

NEGOTIATING CHANGE:
VICIOUS AND VIRTUOUS CYCLES OF EMPLOYEE INITIATIVE-TAKING
AND ORGANIZATIONAL RESPONSE

JEFFERY A. THOMPSON
Richard T. Farmer School of Business Administration
Miami University
307 Laws Hall
Oxford, OH 45056
(513) 529-4746
thomps14@muohio.edu

ANDREW H. VAN DE VEN
Carlson School of Management
University of Minnesota
Minneapolis, MN 55455
(612) 624-9055
avandeven@csom.umn.edu

March 15, 2002

Acknowledgments: We gratefully acknowledge the contribution of our fellow researchers in the Minnesota Health System Integration project: Stuart Bunderson, Jerry Ellis, Shawn Lofstrom, Russel Rogers, and Frank Schultz. In addition, this project would have been impossible without the support, both moral and material, from health care managers and practitioners of *Midwest Health System*.

NEGOTIATING CHANGE:
VICIOUS AND VIRTUOUS CYCLES OF EMPLOYEE INITIATIVE-TAKING
AND ORGANIZATIONAL RESPONSE

ABSTRACT

We report the results of a grounded theory-building analysis of 18 physician cases, elicited via interviews, that reveal “virtuous cycles” of individual initiative and organizational enablement, versus “vicious cycles” of organizational constraint and individual withdrawal, in physicians’ transitions to change. We develop three archetypal narratives of transition and conduct an event frequency analysis. Based on these analyses, we induce a process model of initiative-taking and organizational response. A key theme is that employees who successfully adapt to organizational change tend to view it as an opportunity to participate in the crafting of the organization.

“If you don’t want to be dictated to, go make the policy.”

— A physician employed by a large managed care health system

Organizational socialization has been characterized as the process by which a person “accepts the established ways of a particular organization” (Taormina, 1997: 27) and adapts to norms and rules associated with a new role (Van Maanen and Schein, 1979). Recent research, however, emphasizes employee proactivity in the socialization process. Wrzesniewski and Dutton (2001) depicted employees as “job crafters” who actively construct their work, and Ibarra (1999) illustrated how employees experiment with “provisional selves” to navigate career transitions. Others have emphasized personal initiative (Frese, *et al*, 1996), proactive personality (Bateman and Crant, 1993), and taking charge (Morrison and Phelps, 1999) at work. This research casts the individual in an agentic role, rather than merely as a recipient of socialization.

Most research on employee proactivity has focused on initiating change only within the bounds of organizational goals. For instance, Frese *et al*, (1996) define personal initiative as behaviors consistent with organizational mission, and Wanberg and Kammeyer-Mueller (2000) operationalize proactivity as the use of tactics that align employees to fit the organization. An alternative perspective is that employees pursue initiatives to shape the organization to align with their own preferences. Especially during change, proactivity may reflect an attempt to “enact” a context rather than just respond to it (Louis, 1980; Schneider, 1987). This lens recasts organizational change as a negotiated process of behavioral interactions between individuals and organizations in which both adopt alternately proactive and reactive stances as they mutually accommodate to changing structures and roles. The perspective

also introduces a nuance largely missing from proactivity literature – the possibility that organizational agents will reject initiative attempts. Research on proactive personality, for instance, has focused exclusively on positive outcomes such as career success (e.g., Seibert, Crant and Kraimer, 1999). A dynamic view of initiative-taking as a negotiated process of enactment introduces the possibility that rejection and negative outcomes may follow initiative-taking by proactive employees.

This longitudinal research examines the ways in which eighteen physicians took initiatives and adapted to organizational responses as their private medical clinics were acquired and integrated in to a large medical group practice from 1995 to 1997. Following Poole et al.'s (2000) strategies for process research we adopted an inductive approach to building a process theory of individual-organization interaction that is grounded in the stories and event sequences experience by the eighteen physicians. The model that emerged from our analysis depicts physicians and their organizations engaged in cycles of proactive-reactive behaviors. The model casts organizational change as a cyclical negotiation process spiraling toward virtuous cycles of proactivity and engagement, or toward vicious cycles of constraint and withdrawal. The model's key contributions include introducing a process view of employee proactivity, and portraying change as a negotiated behavioral exchange.

Initiative-Taking as Process

Proactivity research has proceeded in at least three distinct, though conceptually overlapping, streams. One nascent stream has focused on dispositional tendencies toward proactivity and their outcomes. Crant and his colleagues have shown that proactive personality fosters job performance (Crant, 1995), career success (Seibert, Crant and Kraimer, 1999), and supervisor perceptions of charismatic

leadership (Crant and Bateman, 2000). Proactive personality is viewed as a stable trait and is measured as a continuous variable using self-reported items (Bateman and Crant, 1993).

A second stream emphasizes general behavioral manifestations of proactivity. Frese and his colleagues conceptualize initiative as a “behavior syndrome” in which individuals adopt an active orientation that goes beyond formal work requirements (Frese, *et al*, 1996). Relative to proactive personality research, Frese’s initiative research has paid more attention to antecedents. Measuring initiative using interview-based scales from behavioral accounts, his studies show that work control and work complexity foster personal initiative (Frese, *et al*, 1996), and that self-efficacy mediates the relationships between initiative and both control and complexity (Speier and Frese, 1997). Research has shown that initiative is positively related to need for achievement and career planning (Frese, *et al*, 1997).

The most vibrant, yet least integrated stream examines specific proactive behaviors, often by new job entrants. Research shows that employees adopt proactive self-socialization tactics such as feedback-seeking (Ashford and Cummings, 1985; Vandewalle, *et al*, 2000), information-seeking (Miller and Jablin, 1991; Morrison, 1993a), behavioral self-management (Saks and Ashforth, 1996), and tactics designed to gain personal control (Ashford and Black, 1996). These studies tend to measure proactivity as a continuous variable. Implications of these strategies for job performance remain somewhat unclear. Morrison (1993b) found a positive impact of feedback-seeking on performance, but Ashford and Black (1996) did not. Wanberg and Kammeyer-Mueller (2000) found that feedback seeking and relationship building foster job satisfaction and social integration, among other outcomes.

Researchers have also studied specific initiative behaviors not limited to new job entrants. These include task revision, which involves correcting faulty procedures (Staw and Boettger, 1990), innovative behavior, which involves generating and implementing ideas and solutions (Scott and Bruce, 1994), taking charge, which involves discretionary measures to effect functional change (Morrison and Phelps, 1999), and issue-selling, which involves upward influence attempts to direct the attention of top management (Dutton, *et al*, 2001). More attention has been devoted to elucidating these behaviors than to specifying the outcomes associated with each.

Collectively, these streams of research contribute immensely to our understanding of the extent to which individuals assume active roles in shaping their work. Nevertheless, research has yet to shed much light on initiative-taking as a process. Crant (2000) identified the need for process theory as the most important research opportunity in the proactivity literature. This is because proactive behaviors rarely occur simply as discrete events or behavioral tendencies. Behind every incidence of proactivity is a story that may include problem discovery, calculating risks and opportunities, feelings of vulnerability and/or excitement, an organizational response, and an outcome that may impact future initiatives. Such stories, as told by transitioning physicians, piqued our interest in initiative-taking as a process of individual-organizational negotiation of change and provided the grist for the model we develop herein.

Because the term 'process' is used in different ways in the literature, it is important to clarify that we view 'process' as a developmental sequence of events (Van de Ven, 1992). We define 'process theory' as an explanation of how and why a developmental event sequence unfolds in terms of its underlying generative mechanisms and the particular circumstances or contingencies when these mechanisms

operate (Tsoukas, 1989; Poole, et al., 2000). The central concept that distinguishes our process-orientation from other proactivity studies is “initiative-taking,” defined as an incident in which an individual or group undertakes self-directed efforts to expand or change norms of organizational practice or strategy. Initiative-taking is related to other concepts we have described¹, and subsumes behaviors such as principled organizational dissent (Graham, 1986), task revision (Staw and Boettger, 1990), and innovative behavior (Scott and Bruce, 1994). One difference is that our process interest lies in the sequence of events surrounding initiative-taking behaviors, rather than the extent to which they occur. In other words, we view initiative-taking as temporal progression of events, rather than as a variable that ranges from low to high.

Adopting an individual-organization interaction perspective, a second key process concept that we examine is how organizations respond to initiative taking events. Adler and Borys (1996) characterized bureaucratic orientations toward employees as either enabling or coercive. They argued that enabling bureaucracies respond by inviting employee involvement in change and open information and communications about organizational processes, while coercive bureaucracies constrain employee involvement and initiative. We pursued a grounded theory-building analysis of the negotiated or interactive sequence of events in which employees take initiative and organizational agents respond in crafting organizational changes.

Research Setting and Methodology

Field Research Setting

Regulatory and competitive forces in the health care industry have recently spawned large integrated health systems that incorporate insurance plans, hospitals, and clinical practices, which have historically operated independently and often adversarially. As a consequence, many small clinics, unable to compete with the giant health systems, face two painful alternatives: affiliate or liquidate. The popular press has paid much attention to the plight of clinical practices consumed by health systems (e.g., Adelson, 1997), but few scholars have examined how physicians cope with the transition (Hoff and McCaffrey, 1996; Thompson and Van de Ven, 2002).

We have been conducting a longitudinal study of the integration of medical clinics recently acquired by *Midwest Health System*. *Midwest* is a vertically integrated, not-for-profit system with 20,000 employees in two Midwestern states. It is comprised of a hospital organization, a health plan, and a group practice of about 50 primary care and specialty clinics. The merger of the hospital and health plan components of *Midwest* took place in 1994. Most clinics were acquired shortly thereafter. Our study of *Midwest* began in 1994 and is still ongoing. One focus is the transitions of physicians whose formally defined roles and work settings remain ostensibly unchanged, but whose organizational context has changed dramatically. To examine these processes as they unfolded, we pursued multiple methods of data collection, including periodic interviews with managers and physicians, attendance and recording of manager and physician meetings, site visits to clinics, and an annual employee survey.

Initial physician interviews in 1995 to 1996 revealed that some physicians were enthusiastic about integration, but many felt deep frustration and loss. What most distinguished frustrated and enthusiastic physicians was their perception of tension, or lack thereof, between *Midwest* and the medical profession itself. Frustrated physicians reported that their allegiances to *Midwest* and to the profession were mutually exclusive. One noted, "In [*Midwest*'s] quest for efficiency it is often the patient that suffers." Physicians who were energized by the transition reported no such tension. One stated, "*Midwest* makes sense. The combination (of health plan, hospitals, and clinics) is very powerful."

To explain differences in reactions to these changes, we turned to the survey data for insights about tensions between organizational and professional commitment. Annual employee surveys began in 1995 using the Healthcare Organization Survey (Van de Ven, *et al*, 2001). Analysis of changes in physicians' organizational and professional commitments in the 1995, 1996 and 1997 surveys revealed striking patterns. We used a Q-sort technique, conducted by a focus group of colleagues, to categorize patterns of commitment change over the three-year period. Three categories of change emerged: 1) a *compatible* commitments group: physicians who exhibited increases over time in both organizational and professional commitment, 2) a *polarizing* commitments group: physicians who exhibited decreases in organizational commitment while professional commitment increased or remained steady, and 3) a *no-change* group: individuals who exhibited little or no change in commitment over time². Employing these distinctions, we sought to gain a richer understanding of the dynamics of physicians' transitions by interviewing physicians who represent each of the three trajectories of commitment change.

Physician Selection and Interviews

From among the 48 physicians who completed all three annual surveys in 1995, 1996, and 1997, we selected 20 whose responses epitomized the three commitment change patterns (e.g., exhibited the largest changes). This strategy is consistent with Eisenhardt's (1989) and Pettigrew's (1990) prescription to examine extreme cases rather than those who fall at the mean when using cases for inductive research. An additional selection consideration was to maximize demographic variety in physician practice types (e.g., primary care versus internal medicine), gender, experience, clinic size and location (urban versus rural). Ultimately, 18 of the 20 physicians agreed to interviews, seven each from the compatible and polarizing groups, and four from the no-change group. Table 1 provides a general description of the participants.

INSERT TABLE 1 ABOUT HERE

Physician interviews ranged from 40 to 90 minutes in length, with a mean of about 60 minutes. We tape-recorded all interviews and transcribed them verbatim. Interviews were semi-structured and followed a protocol that prompted the physician to relate, in chronological progression, the story of his or her relationship with *Midwest*. Our questions were largely non-directive and generally sought to identify the time frame of critical incidents (e.g., "When did that happen?") or to remind the physician to pursue a chronological narrative (e.g., "So what happened next?").

Analysis

Langley (1999) and Van de Ven and Poole (2001) describe a variety of strategies for theorizing from process data. Two of these – narrative and quantification strategies – represent complementary

strategies for achieving accuracy on the one hand, and generality on the other. To offset innate limitations of each, we adopted the narrative strategy to unearth detail-rich themes in the physician interviews, and then adopted a quantification strategy to determine the generality of those themes and to assist us in inducing a parsimonious model from the data.

Our first step in the analysis of the raw interview data was to develop a chronological list of events that was reported by each physician. Following the procedures described by Poole, et al. (2000), an event was defined as any incident that signaled change in the physician's behaviors, attitudes, or perceptions regarding the organization or profession. For each interview, we created an event sequence table that listed each event in chronological order. The number of events in the tables ranged from 13 to 39 (446 events overall for an average of 24.8 per physician). To establish the accuracy of the chronological events, we mailed each to the home address of the physician whose story it summarized and asked him or her to make needed revisions and return it to us. Thirteen of the 18 physicians responded to the request; none suggested substantive changes to the tables, although several clarified dates or the chronology of particular events.

Our next step in the analysis was to implement the narrative strategy by constructing a detailed story about the chronological event sequences experienced by physicians in each transition group. We developed three composite narratives, each combining the experiences and observations reported by physicians within one of the three commitment change groups. These composite stories were written to capture the key issues and events that physicians expressed in the interviews while insuring anonymity for each physician. Although the narratives combine events in a way that does not represent a "true"

story for any one physician, all of the described events actually occurred among one or more physicians in each group. Because we integrated the most memorable events, the narratives tend to be more dramatic than any one individual's story might be. This is consistent with our intent, however, which is less journalistic than dramaturgical. The narratives convey stories that illustrate, in sharp clarity, distinctions that underlie the experiences of physicians in the three commitment change patterns.

Our procedure for constructing the narratives followed prescriptions for grounded theory-building (Glaser and Strauss, 1967). We read the transcripts many times to become deeply familiar with content. At the same time, we recorded observations about themes that appeared to link some stories, but differentiate between others. After developing themes, we selected elements of each physician's story to integrate into a single, archetypal story for his or her particular group. The first author drafted the narratives. Both authors then collaborated in revising them to ensure accuracy and coherence.

In the third step of data analysis we developed a coding scheme to categorize organizational responses to the initiating events in the chronological event lists of each physician. Consistent with Adler and Borys' (1996) enabling-coercive framework, we defined *a priori* two event types—organizational enabling events and organizational constraining events—because of their utility in characterizing generic organizational treatment of physicians. These *a priori* constructs were used to anchor the coding process. Other codes emerged through an inductive categorization process, in which we first extracted each event from its table, retaining as notes, however, contextual or evaluative information that we deemed necessary for coding the event. Following the coding procedures discussed by Poole, et al. (2000), we next grouped events by actor, i.e., the agent of the decision or behavior that constituted the

event. We identified three actor types. The first was “individual/clinic,” which characterizes events originated by the physician, acting either alone or in concert with clinic partners³. The second actor type was “organization,” which refers to events originating with the decisions and actions of *Midwest* and its agents. The third was “environment” which encompassed contextual events that figured into the physician’s narrative. After coding each event by actor, we next began a process of grouping the events by similarity of content (e.g., career landmark events, clinic merger events, initiative-taking events). Based on a lengthy, collaborative, and iterative categorization process, we settled on the scheme described in Appendix 1, which comprises 17 total event codes.

After categorizing all events, we assessed inter-rater reliability by eliciting the assistance of an independent assistant to code all events using the scheme. Agreement was 92% for actor and 78% for event type. Subsequent to the inter-rater reliability analysis, we discussed all discrepancies with the assistant and reached consensus on proper coding.

Using the coded event data, we tabulated the frequency of event types for physicians in each of the three commitment change groups. We assessed the extent to which differences in frequency and, where observable, sequence of event types conformed to themes derived from the narratives. We also examined unanticipated differences in event type frequency between groups that might suggest important themes to augment our grounded theory. For each difference we identified, we returned to the actual events to evaluate why it might be important. This process allowed us to derive new themes to incorporate into our model of initiative-taking and organizational response.

Results

We begin the results by presenting three composite narratives representing each of the three commitment change groups. We then examine the generality of key themes in the narratives by analyzing the temporal event sequences of all physicians. The first narrative, Dr. Bitter's story, integrates the experiences of physicians who, during their first three years at *Midwest*, exhibited polarizing commitments to their organization and medical profession (i.e., decreases in organizational commitment and increases in professional commitment). The second narrative, Dr. Neutral's, reflects the story of physicians whose commitment scores were mid-range and changed little over the three years. Finally, Dr. Eager's story integrates accounts of physicians who exhibited increases in both organizational and professional commitment subsequent to joining *Midwest*.

Narratives

Dr. Bitter's Story. Dr. Bitter's clinical partners began considering affiliating with a health system because their internal medicine clinic was facing increasing government regulation that taxed their ability to manage the practice. Dr. Bitter saw the issue in semi-conspiracy terms: "There was no future in private practice; the People's Republic of [the state] has ruled: They don't want choice; they want large institutional care."

After a long and tortuous series of discussions with various health systems, the hospital at which the clinic's physicians practiced began to pressure them to join *Midwest* because of its own affiliation with the organization. Dr. Bitter noted that "none of us trusted *Midwest*. They were not up-front people...It

was always adversarial.” Despite the distrust, Dr. Bitter’s partners decided to join *Midwest* against the single contrary vote of Dr. Bitter. To her surprise, Dr. Bitter was asked to assume the role of lead physician in the clinic under the auspices of *Midwest*. She immediately refused, pointing out that “I am not the leader type. I detest meetings.” One of the younger physicians assumed the role.

Although the first months of affiliation brought few major changes, minor annoyances surfaced. For instance, physicians’ names were removed from the yellow pages, replaced by a generic *Midwest* listing. The number of meetings skyrocketed after *Midwest* assigned a new clinic manager. The clinic staff was also required, for the first time, to complete time cards. These minor changes added up to a sense of gnawing irritation for Dr. Bitter. She had hoped that the clinic would proceed as usual after the affiliation, but the new administrative policies were “a reminder that yes, you are an employee.”

In late 1995, Dr. Bitter realized that her minor sense of annoyance masked her denial of how sweepingly the changes were going to affect her. Several events in late 1995 left Dr. Bitter feeling angry and disenfranchised from *Midwest*. First, the president of *Midwest*’s medical group held a retreat for all physicians in September 1995 to articulate his vision for the group. Dr. Bitter felt that the president’s vision reflected a strong bias toward family practice and that he had no vision for how internal medicine would fit into the organization. Several weeks later, *Midwest* announced that another internal medicine clinic was to be consolidated into Dr. Bitter’s clinic. The decision itself was not as upsetting to Dr. Bitter as was its management. The announcement felt to her like an “edict” – there was no participation from either clinic in the decision and Dr. Bitter felt helpless to make an impact. Nor did *Midwest* provide any sort of “matrimony event” for the clinics. They were simply co-located with very little coordination, and

cultural conflicts followed. Third, *Midwest* made an end-of-year announcement that a central billing office (CBO) would be formed, moving all clinic billing processes to *Midwest* administration. This decision resulted in the first layoffs ever to occur in Dr. Bitter's clinic. It also took out of the clinic's control the ability to assist patients with billing problems. The decision was wildly unpopular in the clinic, and Dr. Bitter felt that her autonomy was seriously undermined.

By 1996, *Midwest's* financial performance was eroding. Dr. Bitter's clinic began to receive pressure from *Midwest* management to see more patients. The District Director met with each physician to set targets for patient volume. Dr. Bitter found this insulting and negligent of the fact that internists tend to see sicker patients who require more time. The pressure to produce was embodied within the incentive structure in early 1997. Dr. Bitter calculated that she would have to work 60 hours per week on patient care alone if she were to make her usual salary under the new system. She refused to "churn people through" the clinic at the rate *Midwest* suggested. Largely as a response to the new policy, a physician exodus ensued. Four doctors resigned within a year, as did the clinic manager and several administrative staff. *Midwest* acted slowly to replace them, taking seven months before even hiring a new manager. Dr. Bitter and her physician colleagues began to assume administrative tasks.

With no reinforcements in sight, the physicians attempted process redesign on their own to increase clinic efficiency. A team, including Dr. Bitter, met to discuss workflow improvements. After two months, the team began to implement changes. When the District Director realized what the clinic was doing, he called a meeting with the physicians and, in Dr. Bitter's recollection, screamed: "You don't micro-

manage! *We're* the managers. We'll figure out and deal with the management problems." The physicians relented and abandoned the initiative.

In the face of these efforts to stay afloat despite *Midwest's* neglect, Dr. Bitter was galled to hear in 1998 an organization-wide presentation of management's new vision, entitled the "*Midwest Experience*," which she felt pinned blame for poor performance on the physicians themselves. For Dr. Bitter, this constituted a "last straw." She began to consider how she might leave the organization and re-establish herself in another clinic or give up the practice of medicine altogether. She reflects:

"If I were 19 now, I would not apply to medical school...People who are entering the practice of medicine now have to recognize that they're going to be employees and not individual practitioners... I hope that there will be somebody who's going to give a damn about taking care of patients when my grandkids need some help."

When asked if any good had come from affiliating with *Midwest*, she replied: "We sold our practice at a good price. That wouldn't have happened in the old marketplace. And I paid for my granddaughter's college education." Ironically, her granddaughter wants to be a doctor.

Dr. Neutral's Story. When Dr. Neutral joined his family practice clinic, it was already considering affiliating with a large health system to enhance its ability to negotiate with health plans. Dr. Neutral had no qualms about this:

"It didn't matter to me one way or another, to be honest. I just wanted to practice medicine...Frankly, I was kind of glad to be joining an organization where...
[managers] will worry about the crap."

The clinic began negotiating with *Midwest* in 1994 and quickly reached an agreement to sell. The clinic's lead physician was immediately given an administrative position within *Midwest*, and approached Dr. Neutral about taking his place. Dr. Neutral consented.

Very little changed in the clinic as a result of the merger. Dr. Neutral perceived that *Midwest* generally let the clinic run its own business. He observed: "We work hard and meet our targets, ...break even or make a little money for them, and they continue to leave us alone. A lot of autonomy still remains in the doctor's hands." But by 1995, Dr. Neutral felt that administrative burdens were increasing. Compared to his early career, he was doing much more paperwork and dealing with more referral hassles. Later that year, *Midwest* announced the creation of the CBO, which would remove billing from the clinics. The first sweeping change that Dr. Neutral observed, it caused numerous problems for the clinic and confusion among the patients. This did not surprise Dr. Neutral, however. He reflected philosophically, "I think that it took some getting used to...Frankly, whenever you get a new thing, they screw up."

A decision in late 1996 elicited a more emotional reaction from Dr. Neutral and his clinic, and proved to be a watershed event for the clinic's relationship with *Midwest*. It involved Dr. Optic, a respected ophthalmologist who had worked in the clinic for many years. The clinic's District Director unilaterally decided to move Dr. Optic's practice to a neighboring community that he felt had a more promising eye care market. The directive precipitated intense conflict at the clinic, as Dr. Optic assumed that his partners had been party to the decision. Tremendous animosity ensued. Dr. Optic threatened to resign. When *Midwest* managers became aware of the conflict, they met with Dr. Neutral, Dr. Optic, the District Director and several of the physicians. After very heated and painful discussion, the group reached a solution that allowed Dr. Optic to continue at the clinic. Dr. Neutral was impressed that

“*Midwest* didn’t act like some organization that we couldn’t talk to...They did hear us out...I was mollified, although clearly there was a communication problem.” After the crisis, however, Dr. Neutral had tired of the lead physician role. Early in 1997 he resigned the position because he felt he lacked the ambition to be a problem-solver. He observed, “I got burned out ...I got tired of hearing about problems and being asked to solve them... maybe I wasn’t the right person to do that job because I didn’t feel like I was carrying people’s concerns up the ladder in a way that they wished I had.”

Another sweeping change also arrived in 1997 – the roll-out of a new compensation system based on productivity rather than on salary guarantees. Dr. Neutral at first embraced the system, feeling it would motivate some physicians that he felt were slacking off. However, he soon realized that *Midwest’s* narrow definition of productivity provided a tool to “ratchet down” on physicians to produce large numbers of patient visits. Although the system affected his own salary very little, Dr. Neutral’s specialist colleagues were suddenly making much less than they had in the past, and future cuts appeared inevitable. Two specialists resigned in protest of this “very oppressive system,” and the clinic began voicing its concern about the policy to *Midwest*. Once again, *Midwest* appeared to heed the clinic’s concerns. It eventually backed off from the rigidity of the production-based system, allowing for specialists to be paid at a higher rate than primary care providers. Dr. Neutral expressed relief.

Looking back over his transition, Dr. Neutral feels that it went about as well as could be expected. He noted, “I think we all expect some growing pains...It would be naïve for anybody to imagine that this would just smoothly turn into a big giant beautifully functioning organization.” Nevertheless, Dr. Neutral is not devoted to *Midwest*, nor does he strongly identify with the organization. He comments:

“I don’t feel particularly imposed upon by *Midwest*. I don’t feel particularly supported either...If *Midwest* broke up tomorrow and we were back to being a single clinic, it wouldn’t make us feel good or bad. We’d just wonder how we’re going to pay the bills. It’s not a source of pride or dismay to be part of it, really...I certainly don’t feel any emotional attachment to it whatsoever.”

Dr. Eager’s Story. After earning her medical degree, Dr. Eager performed two years of missionary service in a third-world county providing primary care without pay. Upon her return to the U.S. she settled in the *Midwest* where she joined a small practice on the outskirts of the city. Although Dr. Eager had planned to spend her career as a private practitioner, she closely monitored the legislative and competitive changes that began to roll out in the early 1990s. She realized that these changes might mean that her clinic would someday need to partner with a larger system. By early 1994, the clinic had reached the same conclusion. Faced with competitive threats from health systems buying up clinics in the area, the physicians decided to sell.

Negotiations with *Midwest* went smoothly. One of the most important negotiation points was *Midwest*’s promise to build a new facility to replace the clinic’s aging offices. The facility would house Dr. Eager’s clinic, plus another local clinic *Midwest* had purchased. Before the contract was even signed, Dr. Eager’s partners decided to orchestrate a task force, including representatives from both clinics, to design the facility and plan the workspace. Dr. Eager recalls much enthusiasm in the clinic about the opportunity to participate in planning the new facility.

Dr. Eager's experiences during the first year of affiliation tended to reinforce her confidence in *Midwest*. Although she noticed some changes handed down from the organization, such as increased paperwork and requirements to learn new coding schemes, she realized that these were things the clinic would have needed to do anyway. In terms of the day-to-day practice, however, Dr. Eager felt that her autonomy was protected. In her perception, *Midwest's* approach was:

“this is your clinic, you run it and we'll oversee it' ...I don't feel like outsiders are coming in telling us what to do...Our clinic is our clinic. We have a subculture here that was not tampered with by *Midwest*. We keep dollar figures in good shape. We do our part. We're conscientious and they let us be. So I don't think that *Midwest* has changed us a lot...We are who we are.”

One change that did present a challenge to the clinic was the creation of the CBO in late 1995. Dr. Eager found it “a very awkward time for our patients” as she was no longer able to provide quick answers to billing questions. She recalls: “We knew that would be a challenge...I really didn't want us to lose that control because I knew we were doing so well with turnaround time.”

As *Midwest's* financials took a turn for the worse in 1996, management exerted pressure on the clinic to increase efficiency and productivity. Dr. Eager took this in stride. “We didn't have much emphasis on budget before [joining *Midwest*]. But, if management didn't make us do it, we'd have to be doing it on our own to survive... They're giving us the tools to help figure it out ourselves.” While budgetary pressures themselves did not cause a great deal of frustration for Dr. Eager, corporate *Midwest's* own wastefulness did. Dr. Eager became irritated that, in the face of clinical efficiency measures, *Midwest's*

main office continued to publish numerous and redundant glossy magazines. In late 1996, Dr. Eager and her colleagues confronted management about the issue. To their pleasure, they found an attentive audience and felt they had been heard. The number of glossy publications decreased shortly thereafter.

Two other experiences during the same period solidified Dr. Eager's perception that *Midwest* had the clinic's best interest in mind. First, physicians in the clinic had become very frustrated with the clinic manager, who had been hired by *Midwest*. She had alienated physicians and staff by creating a cadre of administrators who held seemingly clandestine meetings and attempted to implement unilateral decisions. The physicians called a meeting of the entire staff to "retake the clinic" and force out the tyrannical manager. They suspected that *Midwest* managers would try to subvert their decision. Instead, the president of *Midwest* contacted the physicians to congratulate them for stepping up to the challenge. The clinic manager was let go, and the physicians were allowed to choose her replacement.

Second, the physicians in the clinic made a radical decision to stop supporting the local hospital because of quality concerns, and instead to use a hospital owned by *Midwest's* competitor. They knew this would be highly controversial in the community, and extremely unconventional in terms of organizational strategy, but believed it to be in the best interest of their patients. They feared a bitter public outcry and management resistance. After consulting management about the decision and explaining their reasoning, *Midwest* vowed to stand by the clinic's decision, and provided public relations support as the clinic announced the decision to the local media.

In late 1996, Dr. Eager accepted an appointment as clinic medical director and assumed responsibility for clinical quality at the site. In this role, she served on two committees that gave her exposure to the

larger organization. She noted: “Before I became medical director, I had no idea what was out there. It’s only when you accept the responsibility to do something more than just see your clinic patients that you then get a link.” In her director role, Dr. Eager embraced the opportunity to make a difference. She selected several clinical quality initiatives to spearhead. Dearest to her was an effort to improve the quality of pre-natal care. She was pleased with the latitude *Midwest* gave her to pursue this effort. She commented: “There was nothing I wanted to do that was hindered. It was, ‘If you want to do this initiative, go ahead and do it’ ...I never had a ‘No, you can’t do that.’” Others in the clinic followed suit, and the clinic became known throughout *Midwest* as an innovator in healthcare improvement.

A controversial development arrived in 1997 with the rollout of “the *Midwest* Experience,” a vision for the organization that entailed substantial increases in clinics’ accountability for their outcomes. While many physicians expressed anger about the vision’s demands, Dr. Eager appreciated that there was a “really clear direction – a map of how we’re going to do what we need to do and the sense that we could achieve it.” She observed that the people who resisted the vision “were people who really couldn’t fit those expectations into their work ethic...The people who were okay with those expectations, for the most part, were people who were already meeting them.”

Overall, Dr. Eager expresses little sympathy for physicians who complain about *Midwest*. When asked why some physicians struggle so much with the transition, she suggests:

“Maybe they went into it with selfish expectations. They expected *Midwest* was going to do everything for them...My response to that is if you don’t want to be dictated to, go make the policy...It’s a very easy thing to complain. It’s more difficult, but more rewarding to make policy.”

Despite some challenges along her transition journey, Dr. Eager has few regrets: “I would certainly do it again without a second’s thought because the overall benefits have been far greater than the irritations.”

What has been the key to her positive feelings about *Midwest*? “It’s personal growth from...feeling like it is possible to have an impact – that even though we have this huge monolithic system, it is possible for one person to make a difference...And you don’t have to be president...That, I think, spurs commitment.”

Key Themes in the Narratives

The narratives depict three archetypal stories about individual transition to organizational change. Dr. Bitter embodies perceived vulnerability in the face of change; she entered *Midwest* only under duress, and was reticent to assume responsibility beyond her traditional role. Rather than preparing for change, she sought to shelter herself from it, and responded with helplessness when she found she could not avoid it. When she and her colleagues finally did attempt to take initiative (in their attempt to improve work design in the clinic), the organization quashed the effort, perhaps in response to their perceptions of the clinic’s tendency toward passive resistance. Dr. Bitter seems never to have recovered. The clinic’s initiative attempt was a turning point, and the organization’s strong-arm response appears to have sealed the “vicious cycle” of organizational imposition and employee withdrawal and resistance.

Dr. Neutral, in contrast, represents an ambivalent, somewhat complicated approach to transition. His story is evocative of Piderit’s (2000) multidimensional view of change-oriented attitudes, which rejects the simple notion of resistance to change. Piderit suggests that most behaviors that looks like resistance

are actually complex combinations of cognitive, affective, and intentional responses that are simultaneously supportive and reticent. Dr. Neutral's story captures the fits-and-starts and vacillation attendant to uncertainty about embracing and participating in change. His short-lived leadership was marked by apprehension to become involved in difficult decisions. He expressed gratitude for *Midwest's* help with his problems, but expressed no strong identification with the organization's values. He was neither eager to innovate, nor particularly volatile in his frustrations. In turn, organizational agents adopted an ambivalent stance toward him, neither engaging him in change nor finding fault with his behavior. Dr. Neutral's ambivalence seemed to leave him on the "sidelines" of organization change. Dr. Eager's story, on the other hand, depicts a physician who viewed change as an opportunity to enact the definition of the organization for herself. Dr. Eager embraced opportunities to assume responsibility because she sensed that doing so would shape what the organization would ultimately become. A key element of her story is the manner in which *Midwest* enabled each of the initiatives she took, even though many seemed risky or controversial. Each enabling response to Dr. Eager's initiatives lent fuel to her desire to initiate more and assume more accountability. This suggests a "virtuous cycle" of initiative-taking and organizational enablement that benefited both Dr. Eager and the organization.

Based on our analysis of the narratives, the key discriminating differences between the groups appear to be the individual's orientation toward taking initiative and the organization's response to initiative. At the extremes, embittered physicians' stories entailed withdrawal and/or resistance, followed by organizational constraint, which augmented passivity and resistance in a vicious cycle of alienation. On the other hand, physicians who thrived appear to have followed a pattern of engagement and initiative, followed by organizational enablement, fostering further initiative in a virtuous cycle of engagement and

collaboration in which the physician and the organization mutually negotiate the identity of the organization. A process-oriented picture of initiative-taking and organizational response thus emerges. Organizational change serves as a fulcrum for a negotiated change process of mutually determined enactment. This view emphasizes the dynamic nature of initiative-taking and the possibility of positive and negative feedback loops at the nexus of the individual-organization negotiation of change. But these observations are based on an interpretive reading of aggregated stories. Do individual narratives also support these themes? If so, we should see several patterns with regard to the events described by the physicians we interviewed. For instance, we should observe that the “Dr. Eagers” will describe more initiative behaviors than will the “Dr. Neutrals” and “Dr. Bitters,” as well as more instances of organizational enablement. Our second analysis explored these issues, and other thematic differences in the types of events described by physicians in each of the three commitment change groups.

Tabulation of Event Types

Table 2 provides a comparison of event counts across the three commitment change groups. The table is comprised of three major columns, one for each group. Within each column are two sub-columns. The first reports the average number of events of each type reported by all physicians in the particular group, including several aggregated event types. The second reports the number of physicians in the group who provided at least one example of the particular type of event.

INSERT TABLE 2 ABOUT HERE

We first describe differences between the groups on the frequency of organizational enabling and constraining events, as well as initiative-taking events. We then describe other differences that emerged between the groups on other event codes.

Organizational enablement and constraint. As expected, the groups differed markedly on the number of enabling versus constraining events they reported. The compatible group reported a slightly greater number of enabling events (average of 2.6) than constraining events (2.3), and all but one of the seven physicians provided examples of both event types. The polarizing group, however, mentioned more than five times as many constraining events (3.6) as enabling events (0.7). This same pattern held for the no change group (4.0 constraining to 1.0 enabling events). The compatible group was clearly not immune from constraining events, but perceived far more enablement than did the polarizing group. The polarizing and no-change groups, in contrast, reported far more constraining than enabling events.

Initiating events. We noted striking disparity in initiative-taking events between physicians in the compatible and polarizing groups. As depicted in Table 2, the compatible group related an average of 2.3 initiative-taking experiences, while the polarizing group described an average of only 0.6 per physician. For a process view, we also examined event tables sequentially for evidence of cyclicity of initiating and enabling/constraining events. By identifying initiating-enabling and initiating-constraining event pairs, we noted that the former tended to characterize the compatible group, while the latter characterized the polarizing group. Table 4 succinctly describes several of these sequences. The patterns underscore the image of transitioning physicians interacting with the organization in a mutual negotiation of change. The tendency of enabled initiative to characterize compatible commitment

changes suggests that initiative-taking and the organization's response may be a highly formative sequence of events in the transition experience. The organization's response to initiatives, particularly early in the process, is a bellwether of the nature of the physician's transition.

INSERT TABLE 3 ABOUT HERE

Aside from the differences we anticipated in initiative-taking and enabling/constraining responses, we investigated other differences in Table 2 for further evidence of the importance of initiative during transition. Several issues struck us.

Declining (turning down or resigning from leadership roles). Mirroring differences in initiative-taking, physicians differed noticeably in declining leadership roles. A majority of physicians in the polarizing group turned down or resigned (often in protest) a leadership role at some point. In contrast, only one compatible group physician resigned a role (not in protest). This observation provides further support that physician engagement in change was important to the development of dual commitment.

Attending to external events. The groups also differed in the extent to which their stories accounted for change in the environment and the larger organization. As indicated in the aggregate events at the bottom of Table 2, the compatible group was more likely to discuss environmental events, both positive and negative (average of 2.0 per physician) than were the polarizing (0.9) or no change group (0.3). Similarly, when we combined the codes for events pertaining to organizational forming and clinic merging into an overall organizational change event theme, the compatible group cited considerably

more of these events (4.7 per physician) than did the polarizing (3.1) or no change group (2.5). This suggests that physicians in the compatible group attune themselves to the external and organizational context more than do other physicians. This supports Morrison's (1993a) contention that proactive information-seeking about the environment facilitates transition.

Perceptions of support and neglect. One fascinating difference involved perceived organizational provision of support (resources to help or guide the clinic) or neglect (failure to provide such resources). Interestingly, the polarizing group included in their stories more instances of *both* support and neglect (average of 4.0 per physician) than did the compatible (2.3) and no-change group (2.8), as the composite row in Table 3 reflects. Although the implications of this pattern are somewhat puzzling, on the surface they suggest that physicians in the polarizing group tended to attune themselves to the organization's provision of resources, or in other words, "what *Midwest* can do for me." In contrast, compatible and no-change group physicians appeared to focus less on what they do or do not receive from *Midwest*. The relative inattention to the organization's provision of resources seems consistent with our depiction of physicians in the compatible group as proactive, agentic crafters of change.

In summary, our analysis of event frequency among the three groups provides useful themes that flow together to evoke an image of highly committed physicians proactively confronting transition. The data suggest that it is not simply organizational enablement or constraint in isolation that shapes physicians' transition experiences; the physician's enactment of change matter greatly. Moreover, the event sequence suggests that enablement and constraint are most salient after physicians have taken initiative to instigate change on their own. A proactive orientation is also suggested by the frequency with which

compatible group physicians accepted, versus declined, responsibility and by their attunement to the environment and larger organization. Polarizing group physicians, in contrast, appear to attune more to what the organization provides them, reflecting dependency rather than initiative.

Discussion and Model Development

Our analyses lead to a grounded understanding of individual initiative-taking and organizational response during organizational change. In this section, we integrate our observations and develop a model to serve as an impetus for future research and elaboration. The central focus of the model, depicted in Figure 1, is a cyclical relationship between employee initiative-taking and organizational response. We posit that these events feed into each other; initiative-taking triggers the organization’s enabling or constraining response, which in turn impacts the likelihood of future initiating behaviors. This position is consistent with Morrison and Phelps’ (1999) speculation that decisions to initiate change are “heavily influenced by the success of past efforts to initiate change” (p. 416).

Insert Figure 1 About Here

Predictors of Initiative-Taking

According to our model, an individual’s propensity to take initiative is a function of both individual traits and perceptions about the organization. Because our study did not directly assess personality traits that predispose individuals to initiative, received theory is instructive. As discussed earlier, proactivity literature provides evidence that several stable traits predispose individuals toward initiative behaviors. These include proactive personality (Bateman and Crant, 1993), need for control (Ashford and Black,

1996), self-efficacy (Morrison and Phelps, 1999; Withey and Cooper, 1989), and felt responsibility (Graham, 1986; Morrison and Phelps, 1999).

In addition to these traits, perceived organizational characteristics also shape predisposition to take initiative. Eisenberger, *et al* (1986) emphasized the importance of perceived organizational support for individual risk-taking behaviors. Because initiative-taking puts the employee in a vulnerable position, perceptions of organizational support are likely to have a large impact on whether employees pursue initiative opportunities. In addition, researchers have provided evidence that related characteristics, such as openness to ideas and pro-change organizational norms (Morrison and Phelps, 1999) create a “climate for innovation” (Scott and Bruce, 1994) that fosters individual initiative. Such a climate, in concert with proactive individual traits, predisposes individuals to take initiative.

When does an employee’s propensity to take initiative actually result in initiative behaviors? We theorize that two conditions must be met. First, the employee must perceive a need for change. Second, the employee must believe there is a reasonable likelihood of success for the initiative. Our interviews suggested that physicians recognized that taking initiative put them in a vulnerable position.

Consequently, they attempted to calculate the potential risks and benefits before pursuing an initiative.

Potential risks include organizational backlash and political pitfalls. For one physician, the backlash became apparent when “certain administrators who had been acting as our advocates suddenly had different job descriptions” (implying that those who supported the initiative were displaced). Another physician explained that he was politically crippled after pursuing a failed initiative: “Essentially I was damaged goods...And there was some very highly personalized attacks against me.”

Weighed against these risks were potential benefits if the initiative was accepted. One salient potential benefit appeared to be the opportunity to test, and even shape organizational values. For instance, one physician described how his clinic's initiative – a decision to support a competitor's hospital for the sake of protecting quality care – had tested *Midwest*'s values:

“That was really wonderful. A lot of people just can't understand how *Midwest* could do that. For me, as a doc, to see...that our priorities, our understanding of things was accepted...that it was supported completely—that was very nice.”

Another physician, speculating about the organization's eventual response to a new initiative said, “if that actually comes to life, that will be a defining moment.” In short, the decision to take initiative appears to be informed by the individual's weighing of the risks of failure and potential benefits of success of the initiative. Physician comments suggested that a key anticipated benefit of initiating was the shaping of organizational values.

Organizational Response

As the employee pursues an initiative, our model suggests that organizational agents evaluate it to determine an appropriate response. Physician narratives suggested that *Midwest* appeared to evaluate initiatives on several criteria: perceived intent (what is the employee trying to accomplish through the initiative?), perceived competence (is the employee capable of succeeding with the initiative?), and fit with organizational goals (is the initiative consistent with what the organization stands for?). In terms of perceived intent, physicians reported that the success of initiatives depended upon convincing organizational leaders of their intentions and good-faith efforts to benefit the organization. One physician,

who spearheaded the provision of a new service within the clinic, noted that *Midwest* was “reluctant to lay out all this money, saying ‘what if you leave in two years?’ And I said if I leave in two years I will take [the equipment and the expenses] with me. And they insisted I sign a contract [to that effect].” In this case, *Midwest* management enabled the initiative only when the physician’s willingness to take personal accountability convinced them of his good-faith intentions to follow through.

In terms of perceived competence, physicians believed that *Midwest* considered reputation and skills when deciding whether to enable or constrain an initiative. One attributed *Midwest*’s support of her initiative to the perception that “we have such good staff here...[We have] become a benchmark or role model for the rest of *Midwest*.” Another attributed *Midwest*’s rejection of a work redesign initiative to a perception that physicians were not competent to achieve it: “They felt that physicians trying to figure out ways of improving that...was a waste of our time.”

Finally, physicians perceived that *Midwest* assessed the fit of proposed initiatives with the organization’s goals, particularly with regard to whether the initiative augmented patient care. One physician described the organization’s response to her clinic’s initiative in this way: “*Midwest* basically said, ‘we want you to get organized and to give good clinical care...and if you’re doing that, keep doing it.’” As Table 4 makes evident, the initiatives that *Midwest* most frequently enabled were those that focused on improving the quality of patient care.

Vicious and Virtuous Cycles

Cyclical process models create the potential for “vicious” and “virtuous cycles.” Organizational enablement of individual initiative appears to create a virtuous cycle, in which the individual becomes more likely to take initiative in the future, largely because enablement augments perceptions of perceived organizational support, which encourages future initiative-taking. One physician evoked a positive loop when he attributed his clinic’s proactivity to early success with taking charge of designing a new facility to prepare for a clinic merger: “I think that’s a big part of the history of merging and doing what you needed to...there was an openness to adapt. And I think it’s still pretty strong.”

On the other hand, constraint of initiatives tended to cause vicious cycles in which employees withdrew or capitulated responsibility to make positive change. This is because constraint of initiatives tends to undermine perceived organizational support. This was no more evident than with the physician who described her clinic’s response to a rejection of their work redesign initiative: “[The manager] said, ‘We’re the managers. We’ll figure out and deal with the management problems and the administrative problems in running the clinic.’...So we said, ‘Well, fine. Then just, you do it. Fix it. Do it.’”

Our interviews indicated, however, that not all constrained initiatives led to vicious cycles. This suggests an important intermediary process between organizational response and the employee’s propensity to take future initiative. Narratives suggested that, subsequent to the organization’s constraint of an initiative, physicians tended to make two attributions that influenced likelihood of future initiative-taking. First, they made attributions about the intent behind the organization’s constraint. For instance, one

physician recognized that the reason his initiative was constrained was to protect the organization's relationship with another group of physicians. He explained his reaction: "I understood that and I accepted it... it felt like [my boss was saying] 'dammit, we'll be forced into the corner and I'm sorry to say that having this group engaged and functional is more important than [supporting your initiative].'" Other physicians attributed more instrumental intentions (e.g., protecting tax-exempt status) to the organization's decision to constrain initiatives. One physician said, after his attempt to service a new market was rejected, "Whenever we come up with an idea or a proposal, we are told that we can't do that; we are not-for-profit...So tell my why, again, we are not-for-profit? What do we gain from this? I think that has become the greatest excuse." Physicians who attributed pro-physician or pro-patient motives to the organization's constraint appeared more likely to take future initiatives than those who felt the constraint stemmed from a purely financial rationale.

A second attribution that influenced likelihood of future initiative after constraint was procedural justice, which involves the use of fair and impartial procedures in distributing rewards or administering a decision (Thibaut and Walker, 1975). One physician expressed appreciation about the fairness with which his initiative was considered, though it was ultimately constrained: "It did not feel at all personal to me. It didn't feel at all like a criticism of me...There was lots and lots of support for me as a person." On the other hand, some physicians felt the constraints they encountered were not a product of due process but rather of political roadblocks. As one physician put it:

"I just find it so frustrating that nobody makes a decision. [They say,] 'We need to do this, we got to go here, it has to go there, it has to go legal, it has to go through

business development.’ And this is so simple! Somebody just needs to say OK, go ahead and do it. And we can’t find anyone who is willing.”

In summary, although it seems likely that constraint tends to undermine future initiative-taking, attributions of organizational intent and procedural justice appear to play a moderating role in the relationship. Employees who perceive the organization as well-meaning and fair in its constraint of initiatives will not perceive the organization as less supportive, and thus will be no less predisposed to take initiative in the future.

Implications for Theory and Practice

This study makes theoretical contributions in several domains. First, it illuminates the important role of initiative-taking in employee adaptation to organizational change. The tenacity with which some physicians pursued initiatives during organizational integration suggests that they perceived change as an opportunity to shape the organization. This insight extends the concept of initiative-taking beyond an emphasis on socialization during organizational entry (Ashford and Black, 1996; Morrison, 1993a; Wanberg and Kammeyer-Mueller, 2000).

Second, the study delineates the processual nature of initiative-taking. Although considerable research focuses on the exercise of initiative, most studies have treated initiative as a generalized personality trait (Batement and Crant, 1993), as a “behavioral syndrome” (Frese, *et al*, 1996), or as the tendency to pursue some behavior. Few have treated it as a cycle of interacting individual initiatives and organizational response events that with time grow into different possible behavioral syndromes of an

individual's relationship with an organization. This study begins to answer Crant's (2000) call to move the dialogue toward understanding the process of initiative-taking.

Third, the study augments the career transitions literature by introducing the sequential concepts of initiative and enablement as process-oriented determinants of transition. Nicholson's (1984) model of career transition depicted transition as an interaction of individual assimilation and organizational accommodation. This study revealed two vehicles by which the assimilation-accommodation process advances. Physicians who achieve compatible commitments to organization and profession do so because their assimilation (via the exercise of initiative) is facilitated by the organization's accommodation (via enabling responses). The framework thus elaborates Nicholson's model.

Fourth, the study has practical application for employees facing change. It suggests that individuals facilitate their own transitions when they pursue initiatives, and that such initiatives might allow employees to help shape the destiny of a changing organization. Moreover, transitioning individuals should seek to become more aware of global context and avoid the temptation to casually blame frustrating changes on immediate managers. Those who reported the smoothest transitions strove to involve themselves in understanding and influencing change, rather than merely reacting with anger.

Fifth, in terms of organizational prescriptions, the study suggests that enablement of initiatives is critical to employees' organizational commitment. The process observations also provide insight as to *when* enablement is particularly critical. Initiative-taking places employees in a vulnerable position because, although they are exhibiting responsibility and ambition, they are attempting to enact self-directed change

and run the risk of violating organizational norms and inviting backlash. In the midst of this vulnerability, employees are highly attuned to organizational responses to their initiatives. Consequently, managers responding to initiatives face the challenge of choosing the correct response without undermining the employee's future proactivity.

Our model suggests that managers should strive to enable initiatives when possible. However, if an initiative is ill-conceived or likely to fail, the manager's task is problematic. An intriguing aspect of our study was that managers at *Midwest* consistently voiced a desire for physicians to take more initiative, but then often squelched those initiatives. Consequently, physicians sensed hypocrisy when their initiatives were rejected. Future research should shed light on how managers can constrain unwanted initiatives in ways that protect employee morale and do not undermine future proactivity. One example of research that may help to address this dilemma is Bunderson and Sutcliffe (2001), who found that successful top management teams tend to punish mistakes of omission, but to condone mistakes of commission. Such a strategy is likely to reinforce initiative-taking and minimize employee vulnerability.

Conclusion

This grounded theory-building effort illuminates a dynamic negotiation process of employee-organization behavioral exchange during change, and suggests that smooth transition relies upon seeing change as an opportunity to shape the emergent organization. Despite its contributions, however, the study is not without limitations. Because it was set in a specific, fairly unique context – clinics acquired by a new HMO – the generalizability of our observations is unclear. Eisenhardt (1989) emphasized that case study-based research tends to result in findings of questionable generalizability. Future research is needed to evaluate our findings in more general populations of employees (as underway by Engleman

and Van de Ven, 2002) and occupations (as called for by Barley and Kunda, 2001). The popular press includes daily stories of dramatic organizational changes involving mergers, acquisitions, turnarounds, and a myriad of changes. Our model seems relevant for examining how employees and organizations interact to negotiate such change. Of course, the adequacy of the model for shedding light on initiative-taking and organizational response is a matter for empirical scrutiny.

As with any grounded theory-building study, our conclusions should be considered tentative and receive rigorous, controlled study. This study did not “control for” all aspects of the initiating- response process. Future initiative-taking research will no doubt yield further insight and thus augment our model. In the meantime, it is reasonable to advocate a view that initiative-taking is a process in which employees seek to craft a changing organization to fit their own values. Initiative-taking is a trigger for an employee-organization interaction that has potentially momentous consequences for the employment relationship and for the character of the organization. We advocate further study into initiative-taking and organizational response as a negotiated process of organization-crafting.

¹ Unlike “taking charge” and Frese, et al’s (1996) concept of personal initiative, however, initiative-taking involves behaviors not necessarily circumscribed by organizational goals. Initiative-taking may challenge organizational norms and goals in an attempt to shape them to the employee’s own liking.

² Thompson and Van de Ven (2002) describe these patterns and their derivation in detail, as well as the perceptual differences that attend these three groups.

³ Almost without exception, the physicians we interviewed frequently used the pronoun “we” to describe their decisions and actions directed toward *Midwest*. Because physicians often did not distinguish between their personal behaviors and the collective behavior of the clinic as an entity dealing with *Midwest*, we found it most representative to treat individual and clinic-level behaviors as a single category.

REFERENCES

Adelson, A.

1997 "Physician, unionize thyself; doctors adapt to life as HMO employees." *The New York Times*, April 5: 21, 35.

Adler, P. S. and B. Borys

1996 "Two types of bureaucracy: Enabling and coercive." *Administrative Science Quarterly*, 41:61-89.

Ashford, S. J. and J. S. Black

1996 "Proactivity during organizational entry: The role of desire for control." *Journal of Applied Psychology*, 81: 199-214.

Ashford, S. J. and L. L. Cummings

1985 "Proactive feedback seeking: The instrumental use of the information environment." *Journal of Occupational Psychology*, 58: 67-79.

Barley, S.R. and G. Kunda

2001. "Bringing work back in." *Organization Science*. 12, 1: 76-95.

Bateman, T. S. and J. M. Crant

1993 "The proactive component of organizational behavior." *Journal of Organizational Behavior*, 14: 103-118.

Bunderson, J. S. and K. M. Sutcliffe

2001 “Why some teams emphasize learning more than others: Evidence from business unit management teams.” In B. Mannix, M. Neale, and H. Sondak (eds.), *Research on Managing Groups and Teams*. Greenwich, CT: JAI Press.

Crant, M. J.

1995 “The Proactive Personality Scale and objective job performance among real estate agents.” *Journal of Applied Psychology*, 80: 532-537.

2000 “Proactive behavior in organizations.” *Journal of Management*, 26: 435-462.

Crant, M. J. and T. S. Bateman

2000 “Charismatic leadership viewed from above: The impact of proactive personality.” *Journal of Organizational Behavior*, 21: 63-75.

Dutton, J. E., S. J. Ashford, R. M. O’Neill, and K. A. Lawrence

2001 “Moves that matter: Issue selling and organizational change.” *Academy of Management Journal*, 44: 716-736.

Dyer, W. G. and A. Wilkins

1991 “Better stories, not better constructs, to generate better theory: A rejoinder to Eisenhardt.” *Academy of Management Review*, 16: 613-619.

Eisenberger, R., R. Huntington, S. Hutchison and D. Sowa

1986 "Perceived organizational support." *Journal of Applied Psychology*, 71: 500-507.

Eisenhardt, K. M

1989 "Building theory from case study research." *Academy of Management Review*, 14: 532-550.

Engleman, R. and A. H. Van de Ven

2002 "Individual responses to organizational changes: Virtuous, vicious, and ambivalent transition cycles." *Academy of Management conference*, Denver, CO (August).

Frese, M., D. Fay, T. Hilburger, K. Leng and A. Tag

1997 "The concept of personal initiative: Operationalization, reliability and validity in two German samples." *Journal of Occupational and Organizational Psychology*, 70: 139-161.

Frese, M., W. Kring, A. Soose and J. Zempel

1996 "Personal initiative at work: Differences between East and West Germany." *Academy of Management Journal*, 39: 37-63.

Glaser, B. G. and A. L. Strauss

1967 *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: DeGruyter.

Graham, J. W

1986 "Principled organizational dissent: A theoretical essay." *Research in Organizational Behavior*, 8:1-52.

Hoff, T. J. and D. P. McCaffrey

1996 "Adapting, resisting, and negotiating: How physicians cope with organizational and economic change." *Work and Occupations*, 23: 165-189.

Ibarra, H.

1999 "Provisional selves: Experimenting with image and identity in professional adaptation." *Administrative Science Quarterly*, 44: 764-791.

Langley, A.

1999 "Strategies for theorizing from process data." *Academy of Management Review*, 24: 691-710.

Louis, M. R.

1980 "Surprise and sense making: What newcomers experience in entering unfamiliar organizational settings." *Administrative Science Quarterly*, 25: 226-251.

Miller, V. D. and F. M. Jablin

1991 "Information seeking during organizational entry: Influences, tactics, and a model of the process." *Academy of Management Review*, 16: 92-120.

Morrison, E. W.

1993a "Longitudinal study of the effects of information seeking on newcomer socialization." *Journal of Applied Psychology*, 78: 173-183.

1993b "Newcomer information seeking: Exploring types, modes, sources, and outcomes." *Academy of Management Journal*, 36: 557-589.

Morrison, E. W. and C. C. Phelps

1999 "Taking charge at work: Extrarole efforts to initiate workplace change." *Academy of Management Journal*, 42: 403-419.

Nicholson, N.

1984 "A theory of work role transitions." *Administrative Science Quarterly*, 29:172-91

Pentland, B.

1999. "Building process theory with narrative: From description to explanation." *Academy of Management Review*, 24: 711-724.

Pettigrew, A.M.

1990. "Longitudinal field research on change: Theory and practice." *Organization Science*. 1: 267-292.

Piderit, S. K.

2000 "Rethinking resistance and recognizing ambivalence: A multidimensional view of attitudes toward an organizational change." *Academy of Management Review*, 25: 783-794.

Poole, M.S., A. H. Van de Ven, K. Dooley, and M. E. Holmes

2000. *Organizational Change and Innovation Processes: Theory and Methods for Research*. New York, NY: Oxford University Press.

Saks, A. M. and B. E. Ashforth

1996 "Proactive socialization and behavioral self-management." *Journal of Vocational Behavior*, 48: 301-323.

Schneider, B.

1987 "E = f(P,B): The road to a radical approach to person-environment fit." *Journal of Vocational Behavior*, 31: 353-361.

Scott, S. G. and R. A. Bruce

1994 "Determinants of innovative behavior: A path model of individual innovation in the workplace." *Academy of Management Journal*, 37: 580-607.

Seibert, S. E., J. M. Crant, and M. L. Kraimer

1999 "Proactive personality and career success." *Journal of Applied Psychology*, 84: 416-427.

Speier, C. and M. Frese

1997 "Generalized self-efficacy as a mediator and moderator between control and complexity at work and personal initiative: A longitudinal field study in East Germany." *Human Performance*. 10: 171-192.

Staw, B. M. and R. D. Boettger

1990 "Task revision: A neglected form of work performance." *Academy of Management Journal*, 33: 534-559.

Taormina, R. J.

1997 "Organizational socialization: A multidomain, continuous process model." *International Journal of Selection and Assessment*, 5: 29-47.

Thibaut, J. W., and L. Walker

1975 *Procedural justice: A psychological analysis*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Thompson, J. A. and A. H. Van de Ven

2002 "Commitment shift during organizational upheaval : Physicians' transitions from private practitioner to employee." *Journal of Vocational Behavior*. In press.

Van de Ven, A.H.

1992. "Suggestions for studying strategy process." *Strategic Management Journal*. 13 (Summer): 169-188.

Van de Ven, A. H., R. Engleman, J. A. Thompson, R. Rogers, S. Lofstrom and J. S. Bunderson
2001 "An Evaluation of the Healthcare Organization Survey," Minneapolis, MN: University of
Minnesota Strategic Management Research Center, Technical Report.

Van de Ven, A.H., and M. S. Poole

2001 "Field research methods for studying processes of organizational change." In J. Baum (ed.),
Companion to Organizations. London, U.K.: Blackwell-Basil

VandeWalle, D., S. Ganesan, G. N. Challagalla and S. P. Brown

2000. "An integrated model of feedback-seeking behavior: Disposition, context, and cognition." *Journal of Applied Psychology*, 85: 996-1003.

Van Maanen, J. and E. G. Schein

1979 "Toward a theory of organizational socialization." *Research in Organizational Behavior*, 1: 209-264.

Wanberg, C. R. and J. D. Kammeyer-Mueller

2000 "Predictors and outcomes of proactivity in the socialization process." *Journal of Applied Psychology*, 85: 373-385.

Withey, M. J. and W. H. Cooper

1989 "Predicting exit, voice, loyalty and neglect." *Administrative Science Quarterly*, 34: 521-539.

Wrzesniewski, A. and J. E. Dutton

2001 "Crafting a job: Revisioning employees as active crafters of their work." *Academy of*

Management Review, 26: 179-201.

APPENDIX 1. Event Coding Scheme

Coding Steps

- 1) For each event, identify the actor (causal agent) from the following list:
 - **Individual/Clinic:** the physician acting alone or in concert with clinic partners
 - **Organization:** *Midwest*, any of its forerunners, or any individual that represents *Midwest* to the physician
 - **Environment:** any entity external to *Midwest* (i.e., government, competitors, the economy).
- 2) Consult the descriptions, listed below, under the relevant actor of the event and choose the one that best describes the event *according to the physician's perception*. Enter it in the **Code** column of the event table. If none of the codes fit, enter a question mark.

Individual/Clinic Events

Personal Career Change: The physician makes a decision about, or takes a step in, the course of his or her professional career.

Appointment: The physician accepts an appointment to a leadership position or committee assignment.

Initiating: The physician, alone or in concert with clinic partners, initiates an effort to expand or change organizational norms, practice or strategy.

Resisting: The physician, alone or in concert with clinic partners, defies *Midwest* or verbally protests a decision.

Conforming: The physician, alone or in concert with clinic partners, changes behavior to align with organizational or role expectations.

Withdrawing: The physician steps down from a *Midwest* leadership position or leaves *Midwest*.

Problem: The physician, alone or in concert with partners, faces personal challenges or conflict within the work setting.

Clinic Withdrawing: Members of the clinic resign, or the entire clinic leaves *Midwest*.

Clinic Merging: The clinic pursues integration with another clinic or system.

Clinic Growing: The clinic hires additional physicians.

Organization Events

Forming: Components of *Midwest* (i.e., its constituent systems, not individual clinics) integrate.

Enabling: *Midwest* affirms or increases the physician's autonomy and control (i.e., provides change involvement, openness to ideas, and/or work discretion).

Constraining: *Midwest* undermines or limits the physician's autonomy and control (i.e., reduces change involvement, openness to ideas, and/or work discretion).

Supporting: *Midwest* provides tangible resources (finances, personnel or real estate) to benefit the physician or the clinic.

Neglecting: *Midwest* fails to provide needed resources or guidance.

Environment Events

Positive: The environment provides a benefit to the physician or the clinic

External Negative: The environment poses a challenge to the physician or the clinic

TABLE 1. Profiles of Interviewed Physicians

Gender	Practice	Age	MD Yrs	Clinic*
Compatible Commitments				
Female	family practice	45	19	Mid-sized suburban
Male	family practice	54	28	Small rural
Male	family practice	37	11	Small rural
Male	specialist	40	14	Large rural
Male	family practice	40	14	Large rural
Male	family practice	54	33	Small rural
Male	internal medicine	62	37	Small urban
Polarizing Commitments				
Female	family practice	42	15	Mid-sized suburban
Male	family practice	64	39	Mid-sized rural
Male	internal medicine	68	44	Large urban
Male	internal medicine	48	22	Small urban
Male	family practice	61	31	small rural
Male	family practice	47	21	Mid-sized suburban
Female	family practice	33	7	Large rural
No Change				
Female	internal medicine	38	7	Mid-sized suburban
Male	specialist	48	23	Large rural
Male	family practice	41	14	Large rural
Male	family practice	42	13	Small rural

* Small clinics are those with less than 40 FTEs; Large clinics are those with more than 70 FTEs.

TABLE 2. Frequency Table of Event Types by Commitment Change Pattern

	A. Compatible Change Pattern		B. Polarizing Change Pattern		C. No Change	
	Avg # Events	# Doctors (out of 7)	Avg # Events	# Doctors (out of 7)	Avg # Events	# Doctors (out of 4)
Individual/Clinic Events						
Personal Career Change	4.0	7	5.6	7	4.0	4
Appointment	1.0	3	0.4	3	1.0	3
Initiating	2.3	6	0.6	3	2.3	4
Resisting	0.6	3	0.3	2	0.5	2
Problem	0.9	4	2.6	5	0.8	1
Conforming	1.0	3	0.1	1	1.0	2
Declining	0.1	1	0.7	5	0.5	2
Clinic Withdrawing	1.4	7	1.0	4	1.8	3
Clinic Merging	3.4	7	2.4	5	1.3	2
Clinic Growing	0.3	2	0.3	2	0.5	2
Organization Events						
Forming	1.3	4	0.7	3	1.3	2
Enabling	2.6	6	0.7	3	1.0	3
Constraining	2.3	7	3.6	6	4.0	4
Supporting	1.4	5	2.4	6	0.8	3
Neglecting	0.9	3	1.6	5	2.0	2
Environment Events						
Positive	0.4	2	0.0	0	0.3	1
Negative	1.6	5	0.9	4	0.0	0
Aggregated Event Types						
All Environment (positive + negative)	2.0	5	0.9	4	0.3	1
All Org Change (clinic merging + org forming)	4.7	7	3.1	5	2.5	3
All Support and Neglect (org supporting + org neglecting)	2.3	7	4.0	7	2.8	3

TABLE 3. Event Pair Patterns

Initiating-Constraining Event Pairs

Commitment change	Initiating Event	Constraining Event
Polarizing	The clinic establishes a team to address some front desk work problems.	A manager screamed at the clinic: "You don't micro-manage. We're the managers."
Polarizing	A physician writes a controversial essay voicing concern about industry changes	A <i>Midwest</i> manager threatens to punish the physician.
Polarizing	A physician heads up a work redesign team.	<i>Midwest's</i> contract limits the team's ability to expand work area as needed.
No Change	The clinic meets to select three new physician leaders in an attempt to signal a willingness to cooperate with <i>Midwest</i> .	<i>Midwest</i> fires the three previous leaders despite the clinic's change in leadership.
Compatible	A physician advocates the creation of a task force within <i>Midwest</i> .	A backlash from <i>Midwest</i> emerges, halting development of the task force.
Compatible	A physician leader fires a recalcitrant employee.	<i>Midwest</i> management reverses the firing.

Initiating-Enabling Event Pairs

Commitment change	Initiating Event	Enabling Event
Compatible	The site medical director spearheads a preventative care program	<i>Midwest</i> provides encouragement and broad discretion to pursue the project.
Compatible	A site medical director spearheads a pap smear quality improvement program.	<i>Midwest</i> provides encouragement and broad discretion to pursue the project.
Compatible	A physician sets up a pediatric quality care program.	<i>Midwest</i> provides encouragement and broad discretion to pursue the project.
Compatible	A clinic makes a decision, motivated by quality concerns, that is unpopular with the public.	<i>Midwest</i> stands by the clinic's decision and offers assistance with public relations.
Compatible	Physicians organize a meeting to make radical changes in the clinic.	<i>Midwest</i> managers congratulate the clinic and let the physicians make an important decision.
Compatible	A clinic decides to break relations with a former partner.	<i>Midwest</i> stands by the clinic's decision despite adverse publicity.
No Change	A clinic proposes a diabetes initiative.	<i>Midwest</i> approves the proposed projects and provides financial support.
No Change	A clinic proposes a colorectal cancer program	<i>Midwest</i> approves the proposed projects and provides financial support.
No Change	A clinic proposes a preventative health care program.	<i>Midwest</i> approves the proposed projects and provides financial support.

Figure 1. Model of Initiative-Taking and Organizational Response

