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The Drama of Dysfunction: Value Conflict in US Managed Care

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Abstract: The transformation of the American health care environment from retrospective fee-for-service to managed care has been both rapid and chaotic. This period of change has been infected by value conflict, evoking unconscious processes in system participants as they have attempted to cope with personally threatening situations. This article attempts to elucidate this process by presenting an account of events and accompanying value conflict as it occurred overtime. It also includes a systems analysis of the rapidly changing mosaic of unconscious processes that resulted from the divergent values held by the public and health care professionals, using various organization behavior theories. Examples of the types of theory used are jungian archetypes, scapegoating and mutual negative stereotyping, the Karpman Drama Triangle, and Wells' 'group-as-mother' analogue.

The purpose of this article is to explore the evolution of the health care ethical environment using psychoanalytic group theory and other relevant theories. Due to the rapid and chaotic transformation of the health care environment from a fee-for-service system to a managed care system, the health care environment has been characterized by extraordinary value conflict, resulting in systems imbalance. On a conscious level, this value conflict is experienced by some as fear and anxiety about receiving needed care, disrupted relationships with caregivers and anger and frustration with the health care system. I will hypothesize that this high anxiety, frustration and disillusionment has animated a changing mosaic of unconscious processes for many in the health care system. Unconscious processes that may have been evoked are scapegoating and blaming, mutual negative stereotyping, and archetypes, such as Hero and Villain, Mother and Father, the Child, the Group, the Wise Old Man and 'Magna Mater', or Wise Old Woman, and the Self. Finally, the Drama Triangle will be used to illustrate the changing nature of unconscious, collusive roles over time in what I suggest has been a dysfunctional system ever since the beginning of the transformation process.

Curtin has asserted that the moral crisis in health care today is more about 'value dis-integration than economic dis-array' (1996: 71). To set the scene for this drama, it is necessary to understand events as they have unfolded and to elucidate the relevant values inherent in American culture as they pertain to these changes in the health care system. The primary focus in this systems analysis is on interpersonal and intrapersonal value conflict around the increasing business orientation and its practices (i.e. health care rationing, payment plans, restriction of choice, care of indigent populations, quality of care questions, among others) and its consequences. This business orientation is odious to most Americans since health care has always been considered to be in a special category. At the very least, states Dr Jamal Modir, a Surgeon at Good Samaritan for 23 years, 'There is an area beyond which no medicine ought to be jeopardized by business" (Ginsberg, 1996: 20). It is of interest, but predictable, that this sensitivity to the use of market language for health care is also shared by Germany and England (Iglehart, 1998). Sensitivity to the commercialization of health care is probably a universal issue, in that it is associated with quality of care, which is essentially a life/death issue.

Theory to be used in this analysis

The propensity of groups in systems to develop specialized roles in order to survive and accomplish their goals is well established (Barker, 1997; Bowles, 1997; Horwitz, 1985; Main, 1985; Reinhardt, 1998; Schine, 1989; Smith, 1983; Wells, 1985). This process is explained in Wells' article (1985) in which a 'group gestalt and mentality' is formed, resulting in 'role differentiation, role suction, and the prevailing quality of group relations and culture' (Wells, 1985: 116). Of the numerous and varied roles that are unconsciously projected onto and introjected by members of the group are Hero and Villain, Mother and Father, Peacemaker and Troublemaker. These roles (as are all roles) in group process are assigned by the group or system of groups through the process of role suction, are unconscious and are seen as necessary to group survival.

They are based on Jungian archetypes and on role theory in groups as discussed by Wells (1985) and others. As Jung discussed, archetypes are bipolar, as are some roles. A positive Hero is one who may revitalize an organization by articulating a new vision or even by instigating a rebellion against, within or with another group. A negative expression of the Hero, the Anti-Hero, is often an egocentric leader who introjects the heroic projections of others who realize too late that a monster has been created (for example, Hitler, Stalin) (Bowles, 1997). Because of the Hero's high visibility, this role has high valency to become the scapegoat. This can come about when the old Hero, the king, gradually becomes the symbol of the established order. A new generation, stirred by longings to be free themselves from the restraints of the old order, find a spokesperson in a new Hero to express their longings. Eventually the old king and the Hero do battle, and the Hero emerges to free the members of the new generation from their oppression and create a new order of their own. This is a cyclical pattern, based on archetypical patterns of life, and is just as predictable as the seasons of the year (Hardmg, 1965).

The Villain also has a propensity to become the scapegoat due to high visibility. The negative Villain introjects the evil or bad that the group members unconsciously and collusively project onto him, having the possibility to be thrown out of the group as anxiety grows in a dysfunctional group or system. The positive Villain, scapegoat-in-training, introjects the tendency to speak the unpopular, often dangerous, truth. If the Villain is not silenced or thrown out of the group, that person has the possibility of saving the group from impending disaster.

Jungian archetypes are the 'not-I' of the unconscious, as distinguished from the T of the conscious world. They manifest themselves in images or in myths that follow a definite pattern having a consecutive story or outcome. According to Harding, 'The contents of the collective unconscious move and act and live deep within us, but we perceive them only dimly and usually in distorted guise, as they glide across the screen of the world about us' (1965: 135). If we remain unconscious in relation to it, 'We are then at its

mercy, mere puppets of unseen and unrecognized forces', and thus, conscious thought is impossible (1965: 132).

Mother and Father archetypes also have good and bad sides. The positive Mother, or the Good Mother, gives life, protects and nurtures; the negative Mother is the terrible destructive Witch Mother. The combination of these two, the Great Mother, is indeed, a powerful, often frightening figure (Bayes & Newton, 1985). This archetype influences not only the child but the adult, as well. Wells uses the Mother archetype to create the 'group-asmother' analogue that explains the primitive conflict between fear of abandonment versus the wish to be independent, on the one hand, and the fear of engulfment versus the wish to bond with mother, on the other (Wells, 1985). The Father archetype also has two sides: the strong, powerful, authoritative Father who possesses strong willpower, and the fierce, overpowering, destructive Father. The influence of this archetype is second only to the Mother archetype.

Jung also spoke a great deal about religion and its vital function in helping man understand the mysteries of life and death - the gradual loss of religio, or whatever name man gives to 'such factors in his world that he has found powerful, dangerous, or helpful enough to be taken into careful consideration . . . and meaningful enough to be devoutly worshipped and loved' (Whitmont, 1969: 82). He said that there is a 'growing impoverishment of symbols of life and death', that help us understand the continuity of life and death (Jung, 1970: 347-50). 'The negation of life's fulfillment is synonymous with the refusal to accept its ending. Both mean not wanting to live, and not wanting to live is identical with not wanting to die. Waxing and waning make one curve.' (Jung, 1970: 323). This loss of understanding has occurred, according to Jung, with the growth of Protestantism that man 'having pulled down so many walls carefully erected by the church, immediately began to experience the disintegrating and schismatic effect of individual revelation . . . ritual lost its authority, man had to face his inner experience without the protection and guidance of dogma and ritual . . .' (Jung, 1959: 486). And so, said jung, man lost his connection to the Archetypical Self, the 'predestined wholeness' of an individual life which seeks fulfillment. The symbolism of the Self, ' expressing as it does an unknown, superordinated, directive and encompassing entity ... is indistinguishable from the symbolism of the godhead' (Whitmont, 1969: 218-22).

The Child and the Group Archetypes will also be used in this analysis, as well as the Wise Old Man and Magna Mater, or Wise Old Woman. First, the Child, like so many archetypical images is paradoxical. This archetype is related to the wholeness of life, in that the ' "child" symbolizes the pre-conscious and post-conscious essence of man. His pre-conscious essence is the unconscious state of earliest childhood; his post-conscious essence is an anticipation by analogy of life after death. In this idea the all embracing

nature of psychic wholeness is expressed' (Harding, 1965: 168). So the 'Child can mean regression to childishness ... it can also represent a new beginning, the birth of a psychic value with a potentiality for growth and development that the ego-personality has lost' (Harding, 1965: 169).

The Group archetype represents union and cooperation that occurs when the weak join forces to add strength to fight the regressive pull backward to childhood, mother love and the rule of father. During adolescence, father assisted in the struggle to free the individual from mother rule. But eventually the rule of father, which represents the established order, stands in the way of an individual's creative energy. The existence of a group presupposes that a leader will emerge, not necessarily a conscious process, and this individual will be one who best articulates and expresses the needs and emotions of the group. The father is thus overthrown, representing current rules and conventions, and the group gives into the 'impulses that surge from the darkest depths of the unconscious'. The leader expresses the unrealized longings of the group, which can either be destructive (Hitler), or redemptive (the Messiah) (Harding, 1965).

The Wise Old Man, thought by McLynn (1996), to be the most common archetype of the spirit, also has two sides. Its positive image is the ancient sage, such as Merlin, and its negative side is the Evil Wizard. If one identifies with this archetype, there is a danger of ' "psychic inflation" . . . thus producing delusions of grandeur and psychosis (1996: 305). Although the Wise Old Man can appear to a woman, it is much more common for her to experience the Wise Old Woman or Magna Mater, who can also occasionally appear to men. The positive side of the archetype is the Goddess, saint, or female ancestor; the negative side appears as a witch or dragon (McLynn, 1996:305).

The literature on scapegoating in groups, organizations and between organizations is also extensive: it includes Bailey (1997), Brown (1978), Morgan (1986), Reinhardt (1998), Smith (1983), Wells (1985) and Wilson (1993). Scapegoating is very destructive in groups and organizations because, when the scapegoat is cast from the group, there may initially be a feeling of temporary relief, often followed by chaos and fear (who will be next?), destroying careers and, in the end, accomplishing nothing of value. It is suspect any time an unhealthy organization rids itself of (i.e. fires, banishes to the outer edges of the organization, etc.) an individual or group, officially or unofficially blaming that individual or group for its problems.

Brown extends the notion of stereotyping to what he refers to as 'mutual negative stereotyping', or 'we', as good, 'they', as bad (Brown, 1978: 161-80). Mutual negative stereotyping, like stereotyping, harks back to the primordial 'group-as-mother' analog (Wells, 1985). This, Brown says, can occur between groups of equal power when there is decreased awareness of similarities and interdependence and an increased emphasis on differences and conflicts. It is also possible between groups of unequal power. As

group boundaries become less permeable to information and interaction, there is a decreased amount of communication, and when it is received, it is received with increased distrust and distortion. This leads to increasingly distorted communication and mutual negative stereotyping (Brown, 1978).

Another theoretical piece used in this analysis is the Drama Triangle, as conceived of by transactional analysts, mainly Eric Berne (1963), James and Jongeward (1971), Steiner (1971), Windes (1977) and Wollams et al. (1977). The (Karpman) Drama Triangle, like the notion of roles and scapegoating, was originally conceived of as an analytic tool for dysfunctional families and small groups. In this context, interaction is described using three roles, all of which the group members can play, and frequently may switch from one to another. These roles are the following: Victim, characterized by penitent, helplessness, 'under-dog', powerless behavior; Persecutor, displaying behavior that is 'top-dog' (righteous, authoritarian, using demands and threats), limit-setting, rule-enforcing - with a vengeance; Rescuer, recognized by helpful, dependency-inducing, parental behavior, professing superior knowledge (James & Jongeward, 1971; Windes, 1977; Wollams et al., 1977). All three roles are manipulative and unconscious and are 'used to provoke or invite others to respond in specific ways' (James & Jongeward, 1971: 94). Moreover, these roles can also be used to analyze groups in a system, as evidenced by the work of Windes in analyzing prison culture (Windes, 1977).

One could hypothesize that these unconscious processes are animated by the primitive fear of death, as conceived of, first, by Freud, and later, by Melanie Klein (Klein, 1985). Closely related to this is jung's writing, discussed above, on the gradual loss of religio, the increasingly hollow symbols of life and death and the oneness of these two, resulting in impoverished connection to the Self. Primordial fear of abandonment (Wells, 1985) may also be a causative phenomenon. These theoretical pieces just discussed, to which I will refer throughout this article, may help to explain why the American nation is experiencing the various seemingly unresolvable conflicts that exist around the transformation of health care.

Values conflict in US health care

What are the major value conflicts experienced around health care that are so troubling to the American people? The primary ones are cost versus quality, contract versus covenant, and universal care versus care only for those who can pay for it. They all involve the question of whether health care is just another business or should be regarded as being in a special category. The arguments around these issues are discussed in the following section.

Arguing that health care is indeed in a special category is Friedman (1996) who asserts that there is a 'difference between a patient and a bowling ball. . . between a physician and a real estate broker'.

Further, she states that the very principles that serve the proprietary world well cannot serve patients in the health care world. What this means is that good practices in one world may be poor practices in the other world. Health care, she states, is not 'just another business'. Life and death decisions simply cannot be dealt with by using stock values - this is too simplistic. If emerging health care markets don't understand this, the price will be very high (Friedman, 1996).

The other pole of this controversy is expressed in the following statements: first, Richard Rainwater, co-founder, Columbia/HCA Corporation, stated 'The day has come when somebody has to do in the hospital business what McDonald's has done in the fast-food business and what Wal-Mart has done in the retailing business'; second, also a statement by a co-founder of Columbia/HCA, Richard Scott, 'Do we have an obligation to provide health care for everybody? Where do we draw the line? Is a fast-food restaurant obligated to feed everyone who shows up?' (Ginsberg, 1996: 18).

Of course, there are variations in viewpoints along the values continuum between these two polar opposite viewpoints about the nature of health care which comprise the bulk of the controversy that swirls around this issue. Ginsberg jumps into this dialogue, stating that health care is different primarily because it involves human welfare more intimately than many other businesses. In this quasi-business, ethics is highly important because health care involves professionals who have greater power (knowledge) and vulnerable people (perhaps at the most vulnerable point in their lives) who need care from professionals. Informed decisions are not possible because of knowledge inequities (Friedman, 1996; Ginsberg, 1996). LaPuma (1998: 58) echoes these views, saying that 'The doctor-patient exchange has power and knowledge on one side, and need and fear on the other', and Li points out the clinical ethicists define the practice of medicine as 'a moral enterprise grounded in a covenant of trust' (1996: 917-18). A business relationship is thus contractual in nature, but the doctor-patient relationship is based on trust. The right to expect a trusting doctor-patient relationship, states Annas, was established in a series of court decisions in 1972. 'In these opinions the courts made it clear that the law would treat the doctor-patient relationship as fiduciary, or trust-based relationship, not as an arm's-length business relationship' (1998: 695). Also established in these court opinions was the most important of all patients' rights, informed consent (Starr, 1982: 388-93).

There are also other, more moderate voices speaking on behalf of the viewpoint that health care ought to act in a more businesslike fashion. For example, Kleinke states that much of the criticism aimed at health care organizations like Columbia/HCA 'stems from an abhorrence of the realities of rightsizing' (Kleinke, 1998: 12). In fact, says Jeffery Otten, chief executive officer of Brigham and Women's Hospital, for-profit MCOs (Managed Care Organizations) 'exert competitive pressure on us to become more cost effective. It makes us re-examine how we are providing care' (Kleinke, 1998: 24). According to Pan and

Nguyan, managed care is 'industrializing health care of populations using limited resources in integrated health systems. This is the result of the government and employers, who are the primary purchasers, demanding value, which, in turn, requires proof of cost-effectiveness and quality' (1996: 666).

Moreover, Gradison points out that opposition to payment methods used in managed care (specifically, capitation, which is the practice of paying a physician a specific amount of money for the care of each patient) is not based on anything but anecdotes. There is no conclusive evidence that supports the notion that capitated payments, which are designed to limit care and decrease health care costs, result in poor medical outcomes or patient care (1996). In addition, Robinson (1996) reports that managed care has reduced cost inflation in health care by reducing admissions and length of stay. Moreover, a study (2673 respondents in Southern California) by Cooperman revealed that 70 to 80 percent were either satisfied or very to extremely satisfied with the care in their Medicare HMOs (1995).

The fee-for-service era

Let us look back to the 1970s to better understand the causes and context of the current transformation occurring in health care that was stimulated by ever-increasing health care costs. These costs were driven up by extraordinary advances in technology, expansion of facilities, funded by both extensive government and private investment. In 1929, health care cost constituted 3.5 percent of GNP (Gross National Product), and by 1950, it had only risen to 4.4 percent, followed in 1995 by an astounding jump to 11 percent of GNP, and a national health care bill of half a trillion dollars (Morrem, 1995: 8). By 1996, even with cost control measures in place, the HCFA (Health Care Finance Administration) reported that the bill had reached one trillion dollars (Levit et al., 1998). The USA still expends the largest amount of money of any developed nation (Iglehart, 1998), even though the cost of medical care is also a significant concern elsewhere in the global community.

As these costs started their rapid climb through the 1960s, growing at twice the rate of inflation (until recently), health care came under increasing scrutiny by the federal government. The Carter administration instituted voluntary restraints in 1979 and DRGs (Diagnosis Related Groups) were created by an act passed in 1982 in a further attempt to put a rein on rising costs by limiting care (Morrem, 1995). This system of prospective payments was the beginning of health care rationing in the USA that began the radical change in the environment of health care. It altered and disrupted long-standing caregiver-patient relationships and expectations in a once relatively stable, but increasingly unaffordable, system.

By 1989, employers' share of health care insurance for their employees represented 8.9 percent of wages and salaries, up 2.2 percent since 1965. Because of this, there was growing concern that these

costs were putting American products at a disadvantage in the world marketplace; for example, health insurance accounted for $700 of an American-made car versus $200 of a Japanese-made car. Yet, what sealed the fate of fee-for-service indemnity insurance was the accelerated health care inflation between 1988 and 1990. Ninety-one percent of Fortune 500 executives, polled in a 1990 survey said that the health care system needed significant changes or complete restructuring. Even before this survey appeared, some large employers had begun encouraging their employees to join MCOs (Bodenheimer & Sullivan, 1998).

This system instability caused increasing anxiety and frustrations, both for patients and caregivers. Yet, this dissatisfaction was not because fee-for-service health care enjoyed widespread satisfaction, for there were those who were highly critical and dissatisfied with that system. In fact, as health care costs spiraled, the heightened scrutiny of fee-for-service indemnity insurance revealed serious problems. According to Tabak, first, 'the cottage industry-like nature of the marketplace fostered wide variations in medical practices as well as widespread use of inappropriate services'. Second, he asserts that access to care was not consistent or predictable, there were few mechanisms to monitor quality or for efficient, effective treatment protocols. Third, he points out that there was little focus on preventive medicine. And fourth, he states that there was an emphasis on in-patient hospital care using more and more expensive tests and procedures (some found to be of negligible value), increasingly ordered by specialists rather than primary care physicians (1998: 209).

During the fee-for-service era, Starr asserted that often painful and dangerous tests and procedures were ordered by physicians whose incomes were based on the number of procedures they did, and who were often retrospectively paid by insurance plans who could be relied on to pay all usual, customary and reasonable charges for each service. Under this system, doctors had incentive to keep their fees comfortably high and to resist reduction (1982). And since physicians initiated approximately 75 percent of hospital expenditures (Tjosvold & MacPherson, 1996) and often admitted patients to costly hospital beds for procedures that could be done on an outpatient basis, they were held responsible, at least in part, for health care cost escalation.

Moreover, physicians, who were a highly visible and respected professional group and who were expected to have fiduciary relationships with patients, were becoming increasingly entrepreneurial; for example, it was troubling to some that there was an increase in self-referral arrangements to labs and ancillary services by the physicians who owned them (Brock, 1990). Crandall asserts that, as professionals, doctors and other health care professionals have a responsibility to speak out against the 'competitive and largely amoral calculus' contained in the growing business orientation in health care; yet, they have, in fact, been a part of it (1990: 45-6). Due to the harm caused by the 'erosion of respect,

trust and honor accorded to healers' (Crandall, 1990: 50), to the value conflict between the public's expectation of their professional versus their pecuniary behavior, physicians, and to a lesser extent the more amorphous hospitals, were seen as a primary cause of an unaffordable health care system.

Systems analysis of the fee-for-service era

How can this painful, chaotic environment be understood in terms of the theory discussed earlier? What may be at the core of the tangle of fear, disillusionment and anger is the tension between life and death concerns. It appears that these unconscious forces could be what fuels the seemingly unresolvable value conflicts around health care being regarded as a business versus health care as an inalienable human right for all. One hypothesis is that the unreasonable cost of medical care may have resulted from the everincreasing demand for access to expensive treatment for all, which was based on unconscious fear of death. Fear of death is discussed, at length, by both Freud and Melanie Klein. Another factor may have been fear of abandonment (Wells, 1985) by the medical professional. This relentless demand for more and better care, no matter what the price tag, may also be the result of Jung's notion (discussed earlier) of the loss of religio and man's connection to wholeness of the Self, or the archetypical Self (Whitmont, 1969). According to Jung, we have lost our understanding of the interconnectedness of life and death, and therefore the negation of both fulfillment in life and its end. We have also, as a culture, seemed unable to move beyond the image of the pre-conscious Child. The wholeness of the life cycle and the image of the post-conscious child, of which death is seen as a new beginning, seems misunderstood, often rejected (Jung, 1970). As a result, fulfillment in life, the chance to experience advanced stages in the process of individuation (Levinson, 1978; Stevens, 1990) which was always possible for a chosen few, may be even less possible. What is left, for some, is a life hollow of meaning, and living with an ever-increasing sense of dread.

Another cause for the cost escalation in health care was likely to be physician generated. Unconsciously, energized by Father/Mother archetypes, sucked into Hero roles, they colluded with patients' unconscious (the pre-conscious Child) and conscious expectations by ordering more and increasingly expensive medical care. Consciously, their practice of ordering maximum procedures, tests and surgeries, may have been encouraged by the fee-for-service system, fear of lawsuits, increasingly sophisticated and costly technology, medical insurance middle-men that constantly raised premiums rather than acting as gate-keepers, and the desire to increase their own income.

According to Starr, the cost escalation of medical care was due to myriad interacting complex forces in a changing medical environment: exploding technology; population growth; an aging population; the expectation, traditional in the American culture, that quality health care is a right without regard to ability to pay. The fee-for-service payment system also stimulated excesses, especially when coupled

with a litigious environment. Added to this were burgeoning hospital costs fueled by increasingly sophisticated, costly procedures along with escalating cost shifting to pay for growing numbers of patients unable to pay for care. This, in turn, pushed insurance premiums higher and higher (Starr, 1982). The result of all this, according to economist Kenneth Wing, was 'massive price inflation that may be the single most important factor in the overall rise of health care expenditures' (Morrem, 1995: 11-13). It seems inevitable that the system would become too costly for the nation, that continuing to provide advanced medical care for all, on demand, would eventually falter and that these systems' tensions would trigger primitive unconscious fears, causing the irrational behavior that has been observed.

It is also understandable that the physicians, who are the traditional leaders in health care as well as the individuals on whom patients depend most for their health care, would be blamed and scapegoated as attempts were begun to ration health care. According to Whitmont, archetypical 'images may appear spontaneously when inner or outer events which are particularly stark must be faced, when there is a state of psychic or physical emergency' (1969: 74). Moreover, Jung asserts that, as unconscious processes gain potency, there is a corresponding weakness in the conscious mind and its functions (1970).

The Hero archetype may also be evoked by physicians, as well as physicians being possessed by it. The Hero strives for individuality, overcomes adversity and courageously struggles to be free of the 'enclosing Mother archetype' (Harding, 1965: 147). 'His words carry weight beyond their actual value and we can't avoid being influenced by them. We are caught by a spell and are unable to exercise any adequate critique based on his actual accomplishment' (Harding, 1965: 150). The role of physician is often characterized by rational, independent expertise, even though some may yearn for more empathetic qualities in their caregivers (often the role of female nurses), while patients have traditionally found themselves reticent to question them. For some, physicians may have evoked aspects of the Father (protective, assertive, high expertise) and Wise Old Man archetypes as well as the role of the Hero (savior, making magical things happen), suggested by Jung and Wells. The Mother archetype tends to be evoked by nurses (care of the body, empathy). It may also be that some physicians become possessed with the Hero archetype, acting as if they have superior wisdom and authority, expecting others to recognize their superiority and pay them the respect they feel they are due (Harding, 1965).

Archetypes are bipolar and Heroes have high valency to be scapegoated. If physicians were blamed or scapegoated by patients for limitations on care, they often colluded by acting out the scapegoat role, becoming silenced and displaying passive behavior, or becoming the Bad Father by acting in passive-

aggressive, sometimes aggressive behavior patterns. For many patients, the physician, the powerful, knowledgeable Good Father, gradually was transformed into the absent, witholding Bad Father. They and other health care leaders, who had formerly been Heroes, who were capable of magical deeds, became Villains. The Wise Old Man became the Evil Wizard. Again, physicians were often sucked into a role, unconsciously colluding with the role assigned to them by frightened, disgruntled patients and their families. This scapegoating process is indicative of system anxiety, further crippling a system vital to the well being of the nation. And thus, value conflicts invaded health care - cost versus quality, contract versus covenant, universal care versus care for those who can pay, fueling a new set of unconscious processes, causing increasing confusion and irrational behavior.

In the Drama Triangle, physicians, other health care professionals and hospitals which had formerly been Rescuers, gradually transitioned into Persecutors, and the people in the culture, energized by the archetypical image of the Group, began searching for new leaders. One piece of evidence of this transition is the increase in individual and group MCO membership and popularity of alternative medicine. Patients and those who paid the bills or went without care because they couldn't pay, were the Victims. Third party payers were the middlemen who passed increased costs on to patients through increased premiums. The federal government became identified by some as the Rescuer, because it had provided an alternative to unaffordable fee-for-service health care by passing the HMO Act of 1971, which 'required employers with more than 25 employees to offer an HMO as a health care option if a federally qualified HMO was operating in the area' (Bodenheimer & Sullivan, 1998: 1003). Even though only 10 million Americans were enrolled in HMOs in 1980, by 1985, 35 million were enrolled.

The news media are also an interesting entity in the Drama Triangle; by blowing the whistle on the entrepreneurial activities of physicians and the skyrocketing hospital costs, they acted as the Persecutor of the fee-for-service health care industry, which was instrumental in the industry's gradual move into the Victim position. They also could be observed in the Rescuer position, as watchdog and eventual whistleblower for the American public, which was in the Victim position. Finally, lawyers were often viewed as Villains (and sometimes scapegoated) by the medical community and in the press. But perhaps by litigants, they were viewed as Rescuers, as they sought and pursued medical malpractice suits. Attempts were also made by health care writers, the press and the public, to scapegoat them by blaming them for stimulating the already litigious environment and pushing up health care costs.

Transition to managed care

The transformation in health care in the USA represented a basic paradigm shift in the value set, from religious, governmental and charitable values to marketplace values (Fine, 1996). Yet the American public still adhered to the old value system, regarding health care as 'a moral enterprise grounded in a

covenant of trust' (Li, 1996: 917-18). The values of the marketplace, on the other hand, place physicians as gatekeepers who make economic decisions, patients as consumers for whom the watchword is caveat emptor, and health professionals and patients as commodities to be manipu-lated for profit (Li, 1996). Even so, more employers offered managed care as an option, accompanied by little information about quality, focusing instead on plan provisions and cost savings. Increasing numbers of employees responded to these offers for lower-cost health care by switching from costly fee-for-service plans. During this 'honeymoon' period for HMOs, media coverage mirrored the optimism of the public about the decreased cost of health care through HMOs, which usually appeared in the business sections of publications. This positive coverage peaked in 1992 (Brodie et al., 1998).

During this brief 'honeymoon', the rapidly developing MCO industry became the Rescuer in the Drama Triangle and also the Hero. Some patients remained Victims, either scrambling to get acceptable medical care and hoping that MCOs would pay their share, or searching for the dwindling supply of subsidized care. Physicians and other health professionals became Great Mother figures, seemingly having the power to both give and deny care. When they denied care, or limited it, they became Persecutors and bad Witch Mothers/Destructive Fathers. When they delivered care, they were seen as Rescuers and Good Mothers/Protective Fathers. Some health care professionals transitioned into the Victim position, retreating from the fray, and eventually even scapegoated into a relatively powerless position. As fee-for-service health care diminished, these groups acted out their Victim role by engaging in passive-aggressive attempts to demonize managed health care. When they did so, they switched into the Persecutor role as did the news media by increasingly reporting this viewpoint.

For example, Schlafly, writing in the Eagle Forum (1996: 1), quoted Dr Carl Weber, a White Plains, NY, surgeon, as saying, 'We believe the whole concept of managed care is spurious. It is predicated on financial incentives to restrict care and access to care.' She also reported that Kit Costello, a Sacramento nurse, also objecting to financial incentives in managed care, said, 'We see the human wreckage every day.' Moreover, a 1995 survey of 1710 physicians indicated that 62 percent reported fair to poor ability to obtain appropriate referrals, and 41 percent said they had less time with patients (Anon, 1995: 1). Another example is contained in the outcome of a 1997 Congressional survey which indicated high agreement of the need for legislation to stop managed care companies from putting profit ahead of patients (Anon, 1997: 1).

MCO advocates have been less vocal in their criticism of traditional health professionals; nevertheless, they have contributed their part to mutual negative stereotyping in statements like Thomas Pyle's calling health care's revolutionary changes 'the unbungling' of health care (as quoted by Ellwood & Lundberg, 1996: 1084). Budetti, a physician and lawyer, has also observed that there were few ethics

discussions during the fee-for-service era, but when physicians' autonomy and income is threatened, they suddenly feel the need to discuss health care ethical dilemmas (1997).

Backlash to managed care

The so-called 'backlash' over managed health care began in earnest in 1995, after the health care reform debate of 1993-4 and the Medicare/Medicaid debate of 1995. Focus topics changed from economic/corporate issues (employee benefits, employer costs, health care industry profits) to medical care issues focusing on patient/consumer issues (patient care, including treatment and physician-related issues). By 1995, portrayal of MCOs and HMOs as the Villain reached an all-time high of 17 percent (Brodie et al., 1998). A number of writers focused on the value conflict in the American health care systems as the major problem discussed earlier in this article (Brock, 1990; Crandall, 1990; Iglehart, 1998; LaPuma, 1998; Li, 1996; Liedtka, 1991; Werhane, 1990). Liedtka (1991: 4) seemed to summarize many of these viewpoints in her fine discussion of value conflict, both interactional and intrapersonal, in the managed care environment. Within organizations, a set of characteristics likely to produce 'profound value conflict' when combined, are 'the presence of strong group subcultures among members of an institution, shifting power balances between them, decision contexts that are frequently value-laden, and decision boundaries that overlap'. She continued,

More so than in any other sector of our economy, these characteristics can be found in American health care, where the value systems of physicians, nurses, and administrators appear to be increasingly at odds with each other, where administrative involvement in clinical decisionmaking grows more evident daily, and where the decisions to be made, on a routine basis, evoke the most fundamental values that society holds. The results of this conflict continue to be both extraordinarily painful for caregivers and patients, and expensive for American society as a whole.

(Liedtka, 1991:4)

Anderson (1997) echoed Liedka's identification of interpersonal role conflict and lack of appropriate boundaries between professionals as problematic, causing scrambled and conflicting ethical imperatives. Intrapersonal conflict was evident in health care professionals who yearned for the 'good old days' of fee-for-service (for physicians, large salaries and choice of treatment protocols; for hospitals, occupied beds and busy services) and MCO administrators, who wanted to maintain the current system with escalating fee structures, not cutbacks. Moreover, the American people experienced conflicting values in their desire to have it all: caregiver choice, unlimited access at will, all at affordable costs. But it goes even deeper than this, said Anderson; the source of problem is in managed care itself, 'whose origins lie squarely in the nation's failure to agree on acceptable ways to

control medical costs' and has 'benefited from neither dialogue nor consensus. It has taken root in uncharted territory' (1997: 25).

The value conflict between the American people, who hold that health care is in a special category, and HMOs, who make little secret of their 'business first' orientation, flared into open warfare. Previously, commercialism in the medical profession was somewhat covert, but with HMOs, stockholder interests and profits were the topic of daily reports and articles. The American public was alarmed and frightened by this change and what it would entail. The medical profession was also thrown into a state of chaos. The system's propensity for activation of unconscious process was heightened. It was, for some, both a psychic and physical crisis (see Whitmont, 1969). Liedka's statements (see above) clearly elucidate the distress and confusion experienced by professionals as they tried to care for patients in the altered health care environment created by managed care.

The traditional leadership role of physicians and other health care professionals has been undermined by this system that has inserted non-medical managers, with non-medical goals and values (and often, education and experience), into medical decision-making roles. The original, brief optimism which greeted HMOs as the Group's new Hero, quickly deteriorated into disorder and fear. The chaos that resulted in the system was communicated to patients, invoking the pre-conscious Child archetype by enhancing patients' vulnerablity and helplessness, triggering primitive, unconscious feelings and behavior. This may have been due to antecedents, such as loss of contact with wholeness of the Self, the consequent fear of illness and death, and fear of abandonment by their physicians. The physician was no longer only his/her patient's advocate, but often, an employee answering to a non-medical manager. The goal of the enterprise was no longer to optimize patient care, but to make profit. The covenant between physician and patient was no longer intact.

During this backlash period, roles were again redefined in what was now a very dysfunctional system: MCOs quickly switched from Rescuers to Villains, were blamed (scapegoated), and became Victims in their highly public rush to commercialize health care. Patients, health care professionals and hospitals still remained Victims caught in confusing, de-powering value conflicts. The news media remained the Persecutor, as they were then perceived to 'demonize' MCOs (see Brodie et al., 1998: 9-25), as well as Rescuer, when they published frightening anecdotes of lack of patient care. The government (state and federal) has been gradually stepping into the Rescuer role again by beginning to pass regulatory legislation limiting some of the treatment restrictions of MCOs.

The backlash against managed care did not go unanswered. The voices in defense of managed care that were initially less numerous and distinct, were growing in number and strength. For example, Cooperman, a physician, reported on his 1995 Medicare HMO study (N = 2673) in California, that 70

percent were highly satisfied with their HMO and 81 percent planned to re-enroll, although satisfaction rates were 75 percent among the healthy, and only 56 percent among the sick (1995). Dubois and Greenfield (1996), recapping a discussion of six ethicists, found that all agreed that there was nothing intrinsically unethical about capitation and health care rationing, observing that fee-for-service also had its problems. Managed care, they said, was freeing money for care in other areas, caused budgets to be confronted, priorities set, necessitating coordination of care. They concluded that the nation could not spend trillions on health care. They found that new values needed to be articulated, and a new, caring model of physicians and health care organizations (such as that on US TV's ER) needed to be created. Gradison also asserted that there was no evidence indicating that managed care and capitation was less ethical than fee-for-service. Opposition, he found, was mostly based on anecdotes, using no good outcome studies. He echoed a number of other writers (Bock & Schur, 1998; Gabel, 1998; Grimaldi, 1996; Naylor, 1998) who felt that it was imperative to monitor physician outcomes, enhance quality, increase customer satisfaction and decrease litigation. He concluded that managed care reflected a gradual change in the culture of health care, in the way people think about decisions they face (Gradison, 1996).

Moreover, in an address delivered by Robert Gifford, M.D. at the 1997 Yale Medical School commencement, he said,

The opportunities of managed care have never been better able to provide more of our citizens with comprehensive health care. It is a concept made to order for an emphasis on primary care and for the development of long-over-due, effective programs of preventive medicine through routine screening and better immunizations. It also promises centralized record-keeping and fosters new opportunities for clinical research . . . to cut costs legitimately. . . . Costs can be significantly reduced. . . . There have been outstanding examples of well-run managed care organizations in this country. . . .

(PP. 8-9)

Additionally, there are other voices (Dubois & Greenfield, 1996; Gifford, 1997; Iglehart, 1998; Tjosvold & MacPherson, 1996) who are encouraging physicians, other health care professionals and administrators to step into more of a leadership position in managed care.

As health care professionals respond to this encouragement to reclaim their leadership position, as they seem to be doing gradually, it may signal an end to the Victim position of these groups. In doing so, there is a necessity to assume more responsibility for the excesses of the past (Weinstein, 1998: 36-7) and acknowledge the need of the nation to control health care costs and improve health care quality. Ellwood and Lundberg, writing in JAMA, said, 'We physicians no longer have a health system that was

built by us and sometimes for us' (1996: 1083). A very hopeful development is the evidencebased care movement that would establish practice guidelines to deal with the huge information overload for caregivers (Hunt & Newman, 1997; Lagoe & Aspling, 1996). This effort would also help to re-establish physician leadership.

The government (state and federal) is still occupying a somewhat diluted Rescuer position, in responding to the cry for health care regulatory legislation. Annas and others (Klein, 1998; Weinstein, 1998), reported on the necessity for passing Clinton's National Bill of Patients' Rights to restore people to patients, not consumers, and doctors to professionals, not gatekeepers (Annas, 1998). A recent poll conducted by the Washington Post/ABC News indicates that 60 percent of Americans favor tougher government regulation of MCOs (Gapay, 1998). Some, however, feel this legislation is too watered down to be effective (Weinstein, 1998), which may indicate the government is backing off from its Rescuer position as health care professionals assume more responsibility to reduce costs and deliver quality care. The media seems also to be backing off from its Persecutor role of managed care in response to the changing position of health care professionals. Another indicator of a more integrated, healthy system is the relative decrease in scapegoating and mutual negative scapegoating which signal more cooperative group and intergroup behavior. But it is a precarious truce, at best. It is possible that one of the reasons for physician compliance with HMO dictates and the press pursuit of other topics may be simply a 'standoff, born of voices hoarse from protest and lack of availability of remedies, since the system is locked in seemingly unresolvable value conflict.

Outcomes of this analysis of the managed care era

The question left unanswered is whether or not MCOs, who are still in the (somewhat diluted) Victim position and Villain role, will be scapegoated, to be replaced by MSAs (medical savings accounts) or a one-payer system like Canada's (Budetti, 1997; Moffit et al., 1996; Schlafly, 1996; Woolhandler & Himmelstein, 1995). While these options do not enjoy much support, MCOs need to address their bad image (see Tabak, 1998; Weber, 1997; Wickler, 1997) as soon as possible. They have made the same mistake that health professionals made in the fee-for-service system, only more so - blatant commercialism (Ginsberg, 1996; Mitka, 1996). It is certainly a reality that many HMOs are stockholder owned and thus, profit oriented; but they need to do a better job of convincing their customers that they are committed to patient welfare. A remedy to this image problem may be MCO ethics codes (see Belcher, 1998) and report cards providing consumer information on quality, cost effectiveness and prevention (Roper & Cutler, 1989; Rubin, 1996; Weinstein, 1998). These measures may help to lessen value conflicts and the mutual negative stereotyping that does persist; currently, MCOs charge the news media with bias, and the news media charge MCOs with obscuring how they actually operate. By doing

so, the news media allege, MCOs actually contribute to the validity of the media's position (Ignagni, 1998; Weber, 1997).

One thing is clear from the American public's interaction with the health care industry over the past decades, and that is the certainty that health care is considered to be in a special category, defined by covenants, not contracts. It is also clear that we must find a way to cut health care costs that is acceptable to the American public, most likely through some form of managed care - which inevitably means some sort of rationing. There are no easy, readily available answers to these value conflicts. In fact, it appears that there is a movement to take a step backward as various large HMOs are responding to the money crunch by raising rates due to increasing demand, not cutting or even maintaining costs (Steinhauer, 1999). Additionally, one major US HMO has recently begun to segment their market, announcing higher rates for the elderly only, while keeping premiums for the rest of their customers stable. Even more ominous is the statement by a president of an HMO (in Minneapolis, Minnesota), George Halverson, who said a few years ago that 'It is clear to any reasonable observer that US insurers try not to insure sick people' (Jurgensen, 1998: 10A). These worrisome developments may signal a return to conflict and chaos in the health care system, thus triggering an increase in the prevalence of the unconscious processes discussed in this article.

The American public cannot remain a passive actor in this process, wrapped up in the cocoon of the role of Victim, unable to move beyond the image of the pre-conscious Child archetype. The people of this nation (including the medical profession) have played a major role in expecting and demanding quality care for all. The general public seems reluctant to commit to rationing, even though we are still spending too much on medical care and costs are currently escalating. At the same time, there is agreement among many health care researchers that assertive dialogue must take place to resolve current conflicting values representing unattainable ends in health care (Ellwood & Lundberg, 1996; Gifford, 1997). During the transformation of health care, when there seemed to be common agreement and optimism about the ability of HMOs to limit costs, it seemed as if the archetypical image of the Group was evoked to assist in the process of moving away from unlimited care for all and the rule of the Father, represented by physicians. New leaders were sought in HMOs to guide us into a new, more rational, cost-effective era of health care. This hope has dimmed considerably, due to the possible inability of patients to move away from the regressive pull of Father (and Mother), as they keep the pressure high for costly medical care, HMOs seem to be caving in to this public demand by raising premiums to cover increasing costs, rather than limiting ('managing') care and costs. If the HMO era recedes, the search for new leadership (a new Hero) will inevitably occur. This process will surely repeat itself until people in the culture become more in touch with religio and contact with both sides of the archetypical Self, as well as an understanding of the continuity of life and death.

The managed care industry is experiencing a critical point in its development. If it is to survive, it clearly needs a new ethical vision, which will lead to developing 'a strong ethical capacity' (Anderson, 1997: 31) for 'The use of a resources allocation mechanism like managed care expands the needs of conscience with those of man-willed choice' (Curtin, 1996: 71). This industry is in imminent danger of being scapegoated if it continues to respond to increasing demand and costs by raising premiums and segmenting customers with differential premium schedules. It is clearly caught in value conflict between giving in to patient and physician demands for more and better care versus rationing and cost control. It is an unenviable position!

How does this industry avoid becoming a Victim and scapegoat? One way may be to gain an understanding of the unconscious processes active in the system, and refuse to introject the scapegoat role, thereby blocking the projection. Then, it would be useful to assertively initiate a dialogue with leaders in the press and political system and hence, the American public, about the value conflicts which exists. This, of course, entails an understanding by MCOs of the predicament with which they are faced, along with proactive behavior to resolve the conflict that clearly resides in the American culture. Egocentric behavior will be a great deterrent to a resolution of this conflict, as well as unconscious processes evoked in patients and health care professionals. It is the responsibility of health care researchers and writers to be more active and assertive about discussing and explaining the dynamics of this dysfunctional system in a way that ordinary people can understand. Most importantly, all actors in this drama need to understand how and why projection and scapegoating work, and how to avoid colluding in this process; that is, by refusing to play the role assigned to them.

The knowledge of unconscious processes in groups and its consequences, as well as surfacing one's own role in this process and becoming aware of some of the content of one's own unconscious, is often a difficult process involving considerable time, study, personal commitment and the willingness to be introspective. This has been done quite successfully, in some cases, by attending a class or seminar in which participants read and discuss material covering individual, group, intergroup and organizational unconscious processes. Participants are also invited to take part in experiential exercises designed to surface individual, group and intergroup unconscious processes. This type of experience should always be lead by an organizational psychologist who has been trained and is experienced in psychoanalytic group process consulting, and is a seminar that could be offered as part of a hospital-sponsored continuing education program. This type of course is also offered at many colleges and universities. Examples of material to be covered in such a seminar are contained in this article (for example, Bayes & Newton (1985), Berne (1963), Brown (1978), Jung (1959, 1969, 1970), Morgan (1986), Smith (1983), Wells (1985), among other excellent sources of psychoanalytic group process literature).

Additionally, the kinds of experiential exercises that could assist in gradually surfacing individual and group unconscious processes are the following. A good first exercise is to ask participants to write their own eulogy (not about what they have done, but about what kind of person they have been), which, for many, begins the process of introspective examination of existential life goals. Another good exercise for a new group is to work on improving the communication process, role-playing different communication styles (including aggressive) and exploring the reactions of the listener. The leader can then gradually move into exploring unconscious types of communication, such as non-verbals, 'Freudian slips' and double messages. An exercise that is appropriate for more established groups is sharing personal impressions of one's partner in dyads using the Johari Window which includes not only parts of self that are at an awareness level, but parts of self known to others, but not to self, or the 'blind self (Pfeiffer & Jones, 1: 1974b, 65-69). Pfeiffer and Jones is a good source for these types of group exercises for groups at various stages of development. They present a set of 10 volumes of group exercises which they allow to be reproduced for the purpose of self-discovery and understanding group process (Pfeiffer & Jones, 1974a).

Once this existential quest has begun for individuals, there are a number of ways it can be enhanced or continued. For example, the Tavistock Institute, London, began Leadership Conferences that are now presented at a number of major university centers in the USA. Attending one of these conferences can be a powerful experience, imparting insight about groups, intergroups, leadership and, of course, oneself. Another way of expanding this type of quest is to keep a diary, not only of one's conscious thoughts, but of one's dreams, which are a window to the unconscious. One could also participate in an ongoing group lead by a psychologist trained in group process. It is important to point out that the quest for the personal and group knowledge being discussed here cannot be pursued without the help of a trained professional, and done, at least in part, as a member of a group. Most of all, one must be willing to take a look at unknown parts of the personality with the enormous payoff of a deeper understanding of the meaning of one's life, and the life cycle, in general. This type of experience can be, and is for many, a life-changing process that is well worth the time and effort expended. It begins a process that can last for a lifetime!

Summary and conclusion

This systems analysis has attempted to track the unconscious life of groups of players in the health care system as it was transformed from fee-for-service to managed care. Central to this transformation was value conflict around the allegation that health care is just a business like any other, and the belief that health care is in a special category since it deals with life and death issues, vulnerability and fear, pain and suffering. Specific value conflicts were identified having to do with this central issue: covenant

versus contract, cost versus quality and universal care versus care only for those who can pay. The conflict between health care as big business in the HMO era has exacerbated these value conflicts.

After a discussion of various theories that were to be used in this systems analysis, a retrospective view of the fee-for-service era was discussed, followed by an analysis using these theoretical orientations to elucidate unconscious roles and processes of the major players during this period. As the transformation of the health care system ensued, the reader is able to track the changing mosaic of primitive, unconscious processes caused by the chaotic instability of the system due to unresolved value conflicts. Unconscious processes activate when particularly threatening situations appear and gain potency as conscious processes are correspondingly weakened (Jung, 1970; Whitmont, 1969). Archetypes shifted from pole to pole, roles switched back and forth and scapegoats were sought and cast out. These draconian shifts, from dark to light and back again were symptomatic of unconscious processes.

For patients, it was hypothesized that the loss of religio and contact with the wholeness of the Self, as well as fear of death and abandonment, may have triggered unconscious processes, evoking the image of the pre-conscious Child. Others active in the system introjected patients' projections, colluding with them to become Villains or Heroes, Persecutors, Rescuers or Victims, Mothers and Fathers, among other archetypes. In reality, they were just people caught in unconscious processes, sucked into roles not of their choosing.

For a short time, there has seemed to be more stability in the health care system, as the necessity for some sort of rationing was beginning to be accepted as inevitable. As a result, we are beginning to observe more rational, conscious behavior as the vulnerability and helplessness, triggered by the life/death issues, gradually decreases. Physicians and other health care professionals, as well as patients, are gradually becoming more active and engaging in more purposeful behavior. The media seems to be less focused on MCOs, for the time being, and some MCOs seem to be more customer oriented as the competition between them increases and the more poorly managed ones disappear. But the storm clouds may be gathering again with the advent of premium increases and market segmentation, inevitably triggering the chaos and fear that lie just below the surface. As long as health care system values conflicts are not resolved, it is a system at risk.

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