

Strategy and the Underdog In Organizational Politics

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Introduction

The weak think differently from the strong in organizational politics, and it is hard for all members of society to start including those differences, for the following reason. At the time of Aristotle, the great philosopher deliberately excluded from future political discourse the *mêtis*, the way of thinking of “women and the vanquished”.¹ Although this way of thinking did not disappear, discussions of it did, and we find ourselves by and large without the conceptual framework to incorporate it easily. This is especially true since the Aristotelian revival after the Renaissance.² It would be surprising, to say the least, if armed forces were the exceptions to this rule. However, research into the concept of strategy has already allowed for the incorporation of characteristics of this *mêtis*, and the training below provides a simple heuristic device, the core idea, to help soldiers incorporate it into their own thinking. The core idea forces the use of more than the rational powers characteristic of Aristotelian thought dominant, as we have seen, in most western cultures. It allows the participant to call upon experience, judgment, intuition and the tacit dimension of knowledge. It is a purely pedagogical or heuristic device, discussed in more detail below, but it points up to one of the main differences between the strategy of the strong and the strategy of the weak: the added dimension of thinking, almost as if the strong were thinking in two dimensions and the weak are thinking in three. There is also a quick and simple test to determine whether individual members of the armed forces practice it *mêtis*, which is discussed below.

Whether you find yourself in an underdog position in organizational politics or there is an underdog that can affect the outcome, in organizational politics it is important to understand how an underdog thinks strategically. Not all underdogs do. But the underdog thinks differently from the strong, and it is important to understand that, whatever the outcome. For example, US military personnel have a strong can-do ethic which has led to countless successes and victories in the past. But in the case of irregular war, counterinsurgency, counterterrorism, foreign internal defense, fighting narcotics- or people-smuggling, three-block wars, long wars, and many other challenges, it is important for them to consider how the enemy thinks, not just what they themselves have to do. Their very excellence in traditional, middle of the spectrum warfare has driven enemies to either end of the spectrum. Add to this the constraints of liberal democracy, can become liabilities so sharp that the strong may become the underdog. Underdogs are always thinking about what the strongman is about to do – life and limb depend on it. The same is true in organizational politics.

The goal of this paper is to present the strategic thinking of the underdog, and to show how it is possible to teach or train personnel in any organizations in that regard, although not every industry will find it equally interesting. The first part discusses the characteristics of underdog strategic thinking by comparing them to strong-side strategic thinking. The examples are deliberately drawn from a range of areas of human activity, to emphasize that the underdog will never think of only one category of means. The second part proposes some simple exercises to start training people in underdog thinking, first by identifying those who do so naturally, and then in using a simple device, the core idea, to give their own strong-side thinking the beneficial characteristics of the other kind of strategy. I recommend to the reader to start with the part that is of most interest to him.

The strategic thinking here is of the learning, intelligent underdog, not the crazy one, not the inept one, not the stupid or ineffectual one. One should never underestimate any opponent, of course. But underdogs who survive are underdogs who tend to be either lucky or gifted. If they are lucky, then all of you have to do is keep fighting him and his luck will run out. But as the Chinese say, luck is an opportunity for which one is prepared. The underdog is likely someone who can learn from experience and is quick on his feet. The crazy underdog is, of course, much less predictable, but also much more likely to be wasteful. Only in exceptional combinations of circumstances will he be successful, although that will occur from time to time.

Part I: The Underdog's Strategic Thinking

The main differences between strong-side strategic thinking and the underdog's strategic thinking are: the underdog uses a different definition of strategy; the underdog is holistic; the underdog is adaptive at every tactics; the underdog plays a waiting game; the underdog is creative; the underdog sees the big picture much more easily; the underdog uses strategic intervention; the underdog is always trying to figure out what his opponent is thinking; the underdog is constantly forecasting for all events and all other actors; the underdog is constantly coming up with tactics for all the preceding eventualities; the underdog assumes that any direct confrontation will lead to his own defeat; the underdog will break even his own rules of

¹ Marcel Detienne, *Les ruses de l'intelligence* (Paris: Flammarion, 1993), 124.

² Although daring, attempting such a correction is not without recent precedent. Philippe Nemo, *What Is the West?* (New York: Duquesne University Press, 2007).

behavior in order to achieve his goal; and the underdog's passions or passionate feelings are engaged. This is true for a wide range of situations encountered in organizational politics.

Difference #1: the underdog uses a different definition of strategy. The underdog may not have an explicit concept of strategy written down somewhere. But he behaves as if he conceives strategy as an imaginative idea which orchestrates and/or inspires sets of actions (tactics) in response to a given situation. Among the many definitions of strategy as used by the strong, strategy is a plan to use the instruments of national power to achieve a goal; or the art and science of using instruments of national power to achieve military goals. What is different here is that strategy need not be confrontation; it can be used to take advantage of an opportunity; that strategy is more than simply rational or based on rational decision-making; and that the instruments of power are not necessarily national in scope.

Difference #2: the underdog is holistic. That is a consequence of difference #11, that he cannot win a head-on confrontation. Since the underdog is weaker than the opponents in one or more ways, then he is forced to seek out weaknesses in his enemy and strengths on his own side in other dimensions. In all likelihood the underdog is going to do this repeatedly, and this will lead him to consider a wide range of possible tactics, not just one dimension of any particular problem, challenge or opportunity.

Difference #3: the underdog is adaptive at every tactic. This characteristic arises from the constant experience of being at a disadvantage, sometimes critically at a disadvantage. This means that the underdog, in order to survive, must learn with every move of his adversary or competitor. With strategy being an idea, the underdog is free to change actions constantly, without having to go through the process of changing his whole strategy. It also helps that his strategy is metaphorical, and can therefore easily change in terms of actions chosen.

Difference #4: the underdog plays a waiting game. This characteristic is at its most pronounced among the Chinese and other cultures who have a non-linear, non-atomized concept of time, but it is true of much underdog strategy. Since the underdog is certain that direct confrontation will end in defeat, the underdog has no choice but to wait for opportunities for him to act that do not bring him in direct confrontation with his adversaries or competitors. He must also wait to find out what other characteristics his adversaries may have, beyond the dimension where they are at their strongest. This also takes time and observation.

Difference #5: the underdog is creative. This characteristic arises from the constant experience of being at a disadvantage, sometimes critically at a disadvantage. His means are limited, and usually dramatically more limited than the means available to his adversary. Since he cannot meet him head on without being defeated, the underdog, in order to survive, must find new and different ways to counter every move of his adversary or competitor. With strategy being an idea, the underdog is free to change actions constantly, without having to go through the process of changing his whole strategy. It also helps that his strategy is metaphorical, and can therefore easily change in terms of actions chosen. Finally, the underdog will not hesitate to violate the rules of the game, if necessary, all of which can help with creativity.

Difference #6: the underdog sees the big picture much more easily. The underdog is used to living and acting in a hostile and unpredictable environment. If he has survived as long as he has, it is because he has developed the habit of constantly scanning his environment for possible threats and for possible opportunities. He also has to make a connection between events in the environment and possible actions on his part. This habit of moving from the broader environment to the specifics of his own situation means that he has the capacity to see strategy as a set of nesting bowls or Russian dolls, one fitting in with the other. For example, let's say a highly creative professor is seeking tenure in a university and a scholarly system that does not deal well with innovation (as is the case with peer-review). That professor is very likely to watch closely what sort of standards are being applied by the tenure committee, but also to look at the incoming university president, a shift in the editorial boards of major journals, the terms of reference of a granting agency, in a way that a more conventional professor would not. The same is true of an underdog in a military or economic situation.

Difference #7: the underdog uses strategic intervention. By strategic intervention, I mean a tactic specifically designed in very difficult circumstances, to turn the situation around, or in close keeping with the strategy adopted. What this means is that the underdog sees the impact of every action, every tactics, on the whole picture, and takes all the potential consequences into account when he designs his tactics or actions. There is training available in strategic intervention.

Difference #8: the underdog is always trying to figure out what his opponent is thinking. His life and limb depend on it, and the more important or powerful or stronger the opponent, the more the underdog will think about it. It is a little like being a mouse in bed with an elephant: every twitch and quiver is worth examining to see if the elephant isn't about to turn over, and crush the mouse.

Difference #9: the underdog is constantly forecasting for all events and all other actors, and invests in the development of even unlikely scenarios. This is called variously *gedankenexperimenten*, as used by Einstein, thought experiments, behavioral rehearsal, and no doubt other terms. With each of these events, the underdog forecasts all the possible consequences and all of his own and others' possible responses, in a cascading matrix of options and scenarios. This must occur for each event and action throughout the underdog's strategy and political/military life, or he is in danger for his life or limb. This is also what leads him to be adaptive and flexible. He invests in even unlikely scenarios because the outcome of any of them is usually his own extinction.

Difference #10: the underdog is constantly coming up with tactics for all the preceding eventualities. For the underdog, strategy is an idea about action. He has identified the idea he is going to work with, and he is constantly identifying actions and courses of actions that go with this strategy and are suited to the events discussed under difference #9.

Difference #11: the underdog assumes that any direct confrontation will lead to his own defeat. There are possible enemies that could compete successfully with a multinational company, for example, but it is extremely unlikely that a startup would enter into competition while thinking itself superior. This is different of course, from what an underdog might say or do publicly – that is in the realm of posturing.

Difference #12: the underdog will break even his own rules of behavior in order to achieve his goal. It is not so much that the underdog has no rules of behavior, but that his rules are so different that they may seem like they do not exist. I am reminded of the story of one of the first students from the people's Republic of China to study abroad, in the 1990's. The People's Republic of China had become a puritanical society where modesty was essential. However, this student found that the US society was very permissive, by his standards. He was expelled from a university for having changed his clothes in front of a window on the ground floor, where he was seen by other students. His protests were to no avail, but culturally it is easy to understand: to him, the rules in the US were so much more permissive that it seemed to him that there were no rules at all. In which he was, of course, wrong. It was that he could not perceive those implicit rules of behavior because they were so different and so much broader than his own. The same is true of the underdog. He understands the rules of behavior that apply to the adversary or the enemy – but he does not share them and considers it legitimate to ignore some of the rules of war. He has rules of his own, but either those rules do not interfere with his actions or he choose to break them if necessary.

Difference #13: the underdog's passions or passionate feelings are engaged. This became obvious to me when I was teaching a class in political strategy. Strong feelings, even passion, are involved. I am reminded of the year where I was teaching students how to use strategy in analyzing the domestic policies of foreign countries. I required them to identify a core idea in the course of a three-hour seminar, but each successive weak and each successive case, nobody came up with one. Romano Prodi's near legislative defeat in Italy, Spain's terrorism laws, New Zealand's Maori, no student could come up with core ideas for any of those cases. Until we studied the Catholic Church's response to child abuse by clergy in Ireland – then all the students came up with core ideas quickly and easily (Keep the kids in church, keep the church out of kids, and more of that ilk). Underdogs are pursuing a strategy because they are passionately committed and emotionally engaged in achieving their goal. This is a help in creativity, since it allows access to more than rational decision-making.

The Heuristic Device

The core idea is a metaphor at the heart of a strategy that will help a user to include *mètis*, i.e. to make, under pressure, decisions consistent with the broader goals and objectives, and forces the user into using a broader range of intellectual capacity than the rational. In other words, it is a learning tool to give strong-side strategy the benefit of the better characteristics of the underdog's strategic thinking. The second exercise teaches in more detail what the core idea is and how it can be used.

Part II: Teaching and Training in Strategic Thinking

Three Types of Learners

In training people in underdog thinking, i.e in *mètis*, you may expect three types of participants:

- o the natural strategists: those who only need to have a new concept of strategy including the *mètis* explained to them, for them to identify it for themselves, learn how to improve their practice, and implement it immediately;
- o the on-sight strategist: who will need to see the new concept of strategy including the *mètis* demonstrated to them, for them to identify it for themselves, learn how to improve their practice, and implement it immediately; and
- o the coachable strategist: who will need to be coached through a total of five or six applications (using case studies, for example) of a new concept of strategy including the *mètis* to them, for them to identify it for themselves, learn how to improve their practice, and implement it immediately.

At the time of this writing, the number of armed forces personnel is small. However, it is already clear that *habitus* is a major problem, but also that there are a proportion of natural strategists who can be readily identified in this way. It is also clear that there are natural strategists who are not identified in the training itself, but realize it after taking the training. Moreover, the proportion of natural strategists among visible minorities, women, the disabled, and others with some sort of permanent disadvantage is much greater. If this also holds true for armed forces, then those who have made efforts at diversity may be receiving an unexpected dividend.

The workshop proposed below takes about three hours, if given all at once, though the follow-up necessary to train the third type of person, to be completed individually, will take more time. The two exercises of the workshop can be given one at a time. They are: discovery and diagnosis, and development of the core idea.

Exercise 1: Discovery and Diagnosis

In this exercise, which takes about 1 or 1.5 hours, the objective is to introduce the participants to the basics of strategy including *mètis*. Individuals are asked to play a simple board game, such as checkers or chess, and are given a

structured set of tasks of increasing complexity to force the failure of rational thought alone. They are then required to use the core idea, a metaphor that orchestrates all actions in the strategy of the weak. The trainer observes and confirms with them when they are using *mètis*. The materials required are simple: enough board games for every two or four people (the exercise works for people working in teams of two in playing the board game); enough seats and tables for everybody; and either a chalkboard, a flipchart, an overhead projector or a document camera. The board game can be selected to be culturally appropriate. The exercise allows for the use of translators if necessary. What the trainer is looking for is the ability to predict outcomes in increasing numbers of scenarios, and the ability to think ahead to a much greater extent. People who can do this are likely to be natural strategists, and are much more likely to be practicing the strategy of the weak.

At the close of this exercise, the trainer facilitates a discussion about the effectiveness of the first experience with a core idea. In the alternative, if time is short, the trainer can assign the worksheet shown below, an integration learning tool commonly used in management or business.

Integration Diary

Topic of Report:	In my view the important components are:	Because:
Links with previous learning about strategic thinking:	My thoughts about this topic are:	
I have a better understanding of:	I am more effective at:	I am more likely to:
I want to learn more about:	What I can use...	where?

The integration diary's goal is to help the participant become aware of how s/he learns, so that s/he eventually will be able to become a better learner regarding counterinsurgency. The report is structure to bring the participant to increasing levels of abstraction, i.e. it provides an additional chance to experience telescoping. The form is supposed to be completed in point form only, so that the participant works with individual ideas and concepts, rather than having the chance to be descriptive. The diary must be completed in the space provided to force the participant to choose among various possibilities, and therefore learn what priorities on which to focus. There are no right or wrong answers for this, or any other, worksheet. The point is to make explicit the processes of the participant's learning.

Topic of report this is the specific aspect that the participant wishes to analyze in greater detail. There should be only one topic, for example: counterinsurgency, not 'counterinsurgency and planning.' The topic should be specific rather than vague. The topic should also be at the same level of generality as the rest of the content of the worksheet.

In my view, the important components are: here, the participant should break down the topic of his/her choice into components. This process should continue until it is no longer possible to break the topic down any further. The participant then selects the components which will be discussed in the worksheet. Not all components will be analyzed.

Because: Here the participants gives the reasons why the components selected are important enough to continue to work with. Here the participant must select priorities once again, explicitly. This process occurs in everyday life, but it is not explicit.

Links with previous learning in strategic thinking: here, the participant must think over what s/he has learned about strategic thinking in the past, and identify where the topic under consideration connects with what s/he already knows.

My thoughts about this topic are: the reason for this box is that the participant will have a wide range of reactions to the learning that has just occurred. This box allows him/her to make those thoughts explicit, and also to provide him/her with

the opportunity to set them aside for future consideration, if necessary. The participant is now less encumbered with other thoughts to continue the analysis.

I have a better understanding of: for the learning to be genuine, there has to be a greater comprehension of some, possibly several, phenomena. In this box, the participant is expected to provide at least one of these.

I am more effective at: for the learning to be genuine, there has to be a change in behavior. That change can be either an improvement in an existing behavior, or a change in the probability that a particular action or course of action will be chosen. In this box, the participant is expected to list at least one such improvement.

I am more likely to: for the learning to be genuine, there has to be a change in behavior. Sometimes that behavior is mental or psychological. That change can be either an improvement in an existing behavior, or a change in the probability that a particular action or course of action will be chosen. In this box, the participant is expected to list at least one such change in probability.

In the last three boxes, the participant must become very specific and concrete about what the learning has done for him/her.

I want to learn more about: learning is a chain, and in an earlier box the participant was required to identify what previous learning on this topic s/he had done. Here, the participant must identify what s/he would most want to study next.

What I can use: of the learning that has occurred and has been identified, the participant must now select what has practical or immediate applications in his/her responsibilities or life. In this box, the participant must identify the elements of learning that he can actually apply.

Where? Of the learning that has occurred and has been identified, the participant must now specify what applications exist for the elements of learning that s/he has identified. It is important for participants to be as specific as possible.

Sample Integration Diary

Integration Diary

Topic of Report: telescoping	In my view the important components are: Levels of abstraction Changing levels of abstraction Obstacles to changing levels	Because: This is the crux of the task to be done This is the skill I have to learn or develop This is what I have to overcome
Links with previous learning about strategic thinking: Old definition of strategy Old definition of tactics	My thoughts about this topic are: Limits to what I can learn in a single day Why hasn't metis been discussed before anywhere?	Unsure of how much I can actually telescope Confused about the way I'm being trained here
I have a better understanding of: How this can help me understand insurgents	I am more effective at: Picking out fellow soldiers who can do this metis	I am more likely to: take into account who is a strategic corporal and who isn't when I plan
I want to learn more about: How insurgents think	What I can use... The test	where? With soldiers in my unit when we deploy

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Exercise 2: The Core Idea

The third exercise joins the way of thinking of the first exercise with the content of the second. In this exercise, participants must plan a response to the events described in the appendix, first without a core idea, and then using a core idea. Participants are therefore required to use the information and skill to which they have just been introduced. The case study provided is semi-fictional, to ensure that strategy including *mètis* is actually necessary.

Worksheet: Strategy without core idea

Issue
Goal
Tactics
1.
2.
3.
4.

In this worksheet, the participant is expected to identify the components of a strategy to answer a particular challenge. As with the integration diary, the participant should use point form and no more than a single sheet to complete the worksheet. This will force him/her to be conceptually specific, and to choose among competing priorities. This way, the trainer can assess the judgment of the participant as well as his or her capacity to think using strategy with *mètis*. Those components are the problem, to be described succinctly in the top box, “Issue”; the solution to that problem that suits the participant best, again to be described succinctly in the middle box, “Goal”; and the steps that will have the participant reach the goal, or the method he plans to use, of the collection of actions s/he plans to use, in the bottom box, “Tactics.” A strategy need not be developed only in adversarial circumstances – it can be used to rise to a challenge of any type. But because it is demanding to develop and implement, it is usually only used in dire circumstances where there are at least one and usually many enemy players. As usual, the participant must be detailed, specific, succinct, and must stay at one level of generality or detail throughout the worksheet. Below is a sample worksheet for a public policy decision, to encourage physicians in Ontario, Canada to join group practices.

From Sole to Group Physicians’ Practice in Ontario

Introduction

Numerous jurisdictions, both within Canada and internationally, have undertaken some type of reform of the delivery of primary health care services. Although there appears to be agreement over the need for reform, there are many models, existing and proposed, outlining how reform should be implemented.

The goals of primary care reform, as articulated in 1998 when the Ministry of Health and Long Term Care (MOHLTC) adopted recommendations from the Primary Care Reform Steering Committee are: improved access, improved quality and continuity of care; increased patient and provider satisfaction; and increased cost-effectiveness of health care services. In Ontario, seven sites were initially selected to pilot a new model of primary care service delivery. The model currently being evaluated in Ontario is based on a Primary Care Network (PCN) of physicians and other health care providers, who enroll patients for the provision and co-ordination of primary care services. After-hours assistance is provided through a telephone triage service. There are financial incentives for PCNs to provide preventative interventions. It is expected that information technology will be integrated into practice. Two physician remuneration mechanisms are being tested in the Ontario pilot. Most of the pilots are using a “capitation” model where physicians are funded based on the number of patients enrolled with them and not on the amount of service that they provide to each patient. At present, one of

the pilots is testing a “reformed fee-for-service” model which is a modified version of the traditional physician remuneration method where physicians are paid based on the amount and type of service provided to patients.

The description of the experience of implementing the pilot networks rests on the framework developed by Barbara Starfield of Johns Hopkins University. The Starfield framework assesses primary care reform on the following four indicators, which can be closely linked to the four goals set out for primary care reform in Ontario: first contact care, longitudinality (patient focused care overtime), comprehensiveness and co-ordination. Research has shown that primary care reform models centered on these four elements produce the best health outcomes.

At the time of this writing, there were thirteen active PCNs. Some of the networks were formed based on historical relationships among physicians. These groupings were often formed around larger groups of physicians who shared office space and/or after-hours call groups. Critical differences between the networks identified include:

- ❑ The number of physicians in the group (from 4 to 21)
- ❑ Geography
- ❑ The existence of multidisciplinary teams
- ❑ The extent of shared identity
- ❑ Whether or not the offices are in a shared call group
- ❑ The extent to which the participants and practices collaborate in community initiatives and outreach
- ❑ the amount of sharing of common experiences and troubleshooting through meetings and telephone calls;
- ❑ and collaboration related to information technology

Key findings include:

- ❑ Most PCNs consist of a mix of solo and group physician practices; there are two single location networks
- ❑ PCNs range in size from 4 to 21 physicians
- ❑ Three of the PCNs (Chatham, Paris, and Parry Sound) are underserved areas in terms of the number of family physicians
- ❑ Each PCN has a Network Leader who provides leadership in terms of group collaboration, decision-making and administration; they are compensated for their role
- ❑ All PCNs hold group meetings; beyond this the extent and type of collaboration varies

In all networks there appears to be greater interaction among health care providers than prior to PCR.

There were a number of similarities in the characteristics of the 166 physicians participating. Their reasons for participating included a desire to take part in a program that could lead to improved quality of care for their patients, and/or the offer of financial support for the acquisition of new information technology (IT) systems by the Ministry of Health and Long Term Care.

- ❑ Physicians were interested in using the new IT systems to enhance patient care.
- ❑ The average age of the participating physicians is about 48 years.
- ❑ The average length of time in practice is 23 years
- ❑ About 40% of physicians in the pilot are female (provincial average: 32%)
- ❑ Thirty percent formerly practiced in a Health Service Organization (HSO) (provincial average 2.2%)

In order to participate, physicians had to negotiate a contract with the MOHLTC. Participants described the contract negotiation process as arduous and taking up much more meeting time than anticipated. Every network found the process difficult, although physicians were satisfied with their contract when it was finalized. Patients also have to voluntarily enroll in the program. About 245,000 patients have been rostered at the time of this writing. Some communities have had significant success with rostering. For example, the Paris PCN is at 111% of its estimated enrolment target and five other PCNs are above 80% of their enrolment target. Many physicians identified rostering as the biggest challenge to starting up their primary care network, because the process was tedious and labor intensive, impinging on administration and patient care time. Some practices hired extra staff to assist with rostering. There were concerns expressed about the level of English required to complete the forms; the complexity of the consent forms, and the lack of understanding on the part of the patient with regard to their responsibility as a rostered patient. The Ministry has provided funding for seven new nurse practitioner positions and allowed former HSO physicians in the pilot to maintain funding for specialized resources (e.g. mental health counselors, psychiatrists, dieticians). In addition, there are dozens of nurses and administrative staff connected to specific physician offices that also contribute to the delivery of patient care in the PCNs. A telephone advice line has been established for the pilots and is serving ten of the thirteen PCNs. (A plan has recently been put in place to expand the service to the three newest PCNs.)

Under the terms of their contract, all physicians within a network were required to have a written agreement setting out their decision-making approach and signing authority. Individual offices within each PCN tend to operate as separate practices with separate assets, with the only shared asset among the individual practices being a shared bank account for

Ministry funding. All networks have a network leader and some have an executive committee typically consisting of three or four members.

All of the networks are using the capitation method of physician remuneration except one, which is using the reformed fee-for-service method. Some of the issues raised with respect to the capitation method include:

- ☐ Roster limits
- ☐ Outside use or negation rates
- ☐ Inclusions and exclusions of services/procedures in the capitation rate
- ☐ Capitation rates for the elderly
- ☐ Capitation rate increases and on-call coverage

Physicians using the reformed fee-for-service method were much less satisfied. In this case, issues included a lower than expected level of income in the initial stages, difficulty accessing the benefits of the bonus codes, rostering requirements and on-call coverage.

The MOHLTC required budgets for:

- ☐ Administration of the enrolment process
- ☐ Network administration; information technology
- ☐ Nurse practitioners (where applicable)

There were varying levels of satisfaction with the budgets and disbursements of funds across the PCNs. Many physicians had little or no prior experience with budgets and administration; they found there were delays in approval of funding by the MOHLTC.

Nurse practitioners have at least a decade of nursing experience, and areas of specialty (i.e. wound care, obstetrics, women's health etc). The ratio of nurse practitioners to physicians varies across the networks from 1:2 to 1:21. The role of nurse practitioners varies, influenced mostly by the physicians with whom they practice. Their roles include:

- ☐ Well patient exams (especially well female exams on behalf of male physicians)
- ☐ Home visits
- ☐ Preventative care
- ☐ Patient education
- ☐ On-call coverage

Some of the nurse practitioners carry their own patient caseload, providing the full range of services that they are empowered to perform. Patient focus groups indicate that there is a high level of patient satisfaction with the introduction of nurse practitioners.

The pilot PCNs use three strategies to ensure that rostered patients have access to care 24 hours a day, seven days a week:

- ☐ Extended office hours
- ☐ Physician on-call coverage
- ☐ Teletriage service

Some physicians found one of the benefits of PCN's was the opportunity to share on-call with a larger group -- it reduces the burden on individual physicians and improves lifestyle. One of the concerns is the diversity of patient profiles found in different practices. In any event, the high volume of calls for teletriage has been striking. Between October and December 2000, rostered patients made a total of 4,840 calls to the teletriage line, over 200% of their estimate in the contract. The first three months of operation of the teletriage service suggests that the service has redirected callers to different care options than they would have otherwise sought. For example, from October to December 2000, 375 callers said they were planning to seek emergency care. Only 102 callers were actually advised by the teletriage service to seek emergency care. On the other hand, physicians have mixed views on the teletriage service, which may be related to the change in gatekeeper status of the health care system and concerns over loss of revenue for the profession. They report mixed feedback from their patients, but the high and growing number of calls suggests at least a degree of patient acceptance of the service.

The information technology (IT) component is extremely important to physicians as it may well represent the most significant financial benefit to them. A cost-sharing arrangement is in place by which the Ministry pays two-thirds of the cost of new IT systems and the physician pays one-third of the cost. The Ministry has also set out minimum standards in terms of IT functionality. Most physicians cited this as one of their main reasons for volunteering to be part of a primary care network pilot, some expressing a specific desire to implement electronic medical records and move towards a paperless office. This also proved to be the second biggest challenge facing physicians trying to become functional PCNs. Overall, physicians felt ill-prepared for the process of assessing their IT needs and selecting an IT system, sentiments echoed by many users with specialized needs but without specialized expertise in IT. Many PCNs were not fully satisfied with the advice they received

form the consultants they hired through MOHTLC funds. Some PCNs are very pleased with their IT acquisitions but others have experienced a variety of implementation setbacks and ongoing technical support problems -- it is not unusual for physicians within the same network to have purchased different IT systems. This does not bode well for future integration and connectivity; it also says something about the degree of actual versus on-paper collaboration.

Despite the challenges, physicians in most networks report a fairly high level of satisfaction with primary care reform. Most physicians are more satisfied now than they were prior to primary care reform, although 20% are less satisfied now than they were before taking part in primary care reform. Over 70% of the physicians interviewed said their expectations have been met. Seventy percent of physicians have not noticed changes in their practice patterns since joining a PCN. When changes were noted, they most often related to after hours coverage or information technology.

Overall satisfaction of patients was at least seven out of ten. Patients generally agreed that the quality of care was directly related to the way the individual doctor chooses to approach his or her profession. Former patients enrolled in an HSO noticed little change under primary care reform. Those patients not used to after-hours on-call access to their physicians noticed the most difference. Patients appreciated having access to a nurse practitioner. Patients felt that they had an appropriate level of access to the services they needed.

The top five benefits physicians have experienced being part of a PCN is:

- ☐ The lifestyle and practice-style benefits of the capitation model
- ☐ Better care for patients
- ☐ Information technology (IT)
- ☐ Increased income
- ☐ Shared call and coverage for absences

The top five challenges physicians have faced being part of a PCN are:

- ☐ Administrative demands
- ☐ IT
- ☐ Patient rostering
- ☐ Dealing with the Ministry
- ☐ Negotiation

To date, the involvement of nurse practitioners and other health care providers in the networks has been limited.

- ☐ Nurse practitioners play a wide variety of roles which contribute to the delivery and quality of patient care
- ☐ Patients report very high satisfaction with nurse practitioners
- ☐ Role definition and team integration have been a challenges in integrating nurse practitioners into PCNs; the nurse practitioner to physician ratio is extremely low in many PCNs
- ☐ High turnover amongst nurse practitioners is a source of concern
- ☐ Access to specialized resources (mental health counselors, nutritionists, psychiatrists) varies because only former HSO physicians have funding for these resources. These physicians are extremely satisfied with this service which is of great benefit to their patients. Other physicians would also like to have access to specialized resources but funding has not been provided to expand access for all physicians in the PCNs.

Ten PCNs are using the capitation payment mechanism; three PCNs are using the reformed-fee-for-service (RFFS) mechanism

- ☐ There is high physician satisfaction with capitation and preliminary evidence of changed behaviors due to capitation incentives
- ☐ There is low physician satisfaction with RFFS and no evidence at this stage of changed behaviors
- ☐ Roster size and patient profile can influence income; there is a need to ensure that the principle of equal access for all patients is maintained

Integration of information technology (IT) varies from network to network and from physician to physician

- ☐ There are many examples of successful integration of IT into practice including identification of patients on recalled drugs, preventive reminders, recalls for patient monitoring, templates for common conditions and physical exams
- ☐ IT is also used by every physician for practice management
- ☐ Barriers to further integration include delays in development of certain functions (e.g. online enrolment, secure e-mail, drug interaction software), implementation problems, physician readiness, misalignment of stakeholder expectations and reality

For some practices enrolment activities have wound down and the process is no longer a burden; for other practices enrolment continues to be paper-intensive and time consuming

- ❑ Some physicians perceive that roster limits are problematic in areas with a physician shortage
- ❑ Physician initiated de-rostering is occurring for a variety of reasons including outside use
- ❑ Only 33.2% of enrolled patients have signed consent forms

All PCNs are meeting the Ministry requirement for extended hours coverage

- ❑ There are many examples of shared call arrangements
- ❑ Some PCNs are collaborating on innovative approaches to covering physician absences due to vacation, holidays, illness, CME, etc

10 out of 13 PCNs using teletriage

- ❑ Volume of teletriage calls has exceeded forecast; there were 15,624 calls between September 2000 and May 2001
- ❑ Call volumes are low in some communities such as Carlisle, Kingston and Chatham
- ❑ The three newest PCNs do not yet have access to the teletriage service due to contractual issues
- ❑ Data from the teletriage service provider indicates that fewer patients are being advised to go to emergency departments than those whose pre-intent was to go to the emergency department
- ❑ Linguistic accessibility is an issue for after hours access

Primary care reform is encouraging an increased emphasis on health promotion,

- ❑ Prevention and patient education through four initiatives: new staff resources (i.e. nurse practitioners), information technology (e.g. preventive reminders), continuing
- ❑ Medical education fee code, and financial incentives (i.e. capitation, bonus fee codes)

Few new linkages have been forged with community partners; this may be because the PCNs have been very busy and/or because gaps in service make it difficult for physicians to achieve continuity of care.

Observations about the pilots must be interpreted within the context of the goals that were established for the pilots at the outset. The four primary care reform goals are:

- ❑ improved access
- ❑ improved quality and continuity of care
- ❑ increased patient and provider satisfaction
- ❑ increased cost-effectiveness of health care services

Some of the findings and trends observed provide insight into the achievement of specific goals. For example:

Improved Access

- ❑ All PCNs provide extended hours and share call (including on-site at designated locations) to ensure after-hours coverage. The establishment of new on-call and coverage arrangements that did not exist previously has improved coordination of care in some communities.
- ❑ Nurse practitioners are working in Hamilton, Paris and Rural Kingston. Where they exist, nurse practitioners are sharing the patient load and reducing the burden on physicians. Paris is an underserved area.
- ❑ The volume of patients using the teletriage service has surpassed the level of utilization expected.
- ❑ The physician linkage to the teletriage service informs physicians when their patients contact the On-Call Healthline with a health concern. Most physicians report that they are reading this form and then filing it in the patient's chart making it part of the ongoing patient record.
- ❑ In some cases, the increasing of rosters has provided access to patients who previously did not have a family doctor.

Improved quality and continuity of care

- ❑ The literature shows that clinical management systems have the potential to improve quality of care by reducing medical errors and adverse drug reactions. All PCN physicians are required to have a clinical management system. These systems are being used to various degrees within the pilots.
- ❑ Some physicians are using electronic medical records that facilitate analysis of patient histories to identify trends or specific patient groups, templates for specific disease groups or common interventions that improve the standardization of care, electronic reminders of when patients are due for preventive interventions and when patients need to be re-called for monitoring for chronic conditions such as diabetes or high cholesterol; these have the potential to improve quality of care
- ❑ Some nurse practitioners are conducting home visits; in some cases the nurse practitioner coordinates her visits with the home care nurse.

- ❑ Nurse practitioners are providing health promotion programs such as flu clinics, smoking cessation and diabetic teaching.
- ❑ Some physicians on the capitation payment model have said that they have revisited their treatment and follow up patterns.
- ❑ Physicians on capitation feel that access to continuing education has increased because there is no financial penalty for taking time off for CME

Increased Patient Satisfaction

- ❑ Preliminary results from the patient survey suggest that PCN patients are more satisfied than Ontario patients as a whole.
- ❑ According to reports by the teletriage service provider, 89% of callers to the teletriage service report that they agree with the advice provided by the teletriage nurse.
- ❑ Patients report that the addition of a nurse practitioner has enhanced the quality of primary care they receive due to improved access to health information.
- ❑ Very few physicians report having to de-roster patients because they are dissatisfied with primary care reform.
- ❑ However, overall patients have noticed little change in access, waiting time or quality with the introduction of primary care reform

Increased Physician Satisfaction

- ❑ Satisfaction levels appear to be on the increase as the hectic pace of the start-up phase winds down for most PCNs
- ❑ Very few physicians have left the PCNs since they were introduced. To date, no physician has left a network due to dissatisfaction with primary care reform.
- ❑ Satisfaction levels amongst nurse practitioners vary substantially and there are several sources of dissatisfaction that warrant close attention.
- ❑ Turnover among nurse practitioners has been very high

Increased Cost-Effectiveness of Health Care Services

- ❑ The use of practice management software for appointment scheduling, registration and billings have improved office efficiencies.
- ❑ The use of electronic medical records also improves efficiencies.
- ❑ The teletriage service appears to have had a positive impact on emergency room utilization. Data from the teletriage service provider suggests that in the absence of the teletriage service the callers would have made 1,874 visits to hospital emergency rooms. However, the teletriage service advised only 871 callers to seek emergency care – a difference of 1,003 visits.
- ❑ It has been proposed that nurse practitioners might have an impact on cost-effectiveness but there is no definitive evidence on the economic impact of nurse practitioners in the PCNs.

While there has obviously been some progress towards achievement of the four primary care goals many stakeholders have expressed a sense of disappointment that the networks are not further along. There are a number of barriers impeding the progress of the networks. These barriers can be divided into three categories:

1) Implementation barriers. These are barriers that relate, not to the model, but to how the model has been applied in practice. Implementation barriers usually have a high likelihood of being addressed over time as experience is gathered, feedback is obtained and corrective action is taken. It is critical that implementation barriers are identified and addressed as soon as possible. Examples of implementation barriers include delays in various IT components, insufficient multidisciplinary resources, inability to respond to higher than anticipated teletriage call volumes, and insufficient patient and public education about the reform.

2) Model barriers. These barriers speak to fundamental problems with the primary care reform model that is being implemented. Identification of these barriers will be important to Ontario Family Health Network (OFHN) the Ministry and the Ontario Medical Association (OMA) who are committed to learning from the pilots so that the model can be fine-tuned and improved in preparation for the provincial roll-out. Examples of model barriers include a physician-centric approach to the reform, issues with the bonus codes and capitation rates, insufficient feedback to physicians on outside use, and the need for specific performance measures for the PCNs.

3) Systemic barriers. These barriers relate to the structure and nature of the health care system in which the pilot is being introduced. They usually existed prior to the pilot and effect other health care services and programs as well. Addressing

systemic barriers will require significant action on the part of funders, policy makers and planners. The corrective action required will likely be long-term. Examples of systemic barriers include physician shortages, the health care funding structure, lack of integration with reforms in other health sectors, and gaps in service.

FHN FORMATION PROCESS

At the initial stage, a Family Health Network (FHN) consists of at least 5 physicians, who are able to demonstrate to the OFHN that they will be able to enroll at least 4000 patients.

The physicians must show documentation to the effect that they are collectively carrying at least 4000 patients. On or before the date the contract comes into effect, the physicians provide the Ontario Family Health Network the following:

- ❑ a completed Application for Group Registration in a form as may be required by the Ministry;
- ❑ signed FHN Physician Consent for Disclosure of Billing and Financial Information forms (i.e. Appendix G of the contract)
- ❑ a certificate signed by all of the FHN Physicians, to the effect that (1) the FHN Physicians have executed all Governance Documents necessary to meet the Governance Requirements and to perform all of their obligations under this agreement; (2) identify the lead physician and the associate physician with the authority to act on behalf of the FHN

FHN Physician and the Associate FHN Physician having the authority to act on behalf of the FHN as provided herein. Within thirty days of any request by the OFHN, the physicians rectify such inconsistencies or deficiencies and shall notify the OFHN of what changes have been made for such purposes. After the OFHN is satisfied that the FHN have fully and satisfactorily complied with the requirements, the Ministry issues a FHN Identifier Number.

The physicians then have 12 months of the issuance date to invite the patients in each of their practices the opportunity to become enrolled if they meet the conditions set out below.

1. The patient must be, at the time of enrolment, an insured person by OHIP.
2. The patient must reside within 100 kilometers of a location where the FHN Services are regularly provided
3. The patient cannot be a resident of a Long-Term Care Facility, incarcerated in a provincial or federal correctional institution or enrolled in another alternatively funded enrolled general practitioner service.

Patients enroll with an individual FHN Physician, but cannot be required to enroll in order to receive or to continue to receive services from a FHN physician. No patient shall be refused the opportunity to enroll with his or her FHN Physician on account of his or her health status or need for health services. A FHN Physician cannot limit or restrict his or her invitations to new patients to enroll on account of the patient's individual health status or need for health services. Patients who are invited to enroll are provided with the patient Enrolment Form and Consent to Release Personal Information. The Enrolment Form shall become effective upon its completion and signing by the patient and the acknowledgement of the FHN Physician. The FHN Physician, the FHN Physician shall provide a copy to the patient. The OFHN co-ordinates, oversees, supports and administers the enrolment process in co-operation with the FHN Physicians and their FHN, to minimize their work in this regard. Each FHN Physician receives a payment of \$1,000 upon starting the enrolment process after the issuance of a FHN Identifier Number and second payment of \$2000 within 60 days of the start date. (not enough, increase)

A FHN Physician can terminate his or her relationship with any patient in accordance with applicable guidelines issued by the College of Physicians and Surgeons of Ontario. There is no obligation for a FHN physician to go beyond his or her professional competence or that, using the FHN Physician's best efforts, are beyond the reasonable control of the FHN Physician.

Before a FHN can become operational, a FHN must be certified. The lead FHN physician gives written notice to the ministry and the OFHN at least 30 days before the proposed start date. In his/her written notice, the lead physician will include:

- (a) a copy of an insurance certificate, complying with the requirements;
- (b) a signed FHN Physician Declaration from any FHN physician who has joined since the agreement was signed
- (c) a signed FHN Contracted Physician Declaration from each FHN physician
- (d) a current list of all FHN physicians, with their office addresses and office hours
- (e) a description of on-call physician arrangements

The OFHN reviews the documentation. The OFHN gives notice of the inconsistencies or deficiencies as soon as possible. The OFHN works with the FHN to meet the requirements. The FHN physicians understand and agree that the failure to address such deficiency or inconsistency to the satisfaction of the OFHN precludes the certification of the FHN. The FHN is certified by the OFHN.

OPERATIONAL CONCERNS

The FHN physicians will, within the FHN, provide, co-ordinate or oversee the provision of the FHN Services. The FHN physician to whom a patient is enrolled shall be responsible for providing, co-ordinating or overseeing, as appropriate, the provision of the FHN services to that patient. Except for recognized holidays, the FHN physicians ensure that a sufficient number of physicians are available to provide the FHN Services during reasonable and regular office hours from Monday through Friday sufficient and convenient to serve enrolled patients. At least one FHN physician office staffed by a FHN physician or a contracted physician shall be open Monday to Thursday until 8 p.m., and for a minimum of three hours on weekends.

The FHN services are provided during reasonable and regular office hours at the offices of one or more of the FHN physicians, and at appropriate locations of their choice during evenings and weekends, as long as they advise the OFHN of those locations. FHN physicians who provide services in the emergency rooms of public hospitals will do their best to make sure that non-emergency services provided to enrolled patients are not counted by the hospital as a visit to the Emergency Room. FHN services provided by FHN physicians in a hospital must be offered separate and apart from the Emergency Room services. Enrolled patients must be advised by the physician of the office hours and locations, as well as posting those arrangements prominently.

The OFHN agrees that it shall, by the start date, at its expense, arrange the provision of advice and referral information, including triage to self-care, access, where appropriate, to an on-call FHN physician who is permitted access to the medical records of the enrolled patients and, if essential, to a public hospital emergency department. These services will be available to Enrolled Patients from 5 p.m. To 9 a.m., Monday to Thursday, 5 p.m. Friday to 9 a.m. Monday, and during holidays. There will be appropriate feedback to the responsible FHN Physician when an enrolled patient uses those services. There will be no charges to physicians or patients for those services, and the OFHN will pay the FHN \$2,000 a month for:

- (a) ensuring that a FHN physician is available on call during the hours of delivery;
- (b) ensuring that the provider of services is informed of which FHN physician is on call and how to reach that physician;
- (c) in conjunction with the OFHN, promoting the telehealth services among the FHN's enrolled patients and for encouraging its proper and appropriate use;
- (d) providing the telehealth provider with information about available local services to which the staff can direct callers;
- (e) participating in on-going reviews and an overall evaluation of telehealth services

Subject to the approval of the OFHN, where a community has multiple FHNs, on-call services may be provided on behalf of one or more FHN's by a single FHN Physician who is permitted access to the records of the enrolled patients.

Sample Worksheet: Strategy Without Core Idea

Worksheet 1: Strategy		
Issue/Problem	Physician wants different working conditions	
Goal	Form FHN	
Core Idea (metaphor, slogan, etc.)	None	
Tactics (actions or bundles of actions)	1	Recruit physicians
	2	Roster patients
	3	Negotiate contract
	4	Hire staff

Because coming up with a core idea is often the most difficult part of the exercise, there is a short worksheet that can be completed quickly that will stimulate the thinking of the participants.

Worksheet: Developing A Core Idea

Category	Possible Images or Metaphors	List Other Images or Metaphors	Develop a Slogan/core idea
Military	machine gun, rifle, tank		
Geographical	river, waterfall, creek		
Plant	tree, fern, Venus flytrap		
Transportation	bus, golf cart, car		
Sports	Caddy, gymnast, football		
Mechanical	wrench, Allen key, ratchet		
Insects	mosquito, ant, butterfly		
Animals	cougar, puma, rhinoceros		
Role models	Princess Diana, Donald Trump, Gandhi		
Your own category:	Your own metaphors:		

This worksheet is designed to force the participant to start thinking beyond the rational, linear model that has served him/her so far so well. The goal of the worksheet is to get the process of thinking metaphorically established, and then to give the participant some practice. It is deliberately simple to foster and focus thinking with strategy including *mètis*. Not all the metaphors are actually practical or helpful. The point is to produce a number of them so that the participant can then develop the capacity to judge which are better or more practical.

Worksheet 9: Core Idea			
Category	Suggested Metaphors, Images, Analogies, Role Models	Your Metaphors, Images, Role Models, Analogies	Core Idea
Military	Machine gun, rifle, tank		
Geographical	River, waterfall, creek		
Plant	Tree, fern, Venus flytrap		
Transportation	Bus, golf cart, car		
Sports	Caddy, gymnastics, football	soccer	The team will win
Mechanical	Wrench, Allen key, ratchet		
Insects	Mosquito, ant, butterfly	mosquito	I'll buzz around 'til you join
Animals	Cougar, puma rhinoceros	dog	Hound physicians into joining
Role models	Princess Diana, Donald Trump, Gandhi	Mother Theresa	This will do good
Your own Category:	Your own metaphors:		

Then the work can proceed to the development of a strategy with a core idea.

The same is true of the other worksheets, given below for the case study.

Worksheet 2: Key Actors

All Actors	Can this actor affect your achieving the goal? (Yes or No)
MOHLTC	Y
Other PCN's	N
HSO's	N
Other physicians in Ontario	Y
Staff	Y
Potential staff	Y
Patients	Y
Potential patients	Y

Worksheet 3: An Actor's Actions and Tactics		
Actor:physican initiating FHN		XX Individual QGroup
Time/Date	Action	Is this a tactic? (Yes/No)
	Negotiate contract with MOHLTC	Y
	Enroll patients	Y
	Hire extra staff	N
	Call advice lines	N
	Accept capitation method	Y
	Complete budgets for enrolment of patients	Y
	Complete budget for IT	Y
	Complete budget for nurse practitioners	Y
	Organize extended hours' coverage	Y
	Organize on call coverage	N
	Organize teletriage	N
	Organize IT	N
	Recruit physicians	Y
	Meet large number of requirements by MOHLTC	N

Worksheet 4: Resources a Strategy Can Draw On			
Resource	Do you have enough? (Yes/No)	Is this a 'nice have?' to	Is this a 'must have'?
Funds for staff	Y	N	Y
Funds for IT	Y	N	Y
Information for MOHLTC	Y	Y	N
Time to negotiate	N	N	Y
Willingness of other physicians to join	N	N	Y
Expertise on budget	N	Y	N

Worksheet 5: What you can and cannot do		
Rule	Does this rule help you reach your goal?	Does breaking this rule guarantee your failure?
Use funds for purposes other than dictated by MOHLTC	N	Y
Disregard terms of contract	N	Y

Ask for changes in remuneration during contract	N	N
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Worksheet 6: Factors Outside Your Control			
Goal: create PCN			
Factors that help		Factors that don't help	
Better money	→	←	Reluctance to give up control of practice
More money for IT	→	←	Reluctance to provide more services
More money for staff	→	←	

Worksheet 7: Do or Die Moments		
Goal:		
Steps to Goal	Problem 1	Problem 2
Negotiate contract with MOHLTC ▼		
Enroll patients ▼		
Accept capitation method ▼	Hire extra staff ▼	
	Recruit physicians ▼	Call advice lines ▼
		Complete budgets for enrolment of patients ▼
	▼	Complete budget for IT ▼
	▼	Complete budget for nurse practitioners ▼
		Organize extended hours' coverage ▼
		Organize on call coverage ▼
		Organize teletriage ▼
		Organize IT ▼
		Meet large number of requirements by MOHLTC ▼

Use as many columns or rows as you need. When you are done:
BOLD or CIRCLE EACH DO-OR-DIE MOMENT

Worksheet 8: Your Tactics, Other's Tactics			
Your Goal: create PCN		Others' Goal: MOHLTC Controls Costs	
Your Tactics		Their Tactics	
Negotiate contract with MOHLTC	→	←	Require budgets
Enroll patients	→	←	Offer alternative remuneration
Hire extra staff	→	←	Set standards of service
Call advice lines	→	←	Make new requirements for teletriage
Accept capitation method	→	←	Make new requirements for extended hours
Complete budgets for enrolment of patients	→	←	
Complete budget for IT	→	←	
Complete budget for nurse practitioners	→	←	
Organize extended hours' coverage	→	←	
Organize on call coverage	→	←	
Organize teletriage	→	←	
Organize IT	→	←	
Recruit physicians	→	←	
Meet large number of requirements by MOHLTC	→	←	

Should some participants belong to the third type of learners of strategy including *mètis*, it is possible to assign to them additional case studies.

Conclusion

Such a shift in thinking and mindset requires some very important skills be taught and some important characteristics be developed. Their current training does provide the chance to develop self discipline and the ability to do their job under extreme stress. Two other capacities are also required: the ability to change gears quickly, and what I call the ability to telescope: the ability to act within a certain scope and forecast the consequences on a broader scale, or to act on a broader scale and be able to forecast the consequences on a smaller scale.

The possibility of more rigid habits of thinking is more common among large, successful, and affluent armed forces, as in all walks of life. *Habitus* is the system of durable, transferable dispositions produced by the conditioning associated with a particular class of conditions of existence.³ The conditions of existence produce generating, organizing principles of practice and of mental representation of situations, which can be objectively adapted in their aim, but without the awareness of those aims and the mastery explicit of the operations necessary to attain them. The more specialized the training, the more affluent and/or successful the people, the more resistance there can be to learning, the more rigid the way of thinking. However, the *habitus* usually will become less rigid in times of crisis: the more severe the crisis, the more open people will become, and while it may be too late to help solve the crisis at hand, it is possible to introduce training at that time.⁴

There are a number of caveats to the training proposed above. First, the proportions of types of practitioners of *mètis* in most organizations is not known, as is the proportion among the various types of learner may be found in much lower proportions than in other walks of life. Second, the training of personnel troops proposed can be ordered, but the learning cannot. They may participate in the workshop while resisting the learning.

³ Pierre Bourdieu, *Le sens pratique* (Paris : Minuit, 1980), p. 88.

⁴ There is a third factor, of which I am aware, but which I have only begun to analyze, and which I will not address more than in the note: in the generation of people who grew up with access to the Internet and video games, I notice a difference in the ability to think abstractly, to take the initiative, and to concentrate for longer periods.

On the plus side, there are exercises and training developed by the author to fit any schedule, which are polyvalent to suit any of the sister services and any rank or trade. They will not be of equal significance, however to any armed force, service, rank or trade. There are also case studies available for training purposes, and for much broader applications. There is also a new general theory of strategy, and proposal of proposal of strategy as unit of analysis and guide for action and a methodology for theory-building. This new theory is already illustrated with a set of case studies involving states as actors: the analysis of a single state, the analysis of bilateral relations between states, the analysis of multilateral relations among states, and the analysis of bilateral and multilateral relations between an international organization of states and both member and non-member states. The second set of case studies using the individual citizen as actor has also been completed, along with two practical guides to action in the political system. At the time of this writing, a series of semi-fictional case studies involving individuals and groups in systems is being prepared. The future necessity for the inclusion of the application of strategy for the analysis of supra-national groups using strategy in a systemic context is already clear. These necessities figure among the next topics for research.

In parallel to these theoretical works are a series of practical guides, already mentioned, whose goal is to make available the methodologies produced by strategic theory, but without requiring the abstract theoretical work of the other strand. This strand includes books already published on organizational political strategy and tactics for individuals and small groups, as well as a book on using strategy in political activism, on how to use strategy to analyze national and international policies established by governments, on health services, on bioterrorism, and on electoral strategies. At the time of this writing, several books on research, and other applications are in preparation.