

# Today's Concept of Organizational Management

## CHAPTER OBJECTIVES

- Define management and differentiate between the art and science of management.
- Review the basic functions of management.
- Describe the major phases of the development of organizational management.
- Present the concept of the work setting as a total system.
- Introduce the concept of clientele network and describe the application of this concept to the health care setting.

## THE NATURE OF MANAGEMENT: ART OR SCIENCE?

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Management has been defined as the process of getting things done through and with people. It is the planning and directing of effort and the organizing and employing of resources (both human and material) to accomplish some predetermined objective. Within the overall concept of management, the function of administration can be identified. The practical execution of the plans and decisions on a day-to-day basis requires specific administrative activities that managers may assign

to executive officers or administrators. Managers may find that their role includes specifically administrative activities in addition to overall management responsibilities. The workday of a typical department head in a health care institution contains a mix of broad-based managerial functions and detailed administrative actions.

Especially since the turn of the 20th century, management's scientific aspects have been emphasized. The scientific nature of management is reflected in the fact that it is based on a more or less codified body of knowledge consisting of theories and principles that are subject to study and further experimentation. Yet, management as a science lacks the distinct characteristics of an exact discipline, such as chemistry or mathematics.

The many variables associated with the human element make management as much an art as a science. Even with complex analytical tools for decision making, such as probability studies, stochastic (random) simulation, and similar mathematical elements, the manager must rely on intuition and experience in assessing such factors as timing and tactics for persuasion.

## FUNCTIONS OF THE MANAGER

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A manager's functions can be considered a circle of actions in which each component leads to the next. Although the functions can be identified as separate sets of actions for purposes of analysis, the manager in actual practice carries out these activities in a complex, unified manner within the total process of managing. Other individuals in the organization carry out some of these activities, either periodically or routinely, but the manager is assigned these specific activities in their entirety, as a continuing set of functions. When these processes become routine, the role of manager emerges. The traditional functions of a manager were identified by Gulick and Urwick<sup>1</sup> based on the earlier work of Henri Fayol.<sup>2</sup> Chester Barnard brought together the significant underlying premises about the role of the manager in his classic work *The Functions of the Executive*.<sup>3</sup>

### *Classic Management Functions*

Management functions typically include

- *planning*—the selection of objectives, the establishment of goals, and the factual determination of the existing situation and the desired future state.
- *decision making*—a part of the planning process in that a commitment to one of several alternatives (decisions) must be made. Others may assist in plan-

ning, but decision making is the privilege and burden of managers. Decision making includes the development of alternatives, conscious choice, and commitment.

- *organizing*—the design of a pattern of roles and relationships that contribute to the goal. Roles are assigned, authority and responsibility are determined, and provision is made for coordination. Organizing typically involves the development of the organization chart, job descriptions, and statements of work flow.
- *staffing*—the determination of personnel needs and the selection, orientation, training, and continuing evaluation of the individuals who hold the required positions identified in the organizing process. (Some theorists class the staffing function within the organizing function, rather than viewing it as a separate function.)
- *directing or actuating*—the provision of guidance and leadership so that the work performed is goal-oriented. It is the exercise of the manager's influence, the process of teaching, coaching, and motivating workers.
- *controlling*—the determination of what is being accomplished, the assessment of performance as it relates to the accomplishment of the organizational goals, and the initiation of corrective actions. In contemporary management practice, the larger concepts of performance improvement and total quality management include controlling.

Figure 3–1 summarizes the classic functions of managers and their relationship to each other. In addition, managers must continually establish and maintain internal and external organizational relationships to achieve an effective working rapport. They must monitor the organization's environment to anticipate change and bring about the adaptive responses required for the institution's survival.

At different phases in the life of the organization, one or another management function may be dominant. In the early stages of organizational development, for example, planning is the manager's primary function. When the organization is mature, however, controlling functions are emphasized.

### *The Health Care Practitioner as Manager*

In the specialized environment of a health care institution, qualified professional practitioners may assume the role of unit supervisor, project manager, or department head or chief of service. The role may emerge gradually as the number of patients increases, as the variety of services expands, and as specialization occurs



FIGURE 3–1 Interrelationship of Management Functions

within a profession. A physical therapy staff specialist, for example, may develop a successful program for patients with spinal cord injury; as the practitioner most directly involved in the work, this individual may be given full administrative responsibility for that unit. The role of manager begins to emerge as budget projections need to be made, job descriptions need to be updated and refined, and the staffing pattern needs to be reassessed and expanded.

An occupational therapist may find that a small program in home care flourishes and is subsequently made into a specialized unit. Again, this credentialed practitioner in a health care profession assumes the managerial role. The medical technologist who participates in the development of a nuclear medicine unit and the dietitian who develops a nutrition counseling program for use in outpatient clinics may also find themselves in this position.

Practitioners who develop their own independent professional practices assume the role of manager for their business enterprises. The role of the professional health care practitioner as manager is reinforced further by the various legal, regulatory, and accrediting agencies that often require chiefs of service or department heads to be qualified practitioners in their distinct disciplines. The role of manager then becomes a predictable part of the health care practitioner's tenure in an institution. Table 3–1 shows how activities in a typical workday of a department head in a health care institution reflect the functions of a manager in their classic form.

**Table 3–1** The Chief of Service as Manager: Example of Daily Activities

Activity	Management Function Reflected
Readjust staffing pattern for the day because of employee absenteeism	Staffing
Review cases with staff, encouraging staff members to assume greater responsibility	Controlling Planning Leading/motivating/actuating
Counsel employee with habitual lateness problem	Controlling Leading/motivating/actuating
Present departmental quality assurance plan for approval of Risk Management/Quality Assurance Committee	Planning Leadership
Conduct research to improve treatment techniques	Planning Leadership
Dialogue with third-party reimbursement manager about coverage for innovative services	Planning Leadership

## THE HISTORY OF MANAGEMENT

Knowledge of the history of management provides a framework within which contemporary managerial problems may be reviewed. Modern managers benefit from the experiences of their predecessors. They may assess current problems and plan solutions by using theories that have been developed and tested over time. Contemporary executives may take from past approaches the elements that have been proved successful and seek to integrate them into a unified system of modern management practice.

In an examination of the phases in management history, it must be remembered that history is not completely linear and that any period in history involves a dynamic interplay of components that cannot be separated into distinct elements. The analysis of selected processes of the various historical periods tends to obscure the fact that each period is part of a continuum of events. The specific features of management history phases given here are intended to exemplify the predominant emphasis of each period and are only highlights. The second caution is in regard to dating the various periods. The dates given here are intended as guides. There is no precise day and year when one school of thought or predominant approach began or ended. As with any study of history, the dates suggest approximate periods when the particular practices were developed and applied with sufficient regularity as to constitute a school of management thought or a predominant approach.

### *Scientific Management*

The work of Frederick Taylor (1865–1915) is the commonly accepted basis of scientific management. Taylor started as a day laborer in a steel mill, advanced to foreman, and experienced the struggles of middle management as the workers resisted top executives' efforts to achieve more productivity. He faced the basic question: What is a fair day's work? With Carl G. L. Barth (1860–1939) and Henry L. Gantt (1861–1919), Taylor made a scientific study of workers, machines, and the workplace. These pioneers originated the modern industrial practices of standardization of parts, uniformity of work methods, and the assembly line.

Frank Gilbreth (1868–1924) and Lillian Gilbreth (1878–1972) developed a class of fundamental motions, starting with the therblig (Gilbreth spelled backwards but with the *t* and *h* transposed) as the most basic elemental motion. Lillian Gilbreth may be of particular interest to occupational therapists, since much of her later work concerned the efficiency of physically handicapped women in the management of their homes. Scientific management became an accepted, codified concept as a result of a famous case on railroad rate structures heard by the Interstate Commerce Commission. Louis D. Brandeis, who later became a Supreme Court justice, argued against rate increases by citing the probable effects of the application of "scientific management."<sup>4</sup> The concept emerged as the predominant approach to management during this era. It continues to be a basis for continuous improvement in productivity and cost containment.

### *The Behaviorists and the Human Relations Approach*

Although the major figures in the development of scientific management emphasized the work rather than the worker, concern for the latter was apparent. Lillian Gilbreth, for example, was a psychologist and tended to stress the needs of the employee. Frank Gilbreth developed a model promotion plan that emphasized regular meetings between the employee and the individual responsible for evaluating the employee's work.

Unlike adherents of the scientific management approach, who considered the worker only secondarily, behaviorists focused primarily on the worker. The application of the behavioral sciences to worker productivity and interaction was exemplified in the Hawthorne Experiments conducted by Elton Mayo and F. J. Roethlisberger at Western Electric's Hawthorne Works. Through these studies, the importance of the informal group and the social and motivational needs of workers were recognized. The behavioral science and the human relations approaches

may be linked because both emphasize the worker's social and psychological needs, and stress group dynamics, psychology, and sociology. Theorists associated with these approaches include Douglas MacGregor, Rensis Likert, and Chris Argyris. The Deming approach, with its emphasis on quality circles, and total quality management, with a highly participative style of management, is a contemporary example of the human relations approach. A more recent expression of this emphasis is reflected in the appreciative inquiry method of assessing the strengths of an organization.

### *Structuralism*

Since work is done within specific organizational patterns and since the worker-superior roles imply authority relationships, the structure or framework within which these patterns and relationships occur has been studied. Structuralism is based on Max Weber's theory of bureaucracy or formal organization. Robert K. Merton, Philip Selznik, and Peter Blau, major theorists in the structuralist school of thought, gave particular attention to line and staff relationships, authority structure, the decision-making process, and the effect of organizational life on the individual worker.

### *The Management Process School*

The special emphasis in the management process approach is on the various functions that the manager performs as a continuous process. Henri Fayol (1841–1925), a contemporary of Taylor, studied the work of the chief executive and is credited with having developed the basic principles or “laws” that are associated with management functions. His writings did not become readily available in English until 1939 when James D. Mooney and A. C. Reiley published a classification and integrated analysis of the principles of management, including Fayol's concepts.<sup>5</sup> Chester Barnard could be considered a member of this school of thought in that he explored the basic processes and functions of management, including the universality of these elements.

### *The Quantitative or Operations Research Approach*

Problem solving and decision making with the aid of mathematical models and the use of probability and statistical inference characterize the quantitative or operations research approach to management. Also called the management science school, this

approach includes the various quantitative approaches to executive processes and is characterized by an interdisciplinary systems approach. The urgency of the problems in World War II and in the space program speeded the development of mathematical models and computer technology for problem solving and decision making.

The Six Sigma approach to continuous quality improvement relies on statistical analysis as one of its main elements of analysis of organizational performance.

## THE SYSTEMS APPROACH

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Each school of management thought tends to emphasize one major feature of an organization:

1. Scientific management focuses on work.
2. Human relations and behavioralism stress the worker and the worker-manager relationship.
3. Structuralism emphasizes organizational design.
4. Management process theory focuses on the functions of the manager.
5. Management science theory adds computer technology to the scientific method.

The search for a management method that takes into account each of these essential features led to the systems approach. This focuses on the organization as a whole, its internal and external components, the people in the organization, the work processes, and the overall organizational environment.

### *Historical Development of the Systems Model*

The systems model is generally accepted in the area of computer technology, but its use need not be limited to such an application; at its origin, it was not so restricted. A more flexible use of this approach provides the manager with a framework within which the internal and external organizational factors can be visualized. The systems approach to management emphasizes the total environment of the organization. The cycle consisting of input, transformation to output, and renewed input can be identified for the organization or for any of its divisions. The changes in organizational environment can be assessed continually in a structured manner to determine the impact of change.

Management theorists turned to biologists and other scientists to develop the idea of the organization as a total system. With this ecological approach, a change



in any one aspect of the environment is believed to have an effect on the other components of the organization. The specifics are analyzed, but always in terms of the whole. The institution is considered an entity that “lives” in a specific environment and has essential parts that are interdependent.

General systems theory as a concept was introduced and defined by Ludwig von Bertalanffy, a biologist, in 1951.<sup>6</sup> His terminology is the foundation for the basic concepts of the general systems theory.<sup>7</sup> Kenneth E. Boulding developed a hierarchy of systems to help bridge the gap between theoretical and empirical systems knowledge. He noted that the general systems approach furnished a framework or skeleton for all science but that each discipline, including management science, must apply the model, add the flesh and blood of its own subject matter, and develop this analytical model further. Included in Boulding’s hierarchy of systems is the concept of the open system and the idea of the social organization with role sets.<sup>8</sup>

Many contemporary studies of various aspects of organizations are based on the systems model. Areas of specific application include

- *cybernetics*—the science of communication and control<sup>9</sup>
- *data-processing systems*—systems used to guide the flow of information, usually by means of computer technology
- *rhochrematics*—the science of managing material flow, including production and marketing, transporting, processing, handling, storing, and distributing goods<sup>10</sup>
- *network analysis*—the process of planning and scheduling (e.g., PERT [program evaluative review technique] networks and the critical path method)
- *administrative systems*—the planned approach to activities necessary to attain desired objectives

### ***Basic Systems Concepts and Definitions***

A system may be defined as an assemblage or combination of things or parts forming a complex or unitary whole, a set of interacting units. The essential focus of the systems approach is the relationship and interdependence of the parts. The systems approach moves beyond structure or function (e.g., organization charts, departmentation) to emphasize the flow of information, the work, the inputs, and the outputs. Systems add horizontal relationships to the vertical relationships contained in traditional organizational theory.

The systems model is made up of four basic components: (1) inputs, (2) throughputs or processes, (3) outputs, and (4) feedback (Figure 3–2). The overall environment also must be considered.

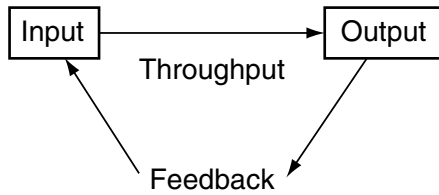


FIGURE 3–2 Basic Systems Model

### *The Nature of Inputs*

Inputs are elements the system must accept because they are imposed by outside forces. The many constraints on organizational processes, such as government regulation and economic factors, are typical inputs imposed by outside groups. Certain inputs are needed in order to achieve the organizational goals; for example, the inputs often are the raw materials that are processed to produce some object or service. The concept of inputs may be expanded to include the demands made on the system, such as deadlines, priorities, or conflicting pressures. Goodwill toward the organization, general support, or the lack of these also may be included as inputs.

A systematic review of inputs for a health care organization or one of its departments could include

- *characteristics of clients*— average length of stay, diagnostic categories, payment status
- *legal and accrediting agency requirements*—federal conditions of participation for Medicare programs, institutional licensure, and licensure or certification of health care practitioners
- *federal and state laws concerning employers*—collective bargaining legislation, the Occupational Safety and Health Act, Workers' Compensation, Civil Rights Act
- *multiple goals*—patient care, teaching, research

### *The Nature of Outputs*

Outputs are the goods and services that the organization (or subdivision or unit) must produce. These outputs may be routine, frequent, predictable, and somewhat easy to identify. The stated purpose of the organization usually contains information on its basic, obvious outputs. For example, a fire department provides fire protection, a hospital offers patient care, a department store sells goods, a fac-

tory produces goods, and an airline supplies transportation. Managers control routine and predictable outputs through proper planning.

Other necessary outputs are infrequent but predictable. By careful analysis of organizational data over a relatively long time period, these infrequent outputs can usually be identified. For example, hospitals or programs are reaccredited periodically, and plans can be made for the reaccreditation process because it is predictable. An organization that is tied directly to political sponsorship could take the cycle of presidential and congressional elections into account. Again, proper planning through identification and anticipation of such special periodic demands on the system leads to greater control and, consequently, stability.

Most managers face a third category: the nonpredictable outputs for which they can and must plan. Certain demands on the system are made with sufficient regularity that, although the exact number and time cannot be calculated, estimates can be made. This is an essential aspect of proper planning and controlling. In an outpatient clinic, for example, the number of walk-in and/or emergency patients is not predictable. In order to plan for these relatively random demands on the system, the manager studies the pattern of walk-in patients, their times of arrival, and the purposes of their visits. Some patient education would probably be done to help clients take advantage of orderly scheduling. Staffing patterns would be adjusted to meet the anticipated needs. The planning is designed to shift the nonpredictable to the predictable as far as possible. Other examples of nonpredictable outputs for which plans can be developed include telephone calls, employee turnover rates, and even activities required by certain kinds of seasonal disasters (e.g., tornadoes or hurricanes) or by seasonal changes in the numbers and types of clients (e.g., in a resort area).

Some outputs are unexpected, such as those that become necessary because of natural disasters or sudden economic chaos. Even in these instances, managers can anticipate and plan for Armageddon in any of its symbolic or real forms. Disaster planning, for example, is a required part of institutional health care management. The renewed emphasis on disaster planning in light of bioterrorism or other major political-social disruption has added an urgency to such planning in contemporary times.

Some outputs for health care institutions are

- maintenance of accreditation and licensure status
- compliance with special federal programs concerning quality assurance or health care planning
- provision of acute care services for medical, surgical, obstetric, and pediatric patients

- provision of comprehensive wellness and preventive health services for clients in a specific area

Outputs in health care institutions may be refined even further by adding specific time factors, quality factors, or other statements of expected performance:

- 100 percent follow-up on all patients who fail to keep appointments
- processing of specified laboratory tests within ten hours of receipt of specimen
- retrieval of patient medical record from permanent file within seven minutes of receipt of request

It may be useful to group outputs with the related inputs by formulating input/output statements. It should be noted, however, that not every input generates a direct output; there is no one-to-one relationship of inputs to outputs. It may be necessary to consider a cluster of inputs in relation to a single output. For example, the goal (output) of retrieving the medical record of a patient who enters the walk-in clinic without an appointment may require considerations (inputs) of accuracy of identification, chart availability, and delivery system procedures.

### *Throughputs (Withinputs)*

Throughputs are the structures or processes by which inputs are converted to outputs. Physical plant, work flow, methods and procedures, and hours of work are throughputs. Inputs originate in the environment of the organization; throughputs, as the term implies, are contained within the organization. Throughputs are analyzed by work sampling, work simplification, methods improvement, staffing patterns, and physical layout analysis.

Managers may be severely limited in their ability to control inputs, but the processes, structures, organizational patterns, and procedures that constitute the throughputs are normally areas of management prerogative. For example, a chief of service cannot control patient arrivals for walk-in service in a clinic; this input is imposed on the system. The policies and procedures for processing walk-in patients, however, constitute a cluster of throughputs that can be determined by the manager. The physical space allotment for a department may be imposed; the manager must accept this input, but the final and detailed physical layout of the department is under the manager's control.

In a specialized service, the control of throughputs is directly related to the manager's professional knowledge. For example, procedures for processing patient

flow within a clinic are developed by the chief of service because of that person's knowledge of patient care procedures, priorities, and the interrelationships among components of the treatment plan. The policies and procedures for the release of information from patients' health records are aspects of highly technical processes that are the domain of the professional health information specialist.

In some cases, elements that theoretically belong to the throughput category are considered inputs. These are elements that are imposed by the environment (i.e., the organization as a whole). Managers may not be able to exert direct control over some aspects of the work (e.g., in the case of physical space limitations, budget cuts, and personnel vacancies), and these elements could be listed as special inputs.

### *Feedback*

Changes in the input mix must be anticipated. In order to respond to these changes, managers need feedback on the acceptability and adequacy of the outputs. It is through the feedback process that inputs and even throughputs are adjusted to produce new outputs. The communication network and control processes are the usual sources of organized feedback. Routine, orderly feedback is provided by such activities as market research and forecasting in business organizations, client surveys in service organizations, periodic accreditation surveys in health care institutions, periodic employee evaluations in work groups, and periodic testing and grading in an educational system. The management by objectives process, short interval scheduling, and program evaluation review technique (PERT) networks constitute specific management tools of planning and controlling that include structured, factual feedback.

If there is an absence of planned feedback, if the communication process is not sufficiently developed to permit safe and acceptable avenues for feedback, or if the feedback actually received is ignored, a certain amount of feedback will occur spontaneously. In this case, the feedback tends to take a negative form, such as a client outburst of anger, a precipitous lawsuit, a riot, a wildcat strike, a consumer boycott, or an epidemic. Spontaneous feedback could take a positive form, of course, such as the acclamation of a hero or leader after a crisis or an unsolicited letter of satisfaction from a client.

Some feedback is tacit, and the manager may assume that since there is no overt evidence to the contrary, all outputs are fine. The danger in such an assumption is that problems and difficulties may not come to light until a crisis occurs. The planning process is undermined because there are no reliable data that can be used to assess the impact of change and to implement the necessary adjustments.

### *Closed Systems versus Open Systems*

Systems may be classified as either closed or open. An ideal closed system is complete within itself. No new inputs are received, and there is no change in the components; there is no output of energy in any of its forms (e.g., information or material). Few, if any, response or adaptation systems are needed because such a closed system is isolated from external forces in its environment and internal change is self-adjusting. Examples of closed systems include a chemical reaction taking place in a sealed, insulated container; a sealed terrarium; and a thermostat. In certain approaches to organizational theory, organizations have been viewed as closed systems—that is, the emphasis has been placed on the study of functions and structure within the organization without consideration of its environment and the consequent effect of environmental change on its processes.

An open system is in a constant state of flux. Inputs are received and outputs produced. There is input and output of both matter and energy, continual adaptation to the environment, and, usually, an increase of order and complexity, with differentiation of parts over time.

An open system constantly seeks internal balance, or homeostasis, by means of an adjustive function of stimulus-response. A change in the organizational environment (stimulus) makes it necessary to take some action (response) to maintain this balance. Notterman and Trumbull, using a laboratory model, noted three processes necessary for a system to maintain this self-regulating cycle:<sup>11</sup>

1. *Detection.* For regulation to take place, the disparity between the disturbed and normal (or desired) state must be detectable by the organism. Obviously, if the organism cannot sense a disturbance (perceptually or physiologically), measures cannot be taken for its correction. Equally apparent is the fact that individuals vary in both the quality and quantity of information they require in order to detect a disturbance.
2. *Identification.* The disparity must also be identified. Corrective action cannot be specific unless a given disturbance is successfully discriminated from other possible disturbances. Here again, individual differences in the form and quantity of information necessary for identification undoubtedly exist.
3. *Response Availability.* Upon detection and identification of the disturbance, the organism must be permitted by environmental, physiological, or laboratory conditions to make the correction.

The management functions of decision making, leadership, and, particularly, correction of deviation from organizational goals are necessary for the detection, identification, and proper response to changes in the organization's environment.

In the open system, the adjustment to the environmental change is made through the input-output cycle and the development of appropriate feedback mechanisms. Another major management function, then, becomes the systematic monitoring of change.

All living organisms have the capacity for maximum disorder, disintegration, and death. This tendency toward disintegration is termed *entropy*. The open system is characterized by the continual striving for negative entropy (negentropy). It tries to overcome disintegration by taking into itself more inputs or higher-level inputs (i.e., whatever it needs to produce the required outputs). Obvious examples of this include a bear storing body fat and changing its metabolism for winter hibernation or the human body building up immunity. In the management context, an organization may build a reserve of money or client goodwill against potential hard times.

### *Application of General Systems Theory*

The systems approach enables managers to focus on the organization as a whole and to view each particular division or unit in the organization in relation to the whole. Through the systems approach, managers can cut across organizational lines to determine interrelationships in the work flow and to assess complexities in the structure and in the environment of the organization. Their attention is drawn to changes in the environment that affect the organization and its units. Managers are aided in their analysis of the organization because the input-output model frees them of personal bias toward or attachment to the existing mode of operations. Furthermore, the classic functions of a manager, which are carried out in the distinct, unique environment of a given organization, are reflected in the systems approach. Table 3–2 summarizes this interrelationship. The remainder of this presentation of management principles is developed in the context of specific functions of the manager carried out in an overall organizational environment. Since the functions of the manager are shaped and modified by the particular organizational environment, the tools for analyzing the organization will be presented first, followed by detailed discussion of individual management functions.

## VIEWING THE WORK ORGANIZATION AS A TOTAL SYSTEM

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There is considerable social evidence to support the basic observation that humans form groups: families, clans, neighborhoods, churches, political parties, businesses, fraternities, work groups, professional associations. The study of these groups as

**Table 3–2** Relationship of Classic Management Functions and Systems Concepts

<b>Systems Concept</b>	<b>Predominant Management Function</b>
Input analysis	
Identification of constraints	
Assessment of client characteristics	Planning
Assessment of physical space	
Budget allocation analysis	
Throughput determination	
Development of policies, procedures, methods	Planning and controlling
Development of detailed departmental layout	
Specification of staffing pattern	Staffing
Methods of worker productivity enhancement	Controlling, leadership, and motivation
Output analysis	
Goal formulation	Planning
Statement of objectives	
Development of management by objectives plan	Planning and controlling
Feedback mechanisms	
Development of feedback processes	Controlling, communicating, and resolving conflict
Adjustment of inputs and outputs in light of feedback	Renewing planning cycle
Adjustment of internal throughputs	

social organizations is the proper domain of the social scientist; their study as formal organizations is the proper focus of administrative analysis.

The successful manager recognizes the impact of the organizational environment on clients, members of the organization, and the public at large as well as on the manager's specific role. An organization does not exist in a static world; rather, it is in a continual state of transaction with its environment. As an open system, the organization receives inputs from its environment—acts on them and is acted on by them, and produces outputs, such as goods and services (and even organizational survival, which can be considered an essential output). Consequently, the organizational environment consists of both internal and external components. The specific functions of the manager are modified by the organizational environment (i.e., the specific attributes of the given work setting). Classical organizational theory provides the manager with concepts to assess the organizational environment. The organizational environment may be assessed by an examination of its characteristics and components through a typology of organizations, a review of the organizational life cycle, and an analysis of the purpose and functions of organizations. The use of clientele network and systems models yields further information about the internal and external components of the organizational environment. Managers may anticipate organizational conflict when stated purposes or goals and



actual practices become disparate; such an occurrence should alert managers to changes in the organizational environment so that they can develop an anticipatory response rather than a reactive response.

## FORMAL VERSUS INFORMAL ORGANIZATIONS

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An organization is a basic social unit that has been established for the purpose of achieving a goal. A formal organization is characterized by several distinct features:

- a common goal; an accepted pattern of purpose
- a set of shared values or common beliefs that give individuals a sense of identification and belonging
- continuity of goal-oriented interaction
- a division of labor deliberately planned to achieve the goal
- a system of authority or a chain of command to achieve conscious integration of the group and conscious coordination of efforts to reach the goal

An informal organization may be characterized by some of the features of formal organizations, but it lacks one or more of these features. Individuals who share a common value may meet regularly to foster some goal, and this group may become a recognizable formal organization. Some informal groups never develop the consistent characteristics of a formal organization, however, and simply remain informal.

Formal organizations almost inevitably give rise to informal organizations. Such informal groups may be viewed as spontaneous organizations that emerge because individuals are brought together in a common workplace to pursue a common goal, which makes social interaction inescapable. Informal organizations arise as a means of easing the restrictions of formal structures, as in the cooperative communication and coordination that may occur outside of the officially mandated channels of authority. Through an informal organization's communication network, an individual may gain valuable information that supplements or clarifies the formal communications. Also, informal groups help to integrate individuals into the organization and socialize them to accept their specific organizational roles. A manager must remain aware of the existence and composition of the informal groups in the organization so that their functioning affects the formal structure in positive rather than negative ways.

## CLASSIFICATION OF ORGANIZATIONS

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When an organization's managers understand and accept its nature, organizational conflict can be reduced and organizational viability increased, because the managers function in a manner consistent with the type of organization shaping the interactions. Personal conflict can be reduced. Should an individual be unwilling or unable to accept certain aspects of a particular organizational type, that individual may decide to move to a different organizational climate. For example, if an individual practitioner prefers not to function in a highly structured, bureaucratic setting, it is better to recognize this before accepting employment in a government-sponsored health care institution. An individual who believes that health care should not be "for profit" would do well to seek employment in health care settings that are not predicated on the business model. An individual may gain an insight into the climate of a particular organization through the use of organizational classifications based on prime beneficiary, authority structure, and genotypic characteristics.

### *Prime Beneficiary*

Peter Blau and W. R. Scott presented a classification of organizations based on the prime beneficiary.<sup>12</sup> Their suggested model for the analysis of organizations focuses on this question: Who benefits from the existence of the organization? Four types of organizations result from the application of this criterion.<sup>13</sup>

1. mutual benefit associations, where the members are the prime beneficiaries; examples include a professional association, a credit union, and a collective bargaining unit
2. business concerns, where the owners are the prime beneficiaries
3. service organizations, where the clients are the prime beneficiaries
4. commonweal organizations, where the public at large is the prime beneficiary; police and fire departments are examples of commonweal organizations

Managers may formulate goals, establish priorities, and monitor activities to determine the effectiveness of the organization in meeting the needs of the prime beneficiary. Actions that do not foster such goals are eliminated and proper priorities formulated. Because the clients are the prime beneficiaries of a service organization, decisions about hours of service, the scope of services offered, and similar matters are made with the needs of clients in mind. In health care, the growing development of home care, flexible hours in outpatient care clinics, and alternatives to full hospitalization are attempts at meeting the needs of the prime beneficiaries, the patients and their families. At the same time, health care worker units involved

in collective bargaining can be considered mutual benefit associations. Managers in health care settings must balance the demands made by both types of organizational forms within one organization.

### *Authority Structure*

The organizational environment can also be classified according to the modes of authority that are operative in the institution. Managers must adopt leadership styles, develop procedures and methods for worker interaction, and determine client interactions in a manner that is consistent with the predominant authority structure. Health care organizations tend to embody more than one pattern of authority structure; for example, there are few limits on the activities of professional staff and greater limits on the activities of semiskilled and unskilled workers. The work of Amatai Etzioni provides a typology of organizations based on the authority structure predominant in the institution.<sup>14</sup> The classification that results from this approach may be summarized as follows:

1. predominantly coercive authority; prisons, concentration camps, custodial mental institutions, or coercive unions
2. predominantly utilitarian, rational-legal authority; use of economic rewards; businesses, industry, unions, and the military in peacetime
3. predominantly normative authority; use of membership, status, intrinsic values; religious organizations, universities, professional associations, mutual benefit associations, fraternal and philanthropic associations
4. mixed structures; normative-coercive (e.g., combat units); utilitarian-normative (e.g., most labor unions); utilitarian-coercive (e.g., some early industries, some farms, company towns, ships)

### *Genotypic Characteristics*

Like the prime beneficiary concept, the classification of organizations by genotype is based on an analysis of their fundamental roots and purposes. Daniel Katz and Robert Kahn viewed organizations as subsystems of the larger society that carry out basic functions of that larger society. These basic functions are the focal point in this system of classification. The typology of organizations developed by Katz and Kahn is based on genotypes, or first-order characteristics: What is the most basic function that the organization carries out in terms of society?<sup>15</sup> These first-order, basic functions are as follows:

1. *productive or economic functions*—the creation of wealth or goods as occurs in businesses

2. *maintenance of society*—the socialization and general care of people as occurs in education, training, indoctrination, and health care
3. *adaptive functions*—the creation of knowledge as occurs in universities and as a result of research and artistic endeavors
4. *managerial/political functions*—adjudication and coordination functions and control of resources and people as occur in court systems, police departments, political parties, interest groups, and government agencies

The charter, articles of incorporation, and statement of purpose are official documents of the organization that can be used to classify the organization according to this typology.

Goal statements are derived and priorities set in terms of primary function. Managers can monitor organizational change when the actual function performed differs from the stated function. When a social service agency spends a great deal of effort determining eligibility of patients for service under a variety of government programs, it is assuming some of the characteristics of a managerial/political organization. Sometimes this adjudication interferes with the delivery of the health care service; managers must make decisions in the light of this conflict. If priority is given to research and education over direct patient care, the health care practitioner must again come to terms with the true nature of the organization.

## CLASSIFICATION OF HEALTH CARE ORGANIZATIONS

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When a health care organization is classified according to these typologies, the complexity of the setting becomes apparent. Classification by prime beneficiary offers several possibilities. In terms of direct patient care, for example, the health care organization can be classified as a typical service organization. On the other hand, if it is a for-profit institution, classification as a business organization is more appropriate. If the health care organization has a mixed goal, as does a teaching hospital associated with a medical school, it can be defined as a service organization with respect to its clients—both the physicians to be educated and the patients to be treated. The potentially conflicting priorities of teaching and direct patient care underlie the selection of patients for treatment, however; preference may be given to those patients who are “interesting” cases for teaching purposes. Even when a health care institution is not directly associated with a medical school, a variety of clinical affiliation arrangements may be developed to meet the needs of such practitioners as occupational and physical therapists, medical technologists, social work-

ers, health information administrators, dietitians, and other groups that require clinical practice as part of their educational sequence. In developing goal statements for a department, the chief of service must keep this secondary goal in mind.

A health care organization also is a commonweal organization insofar as it protects the public interest in matters of general community health, such as the benefits of the facility's research efforts for the public at large. Health care institutions also offer a variety of free health-monitoring programs as a means of fostering health maintenance in the community.

Etzioni included the hospital as an example of normative authority structure. This point could be argued, however, depending on the focus of organizational analysis. Professional staff members tend to function in the normative mode; their codes of ethics, their professional training, and the general level of behavior expected of them modify individual participation in the organization as much as, if not more than, the formal bylaws and contractual arrangements. In this sense, the normative authority structure predominates. When the health care organization is viewed from another perspective, it seems to function more as a mixed normative-utilitarian structure. With business orientation and the increasing unionization of workers in the health care field, the utilitarian model seems to be a more appropriate category.

A coercive element is sometimes introduced into the health care setting, as when individuals are assigned to health care jobs in wartime as an alternative to military service or when hospital volunteer work is given as part of a court sentence. In such cases, a mix of normative-utilitarian-coercive authority is required and the manager must adopt a variety of leadership and motivational styles in working with the different groups in the organization. Worker or member motivation and the source of the manager's authority differ for these different groups.

In the Katz and Kahn genotypic classification, the health care organization fits two categories, again indicating the mixed mandates of such entities. As an organization concerned with restoration, the health care establishment functions to maintain society. It also performs adaptive functions when higher education and research are major goals.

## CLASSIC BUREAUCRACY

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Bureaucracy is such a common aspect of organizational life that it is often treated as synonymous with formal organization. The study of bureaucracy in its pure form was the work of the structuralists in management history: Max Weber, Peter Blau and W. Richard Scott, and Robert K. Merton. Weber's work is pivotal, since

it presented the chief characteristics of bureaucracy in its pure form. Weber regarded the bureaucratic form as an ideal type and described the theoretically perfect organization.<sup>16</sup> In effect, he codified the major characteristics of formal organizations in which rational decision making and administrative efficiency are maximized. He did not include the dysfunctional aspects or the aberrations that occur when any characteristics are exaggerated, as in the popular equation of bureaucracy with “red tape.” From the works of Weber and others, a composite set of characteristics or descriptive statements may be derived concerning the formal organization or bureaucracy.

1. Size
  - a. large scale of operations, large number of clients, high volume of work, and wide geographical dispersion
  - b. communication beyond face-to-face, personal interaction
2. Division of labor
  - a. systematic division of labor
  - b. clear limits and boundaries of work units
3. Specialization
  - a. a result of division of labor
  - b. each unit's pursuit of its goal without conflict because of clear boundaries
  - c. areas of specialization and division of labor that correspond with official jurisdictional areas
  - d. specific sphere of competence for each incumbent
  - e. promotion of staff expertise
  - f. technical qualifications for officeholders
4. Official jurisdictional areas
  - a. fixed by rules, laws, or administrative regulation
  - b. specific official duties for each office
5. Rational-legal authority
  - a. formal authority attached to the official position or office
  - b. authority delegated in a stable way
  - c. clear rules delineating the use of authority
  - d. depersonalization of office; emphasis on the position, not the person
6. Principle of hierarchy
  - a. firmly ordered system of supervision and subordination
  - b. each lower office or position under the control and supervision of a higher one
  - c. systematic checking and reinforcing of compliance

7. Rules
  - a. providing continuity of operations
  - b. promoting stability, regardless of changing personnel
  - c. routinizing the work
  - d. generating “red tape”
8. Impersonality
  - a. impersonal orientation by officials
  - b. emphasis on the rules and regulations
  - c. disregard of personal considerations in clients and employees
  - d. rational judgments free of personal feeling
  - e. social distance among successive levels of the hierarchy
  - f. social distance from clients
9. The bureaucrat
  - a. career with system of promotion to reward loyalty and service
  - b. special training required because of specialization, division of labor, or technical rules
  - c. separation of manager from owner
  - d. compensation by salaries, not dependent on direct payment by clients
10. The bureau (or office or administrative unit)
  - a. formulation and recording of all administrative acts, decisions, and rules
  - b. enhancement of systematic interpretation of norms and enforcement of rules
  - c. written documents, equipment, and support staff employed to maintain records
  - d. office management based on expert, specialized training
  - e. physical property, equipment, and supplies clearly separate from personal belongings and domicile of the officeholder

These characteristics are interwoven, each flowing from the others; for example, the growing size necessitates a division of labor, which, in turn, fosters specialization.

One of the dreams of many direct patient care practitioners is a health care delivery system that does not become bogged down in formalities. The private practice model seems to offer the solution; if the private practice or small group practice flourishes, however, the characteristics of formal organizations inevitably begin to emerge—for example, specialization and division of labor, procedures for uniformity, some form of authority structure, and a variety of rules. The wisest approach seems to involve taking the best features of formal bureaucracy and making

particular efforts to avoid the negative elements, such as impersonality. Family-centered approaches to health care or the team approach are models that tend to offset the impersonalization associated with large health care organizations.

## CONSEQUENCES OF ORGANIZATIONAL FORM

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Managers work in specific organizational environments, and their specific functions are shaped and modified by the organizational form, structure, and authority climate. Some specific consequences concern the following organizational characteristics:

- *Size.* The more layers in the hierarchy, the greater (potentially) the limits on managers' freedom in decision making. Their decisions may be subject to review at several levels, and more decisions may be imposed from these higher levels.
- *Organizational Climate.* The degree to which clients, workers, and other managers participate in planning and decision-making processes is determined in part by the authority climate. Managers may have to modify their management or leadership style if it is inconsistent with the organization's authority structure. The basis of motivation may vary. In the highly normative setting, for example, members willingly participate; in the coercive organization, the basis of motivation tends to rest on the avoidance of punishment.
- *Degree of Bureaucracy.* A highly bureaucratic organization may be associated with great predictability in routine practices but less innovation and more resistance to change. Efforts to offset distortion caused by layering in communication may constitute a large portion of the activities of a manager in a highly bureaucratic organization.
- *Phase in the Life Cycle.* The openness to innovation and the vigorous, aggressive undertakings through goal expansion and multiplication that characterize some stages of the life cycle may permit the manager to undertake a variety of activities that are precluded by concerns for organizational survival in other phases of the life cycle.

For these reasons, managers must assess the organizational setting and their own roles. The major concepts of the clientele network, organizational life cycle, and analysis of organizational goals are tools for such assessments. Their active use fos-



ters in the manager an awareness of the overall organizational dynamics that shape managerial practice, worker interaction, and client services.

## THE CLIENTELE NETWORK

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Managers must devote constant attention to the web of relationships reflecting the needs and interests of individuals and groups both internal and external to the organization. Common terms used to describe these relationships include critical partners, stakeholders, champions, super-users, or communities of interest.

A major charge given implicitly to any manager is the building of external relationships and developing a framework for partnership. This framework connects the people of the organization with one another, and with the larger communities of interest. In order to do this, the manager must identify critical relationships, develop satisfactory working relationships with the several key individuals and groups involved, and, finally, work at maintaining these relationships. With the conservation of organizational resources, time, money, and personnel as a mandate, the manager seeks to capitalize on available external sources of power, influence, advice, and support as well as to identify those areas of potential difficulty, such as competition and rivalry, erosion of client goodwill, and shifting client demand and loyalty. In an era of increasing regulation of health care, the contemporary manager in the health care setting must identify and comply with multiple sets of changing regulations and guidelines issued by federal and state government agencies as well as by the various accrediting agencies, such as the Joint Commission or the American Osteopathic Association.

Like a living organism, an organization exists in a dynamic environment to which it must continually adapt. The manager identifies these units and constructs a network of the pattern of interrelationships. Bertram Gross developed the concept of the clientele network, noting that any organization is usually surrounded by a complex array of people, units, and other organizations that interrelate with it on the basis of various roles. He called these people, units, and organizations the “publics with opinions.”<sup>17</sup>

Wherever the concept of organization is used, a department manager could well substitute individual service or department. Although such a department or service is obviously a part of the organization, the development of the clientele network for a unit within the organization yields information about the critical relationships, clients, adversaries, and supporters of that department. Department-level

managers must be aware of the unique environment of their department or service as well as the overall environment of their organization.

## CLIENTS

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The most obvious and immediate individuals and groups who make significant demands on the organization are the clients. Gross used the term in a broad sense—that is, to refer to those for whom goods and services are provided by the organization.<sup>18</sup> Immediate, visible clients in health care, both for the organization and for any department directly involved in patient care services, are the patients.

The providers of direct health care services are immediate, visible clients for certain units within the organizations. The business office, the legal staff, and the medical record department offer support services to assist physicians, nurses, and social workers in the provision of patient care. Given the traditional and historical development of the modern hospital, it could be said that the physicians are a special class of clients in that the organization of the hospital or clinic gives them the necessary support personnel and services for patient care. Physicians in different specialties are clients of each other, since they depend on each other for consultative services and referrals.

Certain services may be placed into the client category *vis-à-vis* each other. Some service units, such as physical therapy, are income producing; because the resources obtained are used on behalf of the whole organization, other units may be considered clients of the income-producing units. The business office relies on the health information service to supply certain documentation to satisfy financial claims, and the safety committee relies on the several patient care and administrative departments to supply the information necessary to perform its function.

The use of the broadest possible definition of client alerts the manager to the subtle facets of organizational relationships. The manager who recognizes the number of distinct client groups can more effectively monitor their several and sometimes conflicting demands for services.

Although one step removed from the immediate services or goods offered by the organization, less visible clients are nonetheless legitimate users of the services or goods. By identifying these secondary clients, the manager has a key to the primary and secondary goals of the organization or unit. In the many educational programs offered within health care organizations, for example, the sponsoring institutions (e.g., a college or university), the health professionals, and the technical students are

secondary, less visible clients. Hospitals traditionally have direct patient care as a primary goal, with teaching and research as secondary goals. The ordering of priorities should stem from recognition of the multilevel client demands.

The same physicians who are immediate clients in terms of their need for support services for their direct patient care activities are less visible clients in terms of their need for opportunities for education and research. The employees of the organizations are, in a sense, less visible clients, since one of the organizational outputs is the provision of jobs. Occasionally in health care the provision of jobs is an explicit goal; the neighborhood health centers sponsored by the federal government were intended not only to provide health care services but also to afford job opportunities to area residents.

The clients twice removed from the immediate goal of the organization may be termed the remote clients. Many of these individuals and groups do not even know they are being served. In addition to patient care, teaching, and research, a third goal of health care organizations is generally given as the protection of the public at large, that is, remote clients.

The manager, in assessing the stated and implied goals, may readily identify them by analyzing the needs of primary, visible clients as well as those of the less visible and remote clients. If the client demand is relatively stable, the planning, organizing, and staffing needs may be assessed in a stable manner. The net effect is efficiency in the allocation of resources of money, space, and personnel.

There is within the client group a potential capacity to control the organization. When a business has only one major purchaser of its goods or an agency has only one group to serve, the clients could easily take charge of the organization, limiting its independence. On the other hand, the organization with multiple clients must set priorities, balance conflicting demands, and maneuver so as to satisfy several groups.

The manager maintains continuous awareness of potential new clients and their needs; for example, the ever-growing leisure culture and amateur sports creates an increased need for physical therapy services. The aging of the “baby boomer” population and increased longevity lead to an increase in the need for such services as subacute care, caregiver support groups, and adult respite care. Managers reach out to such potential clients in a variety of ways such as participating in community-sponsored events (e.g., blood drives, weight loss seminars, preventive health initiatives). Managers get involved with the many support groups (e.g., kidney disease, breast cancer, arthritis), offering space for meetings and presenting educational lectures.

## SUPPLIERS

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Three categories of suppliers are given by Gross: (1) resource suppliers, (2) associates, and (3) supporters.<sup>19</sup>

### *Resource Suppliers*

Since no organization is totally self-sufficient, it must take into itself the necessary resources, raw material, money, and goodwill that it needs to survive and function. In this sense, the organization is the client of other organizations.

Within the given organization, one department or service is the supplier of another. In assessing work flow patterns, this concept is useful in identifying which aspects of the work are within the unit's immediate control and which originate in one or several other departments. The health information service is the client of several other units in this sense. The proper gathering of patient identification information is the work of the several admissions and intake units; a health information department is dependent on these units for that part of the work flow. Resource suppliers, such as the clinic secretary, control the patient health record at the time of a patient's discharge; consequently, its timely receipt in the health information service after discharge is somewhat dependent on that unit's work flow. A centralized, computerized data processing system is dependent in the same way. The laboratory, radiology department, physical therapy department, and occupational therapy department all depend on the nursing service to bring, send, or prepare the patient so that they can proceed with their own work in a predictable manner. Essential information for the formulation of job descriptions concerning interdepartmental relationships or for the development of cross-training programs within the organization is obtained from an awareness of those organizational components that act as resource suppliers to each other.

In the same sense, the chief executive officer can be seen as a resource supplier, making the final adjudication in the allocation of space, money, and personnel to the units. The manager of the department or service should know the needs of other departments and should develop strategic alliances in the competition for scarce resources.

Resource suppliers are often external to the organization. Companies making specialty products or offering specialty services have a unique relationship to the health care organization. Such suppliers may be limited in number; in fact, there may be only one such supplier in a geographic area. The viability of such an organization is of interest and concern for the manager who relies on these products or services. Furthermore, with the implementation of such federal regulations as

HIPAA and with issues relating to risk management, the health care organization which contracts with one or another such resource supplier needs to work with that resource supplier to ensure that they, too, follow the specific regulations. These include policies, procedures, and safeguards relating to patient privacy and confidentiality. Chain of trust agreements are required for organizations dealing directly with patient care information (such as an outsourced transcription service or a medical billing service). The health care manager will attend to the quality of products and services from external sources because these become part of the services offered by the health care organization.

Managers take opportunities to partner with resource suppliers in special project development. For example, health information educators work with vendors to create virtual laboratory modules for use in educational institutions as well as for in-service training in health care settings. Another example is found in the partnerships of university-based departments of physical and rehabilitation medicine and the PALS (Promotion of Amputee Life Skills) research and training program.

### *Associates*

Individuals or groups outside the organization who work cooperatively with the organization in a joint effort are associates of the organization.<sup>20</sup> Associates have a common interest and common work that unites them with the organization. The manager who recognizes the efforts of associates will actively obtain their cooperation. Through informal sharing of ideas among themselves, the various health care practitioners frequently act as associates to one another. The health information practitioners from several area hospitals may collaborate informally on a release of information policy so that there is area-wide consistency in dealing with requests for data from patient records. The AHIMA-sponsored communities of practice and related sharing of best practices is yet another example of associate activity. The medical technologists of a region may cooperate in a joint venture for blood-banking processes. The Joint Position Statement on Health Information Confidentiality, developed by the American Medical Informatics Association and the American Health Information Management Association, is yet another example of associate interaction.

### *Supporters*

Various politically, socially, and economically powerful individuals and groups in the society may be supporters of the organization. They mobilize “friendly power” for the organization, giving it encouragement and developing a climate of goodwill toward the organization. Such supporters can coordinate major activities, such as

fund-raising, public relations, and intermediate services for the organization. This type of support helps the organization to conserve its own resources for direct application to immediate goals, such as providing direct patient care. Individual organizations may quite simply lack the power to mobilize certain political or economic resources on their own behalf and may depend on a "friend in the castle" to help in these matters. The traditional pattern of appointing the political, social, and economic elite to the board of trustees in health care organizations is often an effort to mobilize such power on behalf of these organizations. Professional associations foster this relationship through regularly scheduled interaction with both state and federal lawmakers.

Occasionally, a nationally prominent figure demonstrates a particular interest in health care because of some personal experience with a particular health problem. In a sense, poliomyelitis, heart disease, and breast cancer received more attention because they affected a president or a member of his family. A leading political figure may work toward the passage of legislation on behalf of some specific health care need. A number of well-known entertainers and sports figures have supported fund-raising activities for one or another health care issues. Such individuals command resources unavailable to a single institution.

The Lions Club programs to support eye care, the Easter Seal program in fund-raising and coordination of volunteers to work with handicapped persons, and the Shriners' traditional support of health care for children with disabilities illustrate the typical activity of supporters. The traditional hospital auxiliary is yet another example of a support group. Supporters may help to coordinate activities to the mutual benefit of all participants, offsetting the destructive aspect of competition and facilitating compliance with standards set by controllers by making resources available for use by the organization.

Although an organization may not actively declare itself a supporter, the net effect of its activities may provide support. Advocacy groups for privacy in general, for example, have helped raise the social consciousness of the public toward all issues concerning privacy, thus helping health care institutions to develop guidelines for the restrictive release of information. In such situations, collaboration in the development of and lobbying for pertinent state legislation becomes possible.

## ADVISERS

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Although they are like supporters in some ways, advisers have more specific activities that tend to set trends for the industry. Advisers provide a particular form of resource or support through their advice. Gross stressed an important difference

between supporters and advisers: The assistance and support of advisers help the organization use its resources and the support it receives from other sources.<sup>21</sup> Advisers stand apart from the organization and often have a more impersonal relationship with the organization than do supporters.

The advice may be in the form of overall guidelines, position papers, data analysis, sample procedures and methods, or model legislation. Examples of documents that are advisory in nature include the American Hospital Association's Guidelines on Patient Rights, the American Medical Association's Model Legislation Concerning Disabled Physicians, and the American Health Information Management Association's Coding and Reimbursement Compliance and Record Auditing guidelines.

## CONTROLLERS

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Those individuals or groups who have power over the organization are controllers. Health care organizations must comply with the regulations of several federal and state government agencies as well as with the mandates of the various accrediting agencies. A multi-specialty health care organization is required to meet detailed regulations from different state agencies as a condition for licensure. For example, social service agencies must meet a variety of regulations:

- adoption and foster care: Office of Children, Youth, and Families
- residential school and outpatient psychiatric clinic: Mental Health and Substance Abuse Services
- personal care home: Office of Social Programs
- skilled nursing facility: Department of Health

Table 3-3 provides a listing of organizations and agencies that have such control power. The level of detail varies greatly from the optimal standards stated by the Joint Commission to the highly detailed regulations (e.g., required room size) in a state law.

Certain controllers are internal to the organization and yet constitute a kind of separate organization. Workers as individuals are a part of the organization, but the unions that represent them stand outside the organization, exerting specific pressure on it. The governing board is an integral part of the hierarchical structure, but in some ways the board of trustees is separate from the line managers, who are controlled by the decisions made by the top-level management group. The assessment of the net effect of such controllers' input gives the manager a sense of

**Table 3–3** Key Controllers

<b>Controller</b>	<b>Requirements</b>
Federal government	Conditions of participation for Medicare and Medicaid, special standards resulting from specific program funding and grants
State government	Conditions of participation for Medicare and Medicaid, special standards resulting from specific program funding and grants
Local government	Zoning codes, fire and safety requirements
Accreditation bodies	Accreditation requirements
Professional associations	Codes of conduct, professional educational requirements
Collective bargaining agreements	Detailed contract provisions
Organizational policy	Detailed provisions for each organizational unit
Various regulatory agencies	Personnel laws and regulations, such as Fair Labor Standards Act, Occupational Safety and Health Act
Third-party payers	Detailed contractual provisions concerning patient eligibility, mode of treatment covered, and similar provisions

clear boundaries for planning and decision making. However innovative an idea might be, for example, the manager must still keep management practices in line with these constraints.

Controllers may also impose conflicting regulations on the institution, such as the mandate of the federal government to maintain almost absolute confidentiality of alcohol and drug abuse records and the mandate of third-party payers to provide satisfactory evidence of treatment for reimbursement. Managers may be forced to change their managerial style as a result of certain constraints imposed by a controller (e.g., the details of a union contract may limit severely the use of the *laissez-faire* style of management). By means of survey questionnaires and site visits, the manager may assess the net effect of these multiple regulations on work flow, services offered, staffing patterns mandated, and job descriptions restricted and refined.

## ADVERSARIES

Health care traditionally carries overtones of great compassion and deep charitable roots. Like any other organization, however, health care organizations have opponents and enemies as well as competitors and rivals. The rising cost of health care tends to make health care professionals and the organizations in which they



work a source of conflict and even a target for opposition at the present time. Indeed, clients themselves at times take an adversarial stance.

Outright opponents or enemies are those individuals or groups who seek actively and aggressively to limit the organization in its activity. These opponents or enemies may have the power to bring an activity to a halt or to prohibit an activity from being started. For example, clients do not wish to have certain facilities, such as drug treatment centers or group homes for the developmentally challenged, too close to their homes. Furthermore, they may want ample parking and easy access to their hospital, but they do not want to disturb the local housing units or the business areas. Zoning codes may be enforced in order to prevent the development of alternative treatment facilities or the expansion of existing facilities. Clients may withdraw financial support as evidence of displeasure.

The concept of competition is well understood and accepted in the economic arena. Within reasonable boundaries, competition is favorable for clients because it forces providers to make products or services better or more accessible. The sharp edge of competition is also evident in health care delivery, possibly because certain factors in contemporary culture are producing shifts in client loyalty. These factors include (1) erosion of strong ethnic and religious ties to one hospital or health center; (2) the passage of the Civil Rights Act, which removed certain barriers to access; (3) urban and suburban migration patterns; and (4) the lowered birth rate.

Given a dropping inpatient census, a hospital may compete actively with a free-standing medical clinic by offering its own outpatient clinic services. In order to attract patients, one obstetrics unit may offer the latest in fetal monitoring, while another may stress family-centered childbirth. An urban medical school or medical center may offer the benefits of highly specialized techniques to offset a census drop due to the fact that certain clients seek to avoid the city. A hospital seeking financial bond approval for an expanded facility or for some special activity may engage in active outreach to increase its patient population.

Rivals, according to Gross, are those who produce different products but compete for resources, assistance, and support.<sup>22</sup> In the health care setting, specialty hospitals could be considered the rivals of general hospitals (e.g., a children's hospital versus a pediatrics ward in a general hospital, a lying-in hospital versus an obstetrics unit). When the emphasis in definition is placed on competition for the same resources, there is evidence of rivalry among health care institutions for scarce personnel (e.g., registered nurses for the 3 P.M. to 11 P.M. shift, trained medical transcriptionists, physicians for the emergency room).

Within an organization, one department may be cast as rival to another for needed space, additional personnel, and special funds. Managers may find that the same departments that are clients may also be supporters and rivals.

## EXAMPLE OF CLIENTELE NETWORK FOR A PHYSICAL THERAPY UNIT

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A tabulation method can be used to analyze a departmental clientele network. The development of such a reference tool for the internal environment of the organization provides the manager with much information concerning relationships to be developed, aspects of the work flow to be considered, and regulations and guidelines that must be satisfied. The following is the clientele network of a spinal cord treatment service in a physical therapy department:

- I. Clients
  - A. Immediate clients
    - 1. Patients on the spinal cord injury service
    - 2. Hospital personnel assigned to the spinal cord injury service
  - B. Secondary clients
    - 1. Family members
    - 2. Hospital medical staff for inservice education and clarification of policies and procedures
    - 3. Physical therapy students on clinical affiliation
    - 4. Local hospitals requesting information on special programs dealing with treatment of the spinal cord–injured patient
  - C. Remote clients
    - 1. Local hospitals
    - 2. Home health agencies
- II. Suppliers
  - A. Resources
    - 1. Physicians within the hospital who refer patients to the spinal cord injury unit
    - 2. Medical supply companies that supply equipment for both the patients and the department
    - 3. Bureau of Vocational Rehabilitation, which covers the cost of treatment and equipment
    - 4. Hospital transport system

- B. Associates
  - 1. National spinal cord treatment centers
  - 2. Other direct patient services (e.g., nursing, occupational therapy, speech, psychology, social services)
  - 3. Home health agencies
  - 4. Professional journals
- C. Supporters
  - 1. Hospital physicians and residents
  - 2. Community service organizations
  - 3. Auxiliary organizations serving the spinal cord service
  - 4. Medical supply companies
  - 5. County Wheelchair Sports Association
  - 6. Public relations department of the hospital
- III. Advisers
  - A. Hospital administrators
  - B. Other direct patient care services within the hospital
  - C. Insurance companies
- IV. Controllers
  - A. Accreditation agencies
    - 1. Joint Commission on Accreditation of Healthcare Organizations
    - 2. Commission on Accreditation of Rehabilitation Facilities (CARF)
    - 3. Accrediting Council for Graduate Medical Education for Residency Program (CGME)
  - B. Federal government
    - 1. Medicare reimbursement regulations
    - 2. Equal employment opportunity
    - 3. Working conditions
  - C. State government
    - 1. Licensing regulations for physical therapists
    - 2. Medicaid reimbursement regulations
  - D. County Hospital Association
  - E. Professional association codes of ethics
  - F. Unions
  - G. Hospital policies
- V. Adversaries
  - A. Opponents and enemies
    - 1. Consumer groups
    - 2. Hospital personnel resistant to change

## B. Rivals and competitors

1. Other local rehabilitation centers sharing the same clientele network

## EXERCISE: IDENTIFYING AND DESCRIBING THE MANAGEMENT FUNCTIONS

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In your own words, describe the classic management functions and their relationship to each other, including the extent to which they may or may not be interrelated. For each function, provide one specific example and explain in detail how this function, in this specific instance, relates to one or more of the other functions.

Next, describe any differences that may be encountered in addressing each function at different management levels; that is: Are there differences in the emphasis on each function for the supervisor or first-line manager as compared with the middle manager? Or for the middle manager as compared with the chief executive officer?

Finally, answer the following questions:

1. There is an old expression: *If we fail to plan, we plan to fail*. Failing to plan suggests doing nothing. Since planning is an active pursuit, how can doing nothing be indicative of “planning” to fail?
2. What is one legitimate example of organizing that the department manager may never encounter or may perhaps encounter only once in a great while? And one example of organizing that the department manager may employ multiple times in a normal workday?
3. What is the management function most closely associated with teaching, guiding, and motivating workers? Explain your answer.

## NOTES

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