different surveys. Jupiter has also championed several social initiatives such as providing free cardiac treatment to underprivileged children, running a foundation to research providing cancer care, and is currently piloting a unique model of holistic healthcare, i.e., providing healthcare for an entire community starting from birth through childhood, adolescence and old age. Since the commercial healthcare industry was in its infancy, Jupiter had managed to combine modern technology and advanced medical treatments with affordability in a country where the majority of the population cannot afford expensive treatments. But it lost this early mover advantage as almost all hospitals today compete with Jupiter on price. Though medical treatments have become costly in India today compared to the 80s, they remain relatively cheaper than the western countries. By catering to a larger population in India, hospitals profit over volume. Besides, a part of the population receives subsidies from regional and central governments through various healthcare and insurance programs. Hospitals also profit by offering different accommodation options for patients that need to stay under observation in the hospital.<sup>1</sup>

This particular case is situated in one of Jupiter’s hospitals in the city of Hyderabad in Southern India. Located in one of the posh localities, it has been one of the first hospitals in the city to provide care for multiple ailments. But the competition has increased several folds over time. Today, three large, multi-specialty hospitals lie on three roads that lead to Jupiter. Emergency cases, where reaching a hospital as quickly as possible is of paramount importance, now come

1. Almost all multispecialty hospitals in India offer different forms of accommodation from shared common rooms to twin rooms to single rooms to even suits. Thus, a variety of options are available at different prices similar to how it is in hotels. Jupiter is particularly one of the preferred hospitals for celebrities, politicians, sportsmen and sportswomen, business leaders, etc. who take pricier options.

across one of these hospitals first. Even non-emergency patients are attracted by the competitors who offer cheaper prices for some treatments. Once a major hospital in the city, Jupiter today has become just one of the hundreds of hospitals available for patients. As such, providing top-notch patient care it has been known for while staying profitable has become a concern for the organization.

### ***CCL and the interventional procedures***

The cardiology department in Jupiter Hyderabad consists of two units: *surgical* and *interventional procedures*. The surgical unit boasts around a dozen surgeons who perform traditional cardiac surgeries such as coronary artery bypass grafting (the most common in the world), arrhythmia treatment, aneurysm repair, heart transplant, etc. In the interventional procedures unit, which is our main focus here, around 20 physicians perform minimally invasive, interventional procedures such as angiogram, angioplasty, stenting, etc.

An interventional procedure is a non-surgical treatment used to treat coronary artery disease where arteries carrying blood from and to the heart are blocked by fat, cholesterol, and plaque. The walls thicken up and the oxygen-rich blood flowing to the heart is limited or, in many cases, blocked. This results in *angina* or chest pain and eventually a heart attack. The major reasons for the formation of the cholesterol or plaque in the arteries include food and lifestyle of the individual, age, stress, lack of exercise, smoking, or even genetic reasons. From little children to teenagers to adults to aged, coronary heart disease is one of the most common ailments in today's world.

In interventional procedures, a plastic straw-like *sheath* is inserted into a blood vessel in the patient's arm or leg<sup>2</sup> through which a long, narrow tube called a *catheter* is inserted. A radioactive *contrast material* is passed through the catheter to guide it through the blood vessel until it reaches the area where the artery is blocked. The passage of the contrast material and the areas it illuminates are visible in real time on the monitor of a special x-ray machine.<sup>3</sup> Once the location and extent of the blockage is identified, the physician diagnoses the severity, complexity, and number of blockages, and determines the next course of action.

If there are more than three very severe blockages, the bypass graft surgery is the preferred treatment. But for anything less than that, interventional procedures of angioplasty and stenting are

2. Very good resources for understanding CCL procedures exist on the internet. To gain more knowledge about these, one can start from the websites of Cleveland Clinic (<https://my.clevelandclinic.org/health/treatments/16833-cardiac-catheterization--coronary-angioplasty-and-stent-interventional-procedures>) and Henry Ford Health Systems (<https://www.henryford.com/services/cath-lab/procedures>). For informal knowledge, one can always start from Wikipedia.
3. Some videos of how a catheterization laboratory looks and works can be found on the website of Philips, one of the companies that manufacture high quality equipment (<https://www.philips.co.in/healthcare/product/HCSLHY01/azurion-hybrid-or/#galleryTab=VID>).

preferred as they are minimally invasive, non-surgical, and can be performed within an hour or so, and the patient can be discharged in a day or two. In angioplasty, a small *balloon* is attached to the tip of the catheter and is inflated thus compressing the fatty plaque against the walls of the artery. The artery widens up thus allowing the blood to flow freely. In most cases, a small metal mesh tube called a *stent* is positioned in the location that acts as a scaffold providing support to the artery. The balloon is deflated and removed and over several weeks, the artery heals around the stent.

### ***The CCL lab at Jupiter Hyderabad***

There are two catheterization laboratories with the special x-ray machines mentioned above, additional equipment and devices necessary to perform interventional procedures. Another smaller “console room” separates the two labs and consists of computers that record and store the procedures, space for filling out paperwork and medical files, a changing room for physicians to change into surgical gowns for the procedure, and a general hangout space for anyone not performing procedures. Both labs are visible into the console room through large glass walls. Please see exhibit 1 for a picture of one of the labs.

The labs and the console room open onto a long corridor at the other end of which lies the Intensive Care Unit (ICU) where the patients are kept under observation for a day or two after the procedures before being discharged. A few feet far from the labs is “Recovery Room”, a big hall with a few beds and nurses.

Around 20 physicians share these two labs. 16 of them are cardiologists, 2 are from neurology and orthopedics each, and 2 are from radiology. The catheterization lab is very costly<sup>4</sup> and having dedicated machinery for a few non-cardiac procedures is not financially viable. So the labs are shared by both cardiac and non-cardiac physicians.

Around ten technicians maintain the expensive machinery as well as liaise with the technical experts from the company that designs these machinery, like General Electric, Philips, etc. for repairs. They also look after the availability and stock of equipment such as catheters, sheaths, balloons, stents, etc. During the procedure, they help the physicians in operating the x-ray machine, calibrating it around, and zooming in and out of the specific locations on patients’ bodies. There are also nurses present who hand over the physician different equipment and devices as needed and control the flow of the contrast material during procedures. This is an important and precise task as the contrast material is a radioactive substance and using too much material is dangerous to the patient.

4. Depending on the manufacturing company, model, technical capabilities, and features, a single cathlab can cost between US\$150,000 – 250,000. Details on different models can be found on the websites of General Electric (<https://info.blockimaging.com/bid/97001/GE-LC-Cath-Lab-Price-Cost-Guide>) and Philips (<https://www.philips.co.in/healthcare/product/HCSLHY01/azurion-hybrid-or#galleryTab=VID>).

Finally, there is a coordinator appointed by Jupiter's top management to act as a liaison amongst physicians. The main job of the coordinator is to oversee the efficient utilization of both labs, including making sure the physicians follow the schedule.

### *The schedule*

As there are only two labs shared by around 20 physicians, if they are allowed to use the labs whenever they want, it would lead to chaos. So, Jupiter's management has developed a schedule that allocates labs to the physicians (exhibit 2). Each day is divided into one- or two-hour slots and labs are allocated to physicians based on the frequency and number of procedures they usually do. Those who perform numerous procedures almost daily are allocated two-hour slots every day while those who rarely do procedures are allocated one or two one-hour slots only a few times a week.

Physicians can use the labs before and after the schedule too, depending on the availability of technicians and nurses. Though the schedule runs from 08 am to 06 pm, physicians often plan procedures from 06 am and until 10 pm, and would ask some technicians or nurses to be present. But sticking to the schedule is not easy for two main reasons.

1. The nature of procedures means that they cannot always stick to the slots. A procedure might be complex and run overtime, or some complications might arise. Physicians understandably cannot just stop the procedure and leave when their slot ends.
2. Not all physicians respect and follow the schedule. They do not come to the lab and start the procedure on time as they deliberately occupy themselves with other work. They often demand the lab when it is not their turn. As such, physicians often compete for the labs beyond the schedule, and the coordinator is expected to resolve the problems.

### *The fee-for-service business model*

Jupiter has a unique business model in contrast to any other medical organization in India. It implements a model of fee-for-service with their physicians. Under this model, Jupiter does not hire physicians as internal employees and pay salaries. Instead, they work as external consultants.<sup>5</sup> As such, they only earn based on the work they do in the hospital. The main job of the physicians is to attend to patients in their out-patient offices. In out-patient, they are free to charge the consultation fee and, due to the sheer volume of patients they see, physicians can earn a lot in out-patient alone. Additionally, they earn a share in the CCL procedures they do. The number of patients they see in out-patient and the number of procedures they do in CCL are correlated because whether an interventional procedure is required or not is determined based on diagnosing

5. So much that the physicians are referred to as "consultants" in the everyday language across the organization.

the patient in out-patient. The more patients they see in out-patient, the higher the probability that those patients would require procedures.

The fee-for-service business model is assumed to be beneficial to the hospital. It acts as a motivator for physicians to work more. Jupiter's logic is that if the physicians are salaried, they do not have an incentive to work harder or attend to more patients. This is often the case in other hospitals where physicians stick to fixed working hours after which finding a good doctor is almost impossible. Even during the working hours, one can find that a doctor is not in his/her office or is working slow despite many patients waiting to see the doctor. Under the fee-for-service model, even though Jupiter gives the entire out-patient fee to physicians, it earns from the tests (blood, x-rays and scans, electrocardiography, electroencephalography, etc.) that the physicians prescribe. Jupiter also earns a part of the surgeries and procedures done, and more if the patient opts for a more private, costly accommodation. As physicians would see more patients to increase their income under the fee-for-service model, Jupiter too would earn more without the need to put pressure on the physicians through formal channels.

The fee-for-service model also inculcates a culture of competition amongst physicians. If their colleagues who have out-patient offices right next door earn more, it puts social pressure on the physicians to earn more themselves. As such, they would engage in a competitive cycle of seeing more patients and comparing themselves with their colleagues.

An additional feature of Jupiter's model is that physicians can also work elsewhere outside Jupiter. So, most of them run their own private clinics or work in other clinics of Jupiter where the facilities required to perform complicated surgeries and procedures would be absent. If a patient visiting these clinics is diagnosed with cardiac ailments and require an interventional procedure, physicians would refer the patient to Jupiter Hyderabad where they could perform the procedure and charge for it. Jupiter thus benefits by getting the patients it would otherwise miss out on if its employees would be salaried.

All in all, the fee-for-service model gives freedom to physicians. Many physicians have remarked that this is in fact one of their major reasons to work at Jupiter. They can start and end their day whenever they want or take breaks to pursue personal works; they would miss out on their income, but they do not have to go through the bureaucratic processes of obtaining permissions. But, frequent absenteeism and unreliable timings would mean the patients do not know when the physician would be in and thus go to other physicians. So, there is some balance between freedom and control under the fee-for-service model.

### ***One entire CCL procedure: How it fits in with physicians' work***

There are a few steps in how an interventional procedure unfolds in Jupiter or any hospital for that matter. It starts with the patient arriving at the "reception" of the cardiology department, either with or without a prior appointment. The reception directs patients to physicians based on the availability of the latter, as well as if patients ask for a specific physician. Depending on the



tests and diagnosis, the physician then determines if an interventional procedure is needed or not. Depending on how soon a procedure needs to be done, and when the physician has a slot, an appointment is set.

On the day of the procedure, the patient arrives at the “registration desk” where an employee would fill out the paperwork, check the insurance if any, and sends the patient’s blood sample for tests to determine the *creatinine* levels in the blood which would determine if the patient is suitable to go through the procedure that day or not. Meanwhile, patient is sent to the Recovery Room where a nurse would complete the paperwork, insert intravenous drips into patient’s veins, and give any extra medication if prescribed by the physician. Once the results of the blood work are back, and the patient is deemed suitable for the procedure, the nurse would inform the physician. When the physician is ready, and when his/her slot begins, physician would let the CCL technicians know. A technician would come and take the patient into one of the two CCL labs. There the patient would lie down on the procedure table (please see exhibit 1), and the technician would connect the equipment to the patient, including the heart rate monitor, blood pressure monitor, etc. The technician would also ready the required equipment and devices like sheath and catheter and inform the physician that the patient is ready.

By this time, the physician is expected to have arrived in the lab. The physician would start with an angiogram to determine the extent and location of the blockage(s) and then, may or may not, continue with the next steps such as angioplasty or stenting if required.<sup>6</sup> Once the procedure ends, the physician writes up the medical report detailing the entire procedure, the diagnosis, the treatment done, or the treatment that is prescribed. He/she would also invite the patient’s attendants, i.e., their family members or friends who might have accompanied the patient, and show them how the procedure was carried out on one of the computers in the console room. For instance, for a simple angiogram, the physician would detail how many blockages they have found and where, and what kind of treatment is appropriate. For angioplasty or stenting, they would also detail what kind of balloons they have used, what kind of stents they have put, how are they expected to perform, and any possible complications and medications. This is done because it helps the patients and their attendants to know what exactly was done and provides a chance to answer their questions. It is also a legal requirement in India to inform the parties involved.

By this time, the technicians would disconnect the patient from all the monitors and equipment, and transfer him/her to the Recovery Room (in the case of simple procedures like an angiogram where the patient could leave after an hour or two of observation) or the ICU (in case of angioplasty or stenting where the patient is kept under observation for a few days). As a physician usually has

6. Even if additional steps are required, most common reasons for not continuing include lack of knowledge about the patient’s ability to afford the procedure, not having the patient’s or his/her attendants’ consent, the patient’s body not being ready to undergo a procedure, or the physician not having enough information, time, or resources to continue with the procedures.



slots that are longer than the procedures, he/she would have scheduled multiple procedures. In such cases, he/she would ask the technician to bring in the next patient. If this is not the case, another physician would take over the lab and start on his/her procedure. For this to be possible, whoever the next patient might be, he/she would have finished the registration, done his/her blood work, and be prepared in the Recovery Room by this time. Thus, while one entire procedure is being performed, preparation for another procedure would have been underway. A diagrammatic representation of this process is presented in exhibit 3.

While this is the ideal process in which work should be performed in CCL, it would have been wonderful if all the individuals involved adhered to these rules. In Jupiter, no single day goes without some form of confusion, delay, obstruction, or conflict, and without the schedule breaking down. When this happens, the coordinator is left to pick up the pieces and make sure the work continues. We will now see how this unfolds and how work is organized under conflicts.

## Part B: Organizing under conflicts

### *Breaking the rules: Causing delays and problems for the workflow*

The reason why there is a schedule and the physicians are expected to follow it is that it guides the physicians' planning of everyday tasks. As physicians not only juggle both out-patient office and CCL procedures but also have to go on rounds to check up on their patients staying in the hospital (i.e., in-patients), attend to patients during some tests, and also attend to patients referred to them from other doctors,<sup>7</sup> the schedule helps them in planning all of these tasks. By giving them an idea of when they can perform their interventional procedures in CCL labs, it enables them to plan the rest of the time for out-patient and all other myriad of tasks. But, as mentioned before, not all physicians care for the schedule. When a physician does not stick to the schedule and use the lab in such a way that other physicians who are supposed to use them at that particular time cannot, it causes severe problems. The following incident gives an example of how physicians could break the rules and disrupt the workflow.

*One day, physician 7 has the 12–02 pm slot but does not use it. At around 02 pm, he calls the coordinator and asks for the lab insisting that he has two or three procedures and he wants to finish them and leave. Under pressure, the coordinator adjusts the schedule and gives him lab I. Meanwhile, physician 4 too has a procedure and asks for the lab. The coordinator asks him to wait.*

*Physician 7 arrives at 03 pm, an hour late, and starts yelling at the technicians: “You moved a different patient. This is a complex one. [Physician 6] should come for this. If you had moved the one I told you, I would have finished it by now. [Physician 6] is anyway coming, so we wait.”<sup>8</sup>*

*Having said that, he leaves the console room. The coordinator and technicians try calling him several times, but he does not respond. The patient complains about the wait, insisting that he cannot lie down any longer. The coordinator asks a technician to go and tell him that they are waiting for some equipment to come.*

*Coordinator tells us: “We cannot tell [the patient] that the consultants are not coming and that is why he is waiting. Then the patient will go and complain to the management. This is always the same story. How can they trouble the patient like this? What would the patient's attendants be thinking outside?”*

*At 04 pm, physician 7 sends a medical student, who goes into lab I, inserts the sheath, and stands there twiddling with the equipment. At 04.30 pm, physician 7 comes and says that*

7. As cardiac issues are considered more crucial and urgent, even during treatments and surgeries for non-cardiac ailments, patients are often checked for possibilities of any potential cardiac problems. For instance, when a patient undergoes brain surgery, bone replacement, dialysis, or any other such major treatment, the respective doctor always refers the patient to a cardiologist to check if their cardiac health is good and there are no potential cardiac issues that might arise.
8. While all other physicians in Jupiter are independent, physicians 6 and 7 work as a team.

*physician 6 is on his way and he would start the procedure in the meantime. He goes into the lab and stands there talking to the medical student.*

*The coordinator informs us that physicians 6 and 7 always do this. Physician 6, being the head of the department at a public medical university, would always work there. When they have a procedure, physician 7 would call him and ask him to come. Until physician 6 arrives, physician 7 would stall by doing things like these.*

*Meanwhile, physician 4 comes into the console room again and says: "I asked for the lab more than two hours ago. You said they have a procedure and that they wanted to do it. You said they would finish an hour ago. Now it is almost two hours. I would have finished in an hour if you had given me the lab."*

*Coordinator replies: "What should I do? We moved the patient into the lab immediately. They said [physician 6] is coming but he never came."*

*Physician 4, looking into the lab I, comments: "What are they even doing? They are not doing anything. Just wasting time."*

*Physician 6 finally arrives at 05 pm and finishes the procedure at 06 pm.*

Thus, for a procedure that needs an hour at most, the lab is blocked for four hours. Including physician 4, many have to reschedule or cancel their procedures. These are major and frequent kinds of problems in Jupiter. Once the patient is moved into the lab and all the equipment is connected to him/her, it is inconvenient to move the patient out of the lab. The patients would already be nervous, scared and/or anxious; moving them out of the lab and bringing them back in later and reconnecting them to the machinery is something that should never be done without proper reasons. The physicians are well aware of this and use this fact to their advantage by saying that they will start the procedure but once the patient is ready, they would disappear on some other work knowing well that the lab will be on hold until they come back.

Alternatively, the physician would ask to move the patient into the lab when the slot is coming to an end. When pointed out, the physician would argue that it is technically still their slot and so they have every right to start the procedure. Once the patient is moved in, whether the physician starts the procedure and runs over time into the next slot or he/she blocks the lab and disappears - in either case - the next slot is occupied so that the physician who is supposed to use the lab in the next slot cannot do so.

Such actions are performed multiple times a day by several physicians thus have a cascading effect: if one slot gets blocked or delayed, all the subsequent slots are disturbed. Not only the CCL tasks of many physicians are disturbed but their other tasks beyond CCL get derailed too. As such delays or disruptions can arise anytime during the day, there is no way anyone can plan and control his/her tasks in the hospital. Most of the physicians are always tensed and in an irritated mood. As the coordinator says:

*"This happens on such a frequent level that there is no way doctors can be sure they will finish their procedures on time. They can schedule their procedures a week ahead and yet they might*

*cancel them on the day because someone else decided to act selfishly. That's not the worst thing. The worst thing is that the patient comes from far away and have to go back home and come back again the next day. It's unnecessary trouble for them. We often lie that some equipment is not working or something like that. We cannot tell them that our doctors here cannot plan well and that is why they are not being treated today."*

In traditional organizations, there is always a hierarchy and formal structure that gives top management power to control the behaviors of their employees, design rules to follow, and impose sanctions on anyone breaking the rules. The top management thus has formal power in terms of decision making, control, and authority. But in Jupiter, because of the fee-for-service model, such a formal hierarchy is absent, at least in practice. On paper, physicians are employees of Jupiter and the top management does have decision making authority but in practice, because the physicians have a relatively high level of freedom, and because physicians do the critical work, i.e., making decisions about and saving patients' lives, they hold some power vis-à-vis the top management. On top of that, physicians work elsewhere too and if they are no longer happy with Jupiter, they can leave for some other hospital and take their patients with them.

Additionally, physicians often defend their actions by claiming that they are doing what they are doing to help the patients. If they want a lab when it is not their slot, they claim that the procedure needs to be urgently done. They would say that the patient has arrived late, or they had to go see other critical patients staying in the hospital or referred to them. In any of these cases, the top management cannot question the physicians' intentions because the physicians argue that they are committed to patient care. Though the top management knows it is not true, they are afraid of questioning the physicians and making them unhappy. Even in the weekly and monthly meetings, the top management avoids confrontations regarding disruptive behaviors in CCL. Even if they receive complaints from other doctors, they cursorily mention the problems without naming any individuals, ask everyone to follow the rules, and move on. The coordinator reflected on the time when physician 6 was questioned by the top management:

*"There have been very few instances when the CEO or the Medical Superintendent called a doctor and said that they are getting many complaints against him. This happened to [physician 6], you know. But then [physician 6] simply said, 'Fine. Then I won't do any procedures here. I will do them back at the university.' That's it, the management just went soft and just asked him to be considerate about others and let him go. This happens, see. They are afraid to be angry with the doctors."*

### ***Selfish behaviors***

Due to the fee-for-service model, there is also excessive self-serving behavior exhibited by the physicians towards patients. For instance, an angiogram takes 15-20 minutes on average. If the physician determines an angioplasty is required, and if the patient agrees immediately, the procedure would continue to take another 30-60 minutes. This is usually preferred as it is much easier to continue with the procedure than move the patients out of the lab, keep them under observation for a few hours, send them home only to ask them to come back again on a different day, and once again prepare, test, and do procedure on them. As such, physicians always prefer that their patients agree for further procedure “on the table”, so to speak, so that work is easier.

But the schedule gets disturbed when this happens. If a physician has scheduled two angiograms during an hour slot, and both of them turn out to be angioplasties, the one-hour slot is no longer enough for both of them. In such cases, some physicians do make a different appointment for the procedure, but many try to continue the procedure without thinking about how it affects others’ schedule if they run over their slot. While continuing a procedure is definitely easier, another major reason stems from the fee-for-service model. If patients are allowed to go home, they get time to rethink their options. They might get scared and do not return for the procedure thus risking their own life, of course, but also making the physician miss out on that procedure. Or, the patient might go to another doctor for a second opinion and decide to get treated there. Hence, most physicians prefer to give patients less time to discuss and decide.

But this has a negative connotation to Jupiter’s ethos of providing the best patient care possible as patients get neither enough time nor opportunity to make the decision best for them. Some physicians also elevate the seriousness of their ailment to scare the patients into agreeing to the procedure on the spot. Others tend to do procedures that are not even “really” necessary, “really” being the operating word here. As physician 1, the head of CCL, remarked:

*“It does not look nice when you do procedures unnecessarily. We all know if a procedure is required or not. We can all, even the technicians, we can look at your angiogram and we know if you did something just because you wanted to earn money from that. It sends a bad message. Not only do they have to spend money where it is not necessary but, sometimes, it also puts them at risk because you are going in, putting a stent or a balloon or whatever, and there is always an element of risk.”*

Many physicians, like 5, 6, 7, 8, and 10, frequently resort to such practices. Physician 5 puts up an ethical facade though. She remarked one day in the console room:

*“In India, people do not have social security and so, when they get aged, they are dependent on their children and children don’t take care of them. They take care only if there is money in it. Money has become the problem. In the western world, when someone dies, their money*

*goes to trusts or charities or churches but they are also corrupted. Everyone is corrupted. Money is corruption.”*

Yet she is infamous for being the one who does most of the unnecessary procedures. She even lets medical students do procedures while she sits in her out-patient or goes on rounds to see other patients so that she can finish more number of procedures. As such, a level of commitment, loyalty, and honesty one would expect from physicians of such high cadre is absent in Jupiter. Lack of control by the top management and the interpersonal competition further adds fuel to this.

### ***Maintaining and Manipulating Images***

A major part of physicians' work-life dynamic in Jupiter has to do with their image. This is not a characteristic that is specific to Jupiter. Instead, it arises from the Indian tradition and culture of keeping doctors on a pedestal as they save peoples' lives. But times have changed and with times, the position and the social image have changed too. Several scholars have shown that trust in the medical profession has eroded in India<sup>9, 10</sup> in recent times. The main reason for this shift in perspective is the increased tendency of doctors to maximize their earnings. As healthcare became a commercial business, and many hospitals have popped up across the country as for-profit enterprises, people have lost trust and respect in doctors. There is a wide belief that doctors often conduct unnecessary tests and give costly medication for ailments that could be easily remedied. The pressure on the physicians working in large, multispecialty hospitals like Jupiter to increase revenues has further added to the problem. Additionally, as the general public has become more aware and knowledgeable about the common health problems, thanks in part to the wide access to the internet and increased awareness campaigns by several non-profit organizations and influential people, a moderately educated person today has resources to assess whether a physician is being genuine or is trying to rob the patient. Patients are price- and skill-shopping for better doctors today. Online reviews, local press media articles, and word of mouth from family and friends contribute to a patient's decision in choosing a physician. As such, maintaining a positive image has become an essential part of any physician's work-life dynamic in India.

In Jupiter, this becomes even more relevant because of Jupiter's business model. Under the traditional salary model, irrespective of the number of patients physicians see, they get their salary. But in Jupiter, physicians earn based on the number of patients, procedures, and, more relevant in the cardiology domain, the returning patients. Cardiac treatments are long-running and patients do not just visit once, get a procedure done, and leave. They need to keep returning to the

9. Kane, S., & Calnan, M. (2017). Erosion of trust in the medical profession in India: time for doctors to act. *International journal of health policy and management*, 6(1), 5.

10. Madhok, R. (2012). Doctors and health in India: an outsider's perspective. *Indian J Med Ethics*, 259-63.

physician for frequent tests and medication. As such, not just attracting new patients but keeping the old ones happy is also an important task for Jupiter's physicians. Physician 1 remarked that 80% of the patients he sees a month are returning ones and the numbers remain between 40-80% for other physicians at Jupiter.

These factors have led to the physicians in Jupiter trying to manage their image. Another reason is that they want senior technicians and nurses to help them during complex procedures. As such, they try to manipulate how technicians and nurses perceive them and their skills. While some physicians engage in appreciative behavior, such as bringing snacks for the support staff in CCL or appreciating and thanking them, others engage in manipulative practices, such as posing as a skilled physician or attempting to come across as superior than their colleagues. They often tell stories that present them in a better light. For example, standing in the console room when several of the technicians and nurses were present, physician 2 told this story one day:

*“He came and showed his [visiting] card. He was some deputy director of some governmental department. I told him, ‘You are government servant no? Go to a governmental hospital. Why come to me if you did not even take an appointment?’ See, I see patients until 05 pm and it was after 05 [pm]. If he had requested, I would have seen him. But he tried to use his power. Now, even if he gave me a million [dollars], I won’t see him. Why should I see him? That’s why I always follow my approach. No one can tell me how to live my life. I have worked hard. I have made myself qualified. I will work as I prefer. Who are you to think you can come and control me? No one can tell me what to do. I am experienced, skilled, and respected. I do not have to heave to someone’s power.”*

He went on to recount the story a few more times throughout that day whenever he came across another technician or nurse, or even a junior doctor who was not present in the console room in the morning. Physicians also brag about how complex their procedures are and how skilfully they perform them. Of course, anyone can take a look at the procedure on one of the computers in the console room and immediately realize whether it is complex or not, but the technicians and nurses have neither time nor interest to verify the physicians' claims.

This need to put forth a positive image even affects junior doctors and resident students. has even led to some physicians pushing blame onto juniors or resident students if something goes wrong. Often senior physicians let juniors assist them in procedures so that the latter can learn on the job. Physicians let juniors perform simple procedures like angiograms by themselves but for advanced procedures like angioplasty, they only let them assist. But with some physicians, when something goes wrong, they would immediately push the blame onto the junior doctors or resident students who helped them. For instance, one of the physician 3's patients went into cardiac arrest a few hours after the procedure one day. A student had assisted him that morning with the procedure. As soon as the news of the patient going into cardiac arrest reached physician 3, even before coming and checking up on the patient, he started complaining that the student did not



close the stent well and that was why a complication arose. Luckily nothing happened to the patient but this was the kind of behavior we often see in CCL.

Such behaviors result in increased animosity by junior doctors towards senior physicians. The former are often reluctant to work with or assist the latter for the fear of being blamed if something goes wrong. At times, junior physicians and medical students outright reject helping such physicians in the procedures. Even when the coordinator asks, they do not show interest. Even when they do have to assist in procedures, they remain silent and do not share their opinions or ideas with seniors that might help with the procedures. On the other hand, when juniors deny assisting them, seniors start complaining about favoritism and that the juniors only want to work with certain top physicians. Physician 14, a medical student close to finishing his training, said during an interview:

*“I don’t want to have anything to do with [physician 6]. It’s fine if I don’t learn. [Physician 1] is good. I’ll learn with him. It’s fine if I get only a couple of procedures to do. But with [physician 6]? No thanks.”*

### ***The wrong role models***

Such image manipulative behavior by senior physicians also sends a wrong message to those who join Jupiter that this kind of behavior is legitimate. As new hires, doctors rely a lot on others’ behaviors to understand how things work in a hospital. While there are codified rules and standard operating processes for treatments, the social expectations of how doctors should behave in the organization, especially in the one like Jupiter, rely on how others around them act. In such a case, seeing so many famed and senior physicians behaving in the ways described above, from blocking the lab to fighting for the slots, and from breaking the schedule to blaming others for mistakes, juniors too think that this kind of behavior is acceptable in the organization. As physician 17 remarked:

*“...everybody wants to prove that I am the best, maybe [patients] will go out and talk, ‘ok, this guy is great and he is doing great’. You need appreciation.... some people who are trying to prove their mettle now, freshers, more enthusiastic, maybe they will talk something regarding seniors who have done 20 years of angioplasties and you are just 2 years old now, so you want to show that [you are better than them, you are more than them], that is wrong.”*

As the last comment by physician 17 reflects, the fee-for-service business model has also contributed to such behavior in Jupiter. Under this model, physicians are evaluated only based on the number of patients and procedures, and the revenue they bring in. It does not matter if a physician performs two very complicated procedures and saves lives; the one who does four simple procedures, uses more materials, and brings in more money would be appreciated more. The senior physicians like 1, 4, 11, who prefer to do procedures as little as possible to avoid unnecessary

financial and life risk for the patient, are often pitted against those who do unnecessary procedures like physicians 3, 5, 6.

Of course, senior physicians' behaviors do not go unnoticed. For one, their skill, fame, and commitment towards patients is highly regarded and appreciated both by the patients and by Jupiter's management and other staff. Secondly, complex procedures do often require more material and longer stays in the hospital, all of which bring in more money. So, they are still in the competition yet the pressure on them exists to do more procedures. On the other hand, the junior physicians see the fame and respect towards the senior physicians and naturally yearn for the same. They still need to prove their mettle in the eyes of both Jupiter's management - who after all hired them - and the patients - on whom their income depends. As such, as the seniors have legitimized the detrimental actions like blocking the lab or doing unnecessary procedures, the juniors too resort to such actions. This interpersonal competition also exists amongst physicians of equal cadre, i.e., many senior physicians despise other senior physicians and many juniors feel competitive towards other juniors. This has led to another dysfunctional behavior in CCL: defaming and trash-talking.

A few physicians, usually those who do fewer procedures or are not as skilled, try to downplay the skills and expertise of someone else rather than trying to elevate their own. They would point out all the flaws in a procedure performed by a physician and explain how they would have performed the procedure and argue that their way is the best. One could better understand how this unfolds with a single analogy: The way Donald Trump compares himself and his administration to Barack Obama's. This defaming or downplaying is not restricted to professional work alone; physicians often get personal and trash talk about other physicians on their back commenting on their demographic background or their region or language that have nothing to do with professional work. At the same time, one could only imagine that they know that their comments might get carried to the person about whom they are trash talking and that they themselves might be victims of others' trash talking. Yet such behaviors continue to exist in Jupiter as a form of competition.

For someone external, these egoistic clashes and interpersonal competition do not seem to be as serious as actually blocking labs and hindering others' work, but that is exactly what they transform into. During our data collection period, we have seen that many physicians block the lab out of spite. For instance, physician 3 despises physician 1, as the latter is the head of the lab and also one of the most famed doctors in the country. The top management too is much more favorable to him. So, when physician 3 has slots before physician 1, the former often delays his procedures by at least half an hour or so. We have seen similar behavior by some other physicians as well, like 6 and 10, whenever more famed ones like 1 or 11 have slots after them. Additionally, when these physicians have to wait for the lab while the famed or more skilled physicians are using them, they would extensively complain to the coordinator that the "big shots" always get the lab whenever they want. Physician 3, one day, yelled, "*Why do you give [physician 11] the lab whenever he wants? Shouldn't we do our own procedures?*" He went on to complain to the CEO lying that

he had an emergency procedure and the lab was not available. Such yelling and complaining are a way to profess their power and social standing in the organization. Knowing that such physicians would trash-talk or complain anyway, and having lack of respect towards them, other physicians often do not care much about vacating the lab on time or being considerate about such physicians.

### *Organizing work under conflicts and rivalry*

The stability of work in CCL is hindered by a myriad of abovementioned behaviors. The schedule no longer guides the physicians' actions; instead, chaos ensues as any physician who is supposed to use a lab according to the schedule, or any physician who wants to use a lab because he/she needs it urgently, has no way of knowing for sure if a lab is available or not. They do not know if the person who is supposed to use the lab at that particular time is getting prepared to use it or not. They do not know if the appropriate person is using the lab or not. They also do not know when the lab might get available because most of the physicians can no longer be trusted to finish their procedures on time. More than half of the physicians regularly block the lab by keeping their patients in and going away on some other work or hold on to the empty lab arguing it is their slot and they need the lab even though their patient is not yet prepared.

Under such conditions, pressure mounts on the coordinator to adjust the slots and allocate labs to the physicians who genuinely need them. Because physicians hold a considerable amount of informal power over the management, when they ask for a lab during others' slots, the coordinator cannot simply deny. There is a pressure to adjust the slots around so that the physician can use a lab. Additionally, not all procedures can be scheduled well ahead. Emergencies may arise when a patient who is thought to be stable suddenly goes into cardiac arrest and needs a procedure on a war-foot basis. Similarly, a patient may be brought in by an ambulance who needs treatment urgently and is rushed to CCL. In such cases, a lab needs to be emptied as soon as possible. To make sure the actions of one physician do not consistently hinder those of others, the coordinator resorts to certain measures.

All the procedures scheduled ahead are reflected in the computers in the console room. As such, the coordinator and anyone else who has access to the computers can see the number of procedures scheduled for that day, those that have finished, and those that are still pending. Whenever a lab is empty, the coordinator calls and follows up with physicians with pending procedures to see if they can do their procedures. He justifies his actions by saying:

*"I would call them and tell them the lab is free now and if you want, you can come and do your procedure. Sometimes they agree. Maybe their patient is prepared. Maybe they have only that procedure. So, if they finish it, their day is free now. They can do other work. They can go home, whatever."*

Some physicians welcome such adjustments. Physician 11 agrees with coordinator's actions:

*"I find it hard sometimes to change my schedule and do a procedure when [coordinator] calls me and asks me. But it makes sense. It's better to do this than try to fight with other physicians for the slot. Also, it's hard for [coordinator] to always give me my lab even when it's my slot. Others would always pose problems. So I just let it go and try to finish my procedures whenever the labs are free."*

The coordinator and technicians resort to another way to bypass possible disruptions. When a physician infamous for causing frequent delays and disruptions ask for a lab, they check who has procedures after that physician and determine whether or not to give him/her the lab. They always assume the worst and try to somehow stall that physician. For example, physician 6 asked for the lab one day. Three other physicians had procedures too. The coordinator told physician 6 that he would give the lab but instead he let the other physicians use it. When the coordinator left the lab for a while, physician 6 came into the console room and saw this, got angry, and questioned the technician present there what happened. The technician said that he did not know what the physician was talking about. Physician 6 waited until the coordinator came back and raised the issue. The coordinator replied, *"I told [a technician's name who was not in the lab at that time] to move in your patient. It seems like he did not. Maybe there was confusion. Maybe someone put a different patient in without knowing. You have to wait now."*

Another similar tact the coordinator uses is something that is a bit legally questionable. If you remember, the patient comes and registers at the registration desk on the day of the procedure. This is an important step for obvious legal reasons: to record that the patient is undergoing a relatively risky treatment, to record the patient's insurance details, and to keep track of all the costs that accrue throughout the process. Oftentimes, to move things quickly, the coordinator skips the registration step, and even the preparation in the Recovery Room, to move the patient quickly into the lab before someone else comes and "hijacks" the lab. As mentioned before, this is a legally problematic manoeuvre yet something that the coordinator does recognizing the need to avoid any potential conflicts.

## Conclusion and in-class discussion

Jupiter is characterized by several unique features that lead to tensions, disruptions, and conflicts in the workplace. The fee-for-service model encourages the selfish behavior of the physicians as well as interpersonal competition. Combined with this unique business model, the national culture encourages ego clashes and behaviors that do not put the patients' health and safety at the centre, as Jupiter's vision mentions. The availability of limited resources - only two labs - and inefficient top management that cannot impose rules and sanctions on physicians lead to frequent hurdles to perform procedures. Lack of commitment, loyalty, and identity by the doctors towards the hospital inconveniences the patients. Finally, the behaviors of senior physicians send the wrong message to junior physicians thus legitimizing the disruptive performances in Jupiter. Without further support from the top management, the coordinator has limited tools in his arsenal to diffuse any situations that arise in CCL.

While we have briefly mentioned how the coordinator tries to make sure the work continues under these ongoing conflicts and consistent disruptions, the main aim has been to present a clear view of the organizational setting and the reasons why the problems might arise. There might be better ways to organize work under these tensions and conflicts but the top management has neither interest nor power to take any steps. Implementing any change would mean irritating the physicians to a point where they might leave the organization. The hospital has to balance providing the best patient care to survive in the competition with keeping doctors happy to not lose its most valuable asset. How can Jupiter achieve this balance? What steps can it take to eliminate or, in the least, minimize problems? What more can the coordinator do? Can the physicians themselves figure out any solution to this problem of organizing?

While these are the crucial questions for the organization, the students can start by discussing the following questions in the classroom under the guidance of the instructor:

1. Briefly summarize the case, indicating the context and people.
2. Where did Jupiter's competitive advantage initially come from?
3. What changed for Jupiter and its competitive advantage from when it was founded to today?
4. What are the underlying key problems in Jupiter? What factors from the context gave rise to these problems?
5. Can you identify any other issues that are not easily visible on the surface?
6. What theories or concepts from the organizational behavior, design, and HRM literature would help us analyze this case?
7. What steps can Jupiter's top management take to control the conflicts in the hospital? What kind of system could replace the schedule and/or encourage the physicians to be more cooperative with one another?
8. What consequences would be there if Jupiter's management takes drastic measures over the physicians? How could Jupiter safeguard itself against the risk that physicians could leave?
9. Make students take two or three sides: of the top management, of the physicians who usually followed the rules and the physicians who did not. They can be asked to argue in support of their position, vent their frustrations, and suggest solutions that would make their life easier.

## ORGANIZING WORK AMIDST CONFLICTS

10. Briefly summarize and conclude the discussion highlighting the main points discussed and ideas that Jupiter can use.

*Exhibit 1. One of the two CCL labs present in Jupiter*





ORGANIZING WORK AMIDST CONFLICTS

*Exhibit 2: The schedule that was in place in Jupiter at the time of the data collection*

**CATH LAB I ROSTER APPLICABLE FROM DECEMBER 16 (OLD) FD10**

	8-10 AM	10-11 AM	11-12 PM	12-2 PM	2-3 PM	3-4 PM	4-5 PM	5-6 PM
MON						RADIO/ NEURO		
TUE								
WED	PED CARD	PED CARD						
THUR								
FRI	PED CARD	PED CARD						
SAT								

  

**CATH LAB II ROSTER APPLICABLE FROM DECEMBER 16 (NEW) FD20**

	8-9 AM	9-10 AM	10-12 PM	12-2 PM	2-3 PM	3-4 PM	4-5 PM	5-6 PM
MON								
TUE							RADIO/ NEURO	RADIO/ NEURO
WED		P						RADIO/ NEURO
THUR								
FRI								
SAT						P		

Note:  
1. Requesting all the consultants to follow the rota strictly unless it is primary or



*Exhibit 3. The steps involved in performing a CCL procedure*

