ABSTRACT

POLICY-MAKING AND DECISION-MAKING IN A COMMUNITY HOSPITAL:
A CASE STUDY OF POWER RELATIONS IN A
VOLUNTARY COMPLEX ORGANIZATION

By

Alexander J. Muntean

In this case study key policy-making and decision-making activities -- at the level of the whole organization and at the departmental level -- are demonstrated to be the most significant of many representative of power relations taking place in a community hospital, a voluntary complex organization. The power relations of this sort within the hospital, described and analyzed extensively, are the products (affected both directly and indirectly) (1) of the immediate community -- especially members of the community's power structure sitting on the Board of Trustees of the hospital -- with largely locality-oriented values -- and (2) of extra-community state-governmental, professional, and semi-professional agencies, mainly, putting pressures or making demands on the hospital toward meeting certain externally-derived standards of performance or service. The internal social structure of the hospital, at both the macro and micro levels, is shown to be increasingly developing and refining its authority, power and influence relationships -- e.g., among or between the Board, Medical Staff, and Administration to these ends and to attain a dynamic balance of sorts. Literature in the areas of community studies and complex organizations is extensively consulted to place this case study in a wider theoretical context than is usual in such studies and to show their close interrelatedness and interpenetration. Specifically, it is found that the

hospital's Board of Trustees, in the persons of key influentials of the community -- all with established power and status, some economic dominants as well -- exert the greatest authority in setting up and enforcing the broadest and most comprehensive of policies for the hospital. As "keepers of the keys and purse strings," they set effective limits to the hospital's operations of a wide-ranging nature and at all levels. They initially designed, built, equipped, staffed, and maintained the organization, with some assistance and advice of others identified. They also are legally and morally responsible to the local community and the state for the hospital's sound financial and medical management. Over time they have retained key financial discretion and continue to decide at a high level on closely related matters, but delegate authority over routine financial, medical, and related matters to the Administrator, Medical Staff, Nursing, and ancillary services. Their policies and decisions are thusly broken down into lesser and more specific policies and decisions, largely of a more technical nature and are enacted or implemented at appropriate lower levels. Increasingly, the Board is found to have to rely on the other departments or units in formulating technically-related policies -- meaning mainly medical or patient care matters. Still, their power to veto or restrict various activities because of their financial control over resources remains relatively undiminished. The Administrator is the agent of the Board and his main function is to translate the bulk of their broadly-formulated policies and decisions into more detailed and implementable policies and decisions, albeit most are financially tinged. This is the key position in the co-ordination of the complex mix of hospital activities.

His main obstacle for the smooth accomplishment of this co-ordinative function is the Medical Staff whose technical expertise and core or crucial function in the hospital carries with it an authority or power and prestige second only to that of the Board and which the Administrator cannot challenge directly. Still, his authority and power is considerable over Nursing and other ancillary departments. As well the Medical Staff has considerable control over many of these departments. This type of hospital contains two lines of authority, then, and this fact informs many of the problems and issues which crop up. They are seen to be structural in nature.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF APPENDICES

PART I

PROBLEMS IN STUDYING COMPLEX ORGANIZATIONS

CHAPTER I

FOCUS OF DISSERTATION

Introduction

In many ways this dissertation is complementary to, and a logical extension of, the collective research in hospital-community relations previously undertaken at Michigan State University.[1] A particular part of that prior research provided the immediate inspiration and the bulk of the substantive background necessary for the present study.[2]

That earlier study was essentially a community case study of a small American town located in the Midwest. Its central focus was on explaining how certain changes, especially in the modernization and liberalization of the significant, informal patterns of power and influence and in the authoritative decision-making activities of that conservative community, had been systematically brought about.

Primarily, the series of changes studied (to be indicated below) were the results of the increasingly obdurate necessity for Mills Springs to adapt in a radically new fashion (for it) to the combined impacts of a number of external and internal, social and cultural forces. The external factors had served mainly to compound, aggravate, and hasten the change effects of certain more slowly-moving, immanent or natural forces already at work and manifesting themselves internally in Mills Springs.

The community power structure was revealed to have been Mills Springs' most important component which, through many years, both made attempts at and was instrumental in the initiation, direction, mediation, coordination or the blocking of changes. In short, it monitored or controlled the adjustment process of the community as a whole. Not only did it function to balance the community interests with the outside world, it also functioned to maintain an equilibrium among the various institutional segments and their units within the community. While striving to balance the various interests and power relations, the C.P.S. (C.P.S. stands for community power structure hereafter) itself was subject to these various forces and it was evolving in form and function to meet these new or redefined community needs, sought or unsought as they were at different times by various prominent groups and individuals. The C.P.S. was a more unitary body and more successful in monitoring and controlling the destiny of the community during the earlier history of the town than later on, for reasons to be spelled out below.

The main procedures used in that earlier study to describe, analyze, and explain these systematic changes consisted in the relating of these combined, external and internal forces and their impacts within the context of the historical evolution and resolution of a series of community issues which were, at one and the same time, uniquely local in some aspects, yet which were generally similar in other respects to issues occurring in other, neighboring communities in that state and in the wider society. Such an investigation quite often necessitates a comprehensive and time-consuming examination of what may amount to quite a broad and complex spectrum of issues and decisions confronting even

the smaller communities in our society. Such was the situation in the case of Mills Springs.

Briefly, at this point, the issues included: (1) an unsuccessful attempt by local workers and outside labor organizers to unionize the major industry in town and a major strike which ensued from that attempt; (2) the construction and establishment of a new community hospital; and (3) a series of, at first abortive but in the long run successful, attempts at school consolidation and annexation.

The first issue had taken place in the late 1930s and had to be reconstructed from documents and from the accounts of the events by various informants; the latter two, both occurring during the 1950s, overlapped and were studied concurrently and while still in progress and in considerable detail.

The social processes of competition and conflict had loomed especially large in the development and resolution of these three crucial issues, although attempts at co-operation played a significant part, too. Conflict was generated in each of these community issues: either openly and from the start, as in the labor union and school issues; or covertly so initially, and then more openly in the later stages, as in the hospital issue. A residue of continuing community friction was left by the school issue, while the other two issues were resolved without such prolonged or negative after-effects.

Loosely organized factions holding strongly opposed values, views, and interests had emerged in the community, as the analysis of each of these issues clearly revealed. A neutral or mediating group also emerged during the last two issues which endures today. This basic split in the community has continued to have serious effects

feeding into more recent issues, both in the community as a whole and in various institutional sectors, the hospital in particular.

From the point of view of the community in general, and of its powerful members in particular, these three key issues and their respective resolutions were considered to have had, historically, the greatest positive or negative consequences for all the people of Mills Springs.

It was the common quality of these issues that they, above all others, most aroused, disturbed, and intimately involved the greatest number of the community's members through either potential or indirect threats or direct, real, and enduring effects on their vital, collective and/or individual interests--economic interests, mainly, but including other social and cultural values as well. It was these benchmark issues which directly posed serious threats to certain powerful status quo positions in the community.

From the viewpoint of our previous M.A. research problem, these same three issues were significant for the reason that they in their essence neatly revealed the systematic, historical, and evolutionary changes--the irrevocable adaptations--that had taken place cumulatively in the patterns of exercising power and influence in the informal and formal decison-making activities of the community. These issues quint-essentially reflected the convergent effects of certain modernizing and liberalizing forces coming from the wider society upon this reluctant-to-change and conservative community. They helped or compelled it to adjust or to attune itself to the increasingly discernible societal trend toward the modernization and democratization of the patterns of power and decision-making. Incidentally and paradoxically, they resulted in

a lessening of community autonomy.

These three benchmark issues served to set the stage for new developments and enduring, redefined conditions in the wielding of authority, power, and influence and in the making of decisions in the community, which were more directly related to authority, power, and influence wielded and decisions made elsewhere, primarily at the state level. To that extent, study of these key issues lent a modicum of predictability to the outcomes of later events of this kind and their potential effects on the community and its reactions. This information has been invaluable in the context of the present study.

The Problem

The main focus of this dissertation follows logically and cogently from the preceding study and it is on explicating how the key organizational activities of policy-making and decision-making in the new, voluntary, general, short-term community hospital (founded and established in Mills Springs in the 1950s) were and are conditioned by the foregoing events or factors, and how they were and are being made under a newly generated set of conditions. An attempt will be made herein to show that these and various other organizational activities are both directly and indirectly affected: (1) not only the distinctive, internal, organizational makeup of the hospital--consisting of its particular type of normative structure and functions and of such critically important factors as its components of power (its formal authority structure and informal power and influence networks) and other internal social relations, both informal and formal, to be discussed in detail below--but as well, (2) by the concomitant, external,

social relationships the hospital unit has with its immediate social environment -- the local community -- and by other outside factors, conditioning and affecting its operation, more remotely located.

The external social environment of the hospital is broadly construed herein to consist of two concentric rings: (a) the inner one of the local community system, containing its established modes of organizational decision-making and policy-making as regulated (or not) by its power structure, primarily; and (b) the outer ring containing those incessantly impinging, social and cultural forces which are represented in the activities of certain extra-community organizational systems. These external social systems are directly and/or indirectly impinging upon and influencing in many ways the operation of the local hospital, and the operations of the rest of the organizational system of the community similarly. A look at some of the other local organizations and their operations is necessary because they have affected the operation of the hospital in various ways.

As in the prior study, an historical and evolutionary approach will be basically employed in this analysis. Highlighted will be the reciprocal interplay between organizational and community power, between key internal (hospital) and external (community or societal) issues and events and their interlocking resolution through collective decisions of formal, organizational and informal, community leaders. These are some of the more prominent features dealing with the dynamics of the hospital as an organization requiring considerable study. Of aid also in revealing other significantly related organizational dimensions or aspects of power, and the more subtle changes occurring in the hospital setting in this respect, lie at the more mundane levels

of its departmental policy-making and decision-making activities. Their part and place in the overall structure and functioning of the hospital organization -- again appropriately related to the social environment where indicated -- will be analyzed.

This open systems approach, by which one establishes the complex and multi-faceted patterns of power and other relationships -- both routine and critical -- which an organization's internal structure and functioning has with selected, significant aspects of its social environment, although recognized as important by an increasing number of researchers in the area of modern or complex organizations, has actually been little employed. With respect to hospital-community research, there are relatively few studies using such an approach. Yet, as this case study will attempt to demonstrate, the open systems approach has considerable theoretical as well as methodological merit, and it offers explanatory advantages which the traditional studies (sociological and those of other disciplines) dealing with organizations as closed or relatively self-contained entities or systems do not.

From a theoretical as well as a methodological point of view, for example, it is a most convenient, effective, and efficient means of actually demonstrating or testing whether the systemic linkages posited by a number of theorists[3] as binding institutions (or organizations), communities, and society together do exist, and, if so, what is the nature of such bonds: e.g., whether they be tight or loose, and why so in the range of cases of difference communities, their organizations in various institutional sectors and societies.

It is our contention that the notion of power relations offers such a crucial link. It is necessary, however, to empirically collect

many more such case studies and to inductively arrive at or to demonstrate the general nature of such systemic linkages; it does not suffice to vaguely assume that it holds generally, or to merely deduce it from posited models, valuable as these may be. This case study will modestly undertake to demonstrate the power linkages in some detail which obtain between the two immediately related systems encompassed herein: the hospital as an organizational system and that of the local community. The, at this point, assumed-to-be less immediate and binding or more tenuous links of both the hospital and the community to extra-community organizational systems and of other societal units will also be incorporated in this analysis.

Literature Consulted

A study such as this has necessarily entailed a comprehensive and critical review of the already extensive and growing sociological literature in the immediately relevant two areas of complex organizations and community studies. Some very pertinent material has been published on community decision-making and power structure analysis in the time elapsed since our previous research was completed. As well, it has been necessary to undertake a careful survey of the literature in several related areas of social science. The research dealing with decision-making at the level of organizations in political science and in administration studies carried out under the auspices of various other disciplines was consulted. In addition, studies at the level of community decision-making in political science and anthropology were reviewed. The literature bearing on related aspects of the problem of policy-making and decision-making produced by those professionals and

semi-professionals working in or closely with the type of hospital studied herein was also canvassed. This essential spadework has been done to supply the factual, but often unorganized, information available about the problems of policy-making, decision-making, and influence, power, and authority in general, and in the specific contexts of organizations such as the hospital and small communities.

It has neither been the easiest nor the most pleasant of tasks to sort out and boil down the valuable portions of these disparate materials. The greatest difficulty encountered was largely due to the relatively unco-ordinated and underdeveloped state of affairs existing between theory and research in the two areas of sociology indicated (as well as, unfortunately, within those specialized areas). This fragile and tenuous interconnection also existed between theory and research in the literature of the other fields mentioned. Their theories and research findings varied widely in their modes of presentation, emphases, and systematic content. Nevertheless, it has been found necessary to consult all of these various sources and to refer to some of them rather extensively below, if for no other reason than to discard the chaff from the kernels of use to the particular set of purposes of this dissertation. However, reliance on sociological materials predominates.

Sociological vs. Psychological Emphasis

An increasingly apparent and interesting trend has been developing in the United States during this last third of the twentieth century. In this period the sociological perspective has been coming into its own and is challenging the heretofore heavily favored emphasis

upon the individual and personality, or the psychological basis for understanding human behavior. Amply clear and varied support for this observation exists not only in the academic sphere of American life but also in the popular or lay spheres.

Academically, sociologists seem to be contributing both the technical means to gather pertinent social data (and to be collecting such data) and the theoretical formulations required in realizing the social and scientific objectives of a completer explanation and a fuller, more satisfying understanding of human behavior. The sociological perspective appears also to be having an important impact (if not always intended on the part of many sociologists) upon the less scientific, unsystematic, common sense approaches to the explanation and understanding of human events. While generally beneficial, the total contribution and impact of sociology in both of these respects are not without blemish.

The widespread growth in the popularity and influence of sociology is quite clearly evident in the mass media and in several of the arts, literary and graphic. There, sociological references or themes abound and are often vividly employed. For example, in journalism, in television programming and advertising, in plots of motion pictures and dramas, and in fictional and non-fictional literature. The implicit or subliminal use of sociological, in conjunction with psychological, appeals is especially extensive in mass media advertising. It is hard to say how many professional sociologists are directly responsible for much of this usage.

Notably, more members of certain professions, such as of medicine and law, are showing a greater awareness and sensitivity for,

and an increased reliance upon, sociological factors to aid themselves in the analysis and solution of problems occurring within their respective domains than they had previously shown. Semi-professionals, such as hospital administrators and nurses, are also more keenly aware of the pertinence of sociology in their areas of concern. Some sociologists have been directly employed as consultants by people in these various professional and semi-professional fields and have, as well, undertaken research in these areas on their own, in the process developing or establishing specialties such as the sociology of medicine and the sociology of law.

Huxley on Scientific Strategy

Juliam S. Huxley, in a stimulating and very illuminating article entitled "Evolution, Cultural and Biological,"[4] has outlined the development of some of the general concepts and scientific principles of modern biology which, he suggests, may possibly have applications or implications for the scientific development of anthropology. He has therein discussed the various methods of approach and the order of scientific procedures which have proved beneficial in this regard and which have advanced biology, and suggests that they might be of similar benefit, possibly, to anthropology. Sociology, being closely related to social and cultural anthropology, might benefit, too. In what follows, the lessons drawn by Huxley will be seen to apply to sociology without much difficulty.

Of course, one must be cautious in attempting any such applications or in the derivation of implications. Some uncritical scholars in the past who had attempted such exercises in an isomorphic fashion

were misguided, and their work, although valuable or suggestive in some respects, resulted for the most part in confusion, not clarification. Spencer's abortive attempt to apply literally certain biological principles hinging on the then little-developed and ill-understood general concept of evolution to the analysis of human social behavior springs immediately to mind.

Any purely biological concepts and principles (or those of other natural sciences for that matter) cannot be immediately or directly transferred to sociology, anthropology, or the other social sciences. The basic reason for this modern belief is that although the history of the development of man as a species and of the nature of his behavior is clearly a part of a more general evolutionary process, it is still a thing in itself: the basis and mechanisms of such phenomena are something sui generis. Man, although he shares some vital characteristics with the rest of creation, is an unique organism with unique, distinctive properties and to that extent, then, sociological (and other social scientific) concepts and principles must be specific and restricted to man in their application and, in this instance, to the social behavior of man.

In a broad sense the whole of phenomenal reality may be considered to constitute a single process called evolution, Huxley asserts. His general definition of it would embrace the whole expression of human behavior,[5]

> "...evolution is a self-maintaining, self-transforming, and self-transcending process, directional in time and therefore irreversible, which in its course generates ever fresh novelty, greater variety, more complex organization, higher levels of awareness, and increasingly conscious mental activity."

Viewed from this perspective, the process of evolution is unitary. It embraces the entire universe both in time and space. Yet it is, nonetheless, divisible into sectors and into stages or phases, each with its own mechanisms of self-transformation, its own tempo of change, its own products. These sectors are as follows. The inorganic or cosmological sector which originated earliest in point of time and which is largest in scope, in extent or distribution in space. Emerging from the foregoing at a later date is the much restricted biological or organic sector. The supra-organic, human or psycho-social sector derives from the organic at a much later time and is the most restricted of all in space, but by no means least in importance.

Huxley points out that in the biological sector adaptation and exploitation of the environment by living things has been accomplished through a limitation of genetic systems resulting in divergence or radiation of life forms. Separate strains of living things have adjusted to their special ecological niches through the eons of time. Adaptation to a variety of environments via genetic means resulted in limited, variation-tight species and a relative insulation of these from each other. Biologists have used these factors, in part, as a sound basis for their effective (though constantly modifiable and modified) classifications of living things into kingdoms, phyla, classes, etc. -- metamorphically representing branches radiating out of the basic tree of life.

The concept of biological evolution includes the notion that there is an advance or improvement in the organization of life which is expressed in the specialization of a stock for a particular way of life, a particular ecological or adaptive niche which, in essence, means the

improved exploitation of environmental variety. There are also expressed better physiological performances of some functions, improvement in awareness generally, and improvement in general organization. Evolutionary advance is achieved through a succession of dominant or successful types. In this regard, advance eventually reaches a limit and stability sets in; as well, advance in the aforesaid modes of organization comes to a halt or stabilizes in time. After two billion years biological evolution has, for all intents and purposes, reached the limit of its advance on Earth, according to Huxley.

There are, however, still unrealized potentialities in life. The possibility for developing (evolving) fuller awareness is preeminently, if not exclusively, resident in the set of psychological or mental attributes which man possesses. These attributes of man represent a new-type of entity, or organization, called by Huxley the noösystem. Evolution in the human sector is basically cultural, not biological or genetic, however; the latter fund of evolutionary capital having been practically exhausted.

Huxley's thesis is that an adequate general understanding or theory of the biological sector of the evolutionary process came about through the more or less conscious and systematic use of the following order in scientific procedures. First, a detailed, descriptive study of what evolves was accomplished in terms of the identification of lineages of organisms of various types, along with their structure, physiology (function), ontogeny, and ecological relations. This study had been preceded by a less systematic, trial-and-error period of natural history which laid the foundation for this undertaking. (A kind of "barefoot" empiricism, perhaps?) Then, the genetic basis of

evolution was formulated upon the discovery of the mechanisms of reproduction, hereditary transmission and transformation, the gene-complex, variation, and natural selection. Evolution as a process was next traced through the mechanisms and modes of its self-transforming course as revealed in phases of change and stabilization, in radiation and extinction, succession of dominant types, and the emergence of higher material and mental organization. The last step was the synthesis of the relevant results in all three of the above areas. In short, knowledge of the mechanisms for maintaining existence, the mechanisms of reproduction and variation, and the modes of evolutionary transformation had to be laboriously gathered -- basically in that order -- and then synthesized to give an adequate understanding of life's total process. Each step is logically related to the others and mutually reinforcing.

A similar procedural order for study must assuredly hold for the human sector, Huxley claims; so that anthropology (as in his case) or sociology (in ours) at the outset must not overly restrict its field to make full and comprehensive progress. But a coherent strategy and productive tactics are required. Very briefly, what both sociology and anthropology need is a knowledge of the mechanisms for maintaining psycho-social existence, of the bases of their reproduction and variation, of the mechanisms and modes of transformation in time. Then comes the synthesis of the relevant results to give a general understanding of the psycho-social process as a whole. As laborious a task (if not a vastly more laborious one) confronts not only sociology and anthropology but the other relevant social sciences and certain specialties of psychology as well, because the job as envisioned is

enormous and surely encompasses them all.

Returning to the case of biology: there is always found by biologists some organization of living matter whose function it is to maintain itself in direct interaction with its environment. This phenotypic system consists of individual organisms, usually of the two sexes, or of communities or societies of such related individuals. There is always found a system for maintaining collective existence, the structure and form of which is to be studied (its morphology). The methods of its working, its functions (physiology, behavior); its relations with the environment and other organisms also organized (ecology); its development and growth (embryology and ontogeny): all are studied necessarily. A division is made in biology between (1) the phenotypic system, concerned with self-maintenance and contact with the environment, and (2) the genotypic system, concerned with self-reproduction which is locked away from the environment. Genetics deals with the latter -- with the mutation and re-combination in germ plasm, with mechanisms of hereditarily transmissible variation. Somatic or non-transmissible variation refers to acquired characteristics induced by the environment or occurring in the course of normal development.

Huxley, although an outsider, recognizes that the greatest handicap to a unified science of man at present lies in the lack of agreement in defining the objects of its study -- the three members of the interlocking trinity of its subject matter so often emphasized but disputed over by Sorokin et al.[6] -- namely, society, culture, and personality (the individual). In all of the social sciences, but especially in sociology and anthropology, there has been a vacillation between regarding these respective master concepts or their derivatives as

either material or mental. There has also been (and there remains) disagreement over the nature of the relationships and priority among the three. These basic disagreements stem (Huxley thinks vis-a-vis the first two) from the lack of as sharp a distinction in the psycho-social sector that exists in the biological sphere between soma and germ plasm. Further complicating the situation in the psycho-social sector is what Huxley describes as an increasing trend toward evolutionary convergence superimposed upon that toward divergence in culture.

Culture, which is a property distinctive to man as a species, is both a mechanism of maintenance and of reproduction or transmission. As such it can take different forms. The material objects man produces and the skills essential in producing them are both culture and directly transmissible, the latter through symbolic communication (yet another form of culture) in time and space and between societies or sub-units of a society or community. This new evolutionary mechanism of communication of culture results in the increasing trend toward cultural convergence superimposed upon that toward cultural divergence. Man is radically different from the rest of the animals in that he has not diverged into biologically separate species and lineages; rather, man makes up a single, inter-breeding group which, due mainly to relative geographic isolation and spread occurring early (and unclearly understood) in his history, diverged culturally. Man's general improvement in organization at the socio-cultural level, however, is of decisive importance in his adaptation as a species, and upon cultural contact and through the ensuing diffusion of mentifacts, socifacts, and artifacts,[7] this faculty has contribued vastly to the increasing trend toward cultural convergence of late.

Culture, definable as "a shared or shareable body of material, mental, or social constructions created by human individuals living in society,"[8] has characteristics which are not simply explicable or directly deducible from a knowledge of general psychology or the physiological properties of human individuals. Although culture has a material basis in the environment -- such as the resources of food, raw materials, and energy -- this, again, does not determine culture in detail. The nôôsystem is most relevant in this sector.

To adequately describe and analyze a cultural system, one must distinguish its distinct components, among which the material or resoure basis is only one, albeit an important factor. The basis of communication or language, the various skills and techniques, the material objects and other products produced with the aid of skills and techniques, the systems of social organization, the knowledge systems, and the attitude systems, all are important aspects of the particular nôôsystem studied and need to be described and analyzed in their patterned relationships: a mere enumeration of them is insufficient if one is to study culture or its sub-unit(s) as (a) self-reproductive system(s).

One of the best methods, perhaps, to so study culture and society (and their respective sub-units) is the functionalist which is analogous to the physiological approach in biology. In and of itself, it is insufficient, however. The structural or morphological approach (analogous to comparative anatomy) is necessarily the first, alternative or complementary, step in such an overall attempt; but in order not to present an incomplete or static picture, the latter must not be used alone. It must be incorporated into a broad functional and historical analysis asking such questions as: "how does culture (or

society or sub-units of each) work? What operations and functions does it perform, and how and with what 'organs?' How does it change over time?"

In such analyses the individual cases or uniqueness may be quite important and should be highlighted. With the further accumulation of "case" studies of this inductive sort, the method of approach will largely be dictated by the type of new answer sought, since a method of approach is really a kind of question. Questions posed will alter with time and progress in discovery. To answer new but related questions new methods of approach are required; flexibility is needed.

In biology the first studies were originally descriptive and contained questions with the above characteristics. Due to the shorter history of sociology and anthropology -- of the social sciences generally -- much of the work done today is still at this descriptive level, concerned with such questions, and they may be expected to remain so for some time to come in a science built inductively and empirically. What is essential at this stage of development is accurate and adequate description of a variety of organizations and communities -- speaking in terms of our own particular research problem -- and of the phenomena which they exhibit, just as in biology the various organisms organized in their communities and the phenomena which they exhibited were studied. "What are the facts?" is the broad question to be posed and to be answered.

The next stage of biological study was concerned with implementing the comparative approach, in which a grouping or classification based upon a close and critical examination of the systematic similarities and differences occurring in a large number of cases was the aim.

"What pattern or system of characters does an assemblage of organisms have in common? What distinct types are there at various levels of characterization?": these are some of the important questions which were posed and a hierarchical system of groups were classified thereby. In biology a phylogenetic classificatory system resulted to express evolutionary descent and relationships. Thus far, the lessons for sociology should be obvious, as well as for our present problem.

The method of differential analysis, in which the question of "What is the cause of differences between the members of a related group or class?" is posed, followed. The time factor or the historical component was correlated with geographical or ecological differences in habitats and with the degree of biological isolation, as well as with genetics.

The last approach of constitutive integration comprehends the relationships and total patterns of a system of analytically detectable components. It is addressed to the problem of delineating complex yet unitary patterns and in doing so Gestalt and similar approaches are required. The vectorial, diachronic enlargement or directed-time dimension to determine how a given initial state of things becomes converted in time into a different state is brought to bear here. "What trends are involved?; What is their shape and direction?; How do they operate?; and How do they produce their observed results?": these are key questions at this stage.

The application of these methods of approach to our specific research problem shall become more obvious later on. The first and second steps have been begun or are fairly well-advanced in sociology in the two areas germane to our dissertation topic, but much more work

must be done before the latter two steps can be effectively or fully implemented. At the middle-range level, the area of complex organizations is further along in its theoretical development with respect to fulfilling the requirements of the first two steps, even though it shows uneven growth and empty spots, than the area of community studies; in respect to the latter two steps, the former area again will probably sooner fulfill the requirements.

Implications of Huxley's Views to Dissertation

Following more or less explicitly from the material thus far presented and from material to be presented shortly, it is herein posited that the generic human community is a socio-cultural system caught up in the process of cultural evolution and that it involves as such an identifiable social structure and cultural behavior. Any particular community resembles markedly other communities situated in its immediate region and the wider society of which it is a part. Although it shares many major characteristics in common, it may also display some unique aspects or characteristics of its own -- some of them of major import. There is constant development or potential for development of convergence overlaying divergence. In other words, a basic social organization or a community pattern consisting of regularities in interaction among groups of people develops in their collective adaptation to the physical and social environments in which they find themselves. The latter is made up of collections of other groups of people or communities, many of which being similarly situated are similarly organized, and of other communities being dissimilarly situated in some respects are potentially or actually somewhat dissimilarly organized -- in part because they are more distant, but in

greater part because they are functionally and/or structurally different. These differences may be attributable to different historical developments, too. Nevertheless, given modern developments, all communities are susceptible to change over time to more resemble each other in key respects as communication and cultural contact and diffusion takes place among them.

The relatively stable forms of sociofacts or social structures are made up of interaction patterns addressed to various collective needs. The contents of behavior or action consist of patterns of mentifacts or artifacts used to meet these needs. In reality there is an almost inextricable relationship between the two. Anatomically, the community structure may be viewed as a complex master system which encompasses the discrete social forms and cultural behaviors in interdependent subsidiary systems called institutions which, in turn, may be broken down for analytical and other purposes into sub-systems or actual social units commonly labeled organizations or associations. From this perspective, then, organizations are those community units representing the particular social forms and cultural behaviors that certain collective adaptations take in the fulfillment of functions for the community as a whole. These units may in time, of course, develop some needs or goals of their own, which may come into an imbalance or conflict with the other community goals.

A particular type of community -- say a farming community or a one-industry town -- uses geographical space in a distinctive and basic fashion and its particular settlement pattern in this sense is a cultural expression of the particular interaction patterns it contains. Certain socio-cultural limits may be set by such an adaptation which

may hinder the community in its future development. Nevertheless, the economic functional base may change with or without the active intervention or support of the community as a result of changes brought about by forces not under its control -- forces within and without, and not all of them are economic.

The institutional values, relationships, and activities -- concretely those situated in the subsidiary organizations of the community and outside of it -- are the aspects of the social environment upon which the major emphasis will be placed herein, even though the environment is both physical and social. In focusing on the functional interdependence between the social environment, social forms, and cultural behavior a departure from traditional social analyses which consider the community more exclusively as an expression of social forces such as co-operation, competition, conflict, etc. -- the ecological approach -- will be made, but these forces will be incorporated, as necessary, as a part of the overall community process, along with other factors we can similarly label as forces.

The on-going quality of the community -- not a static state of being -- an open not a closed systems approach, will be stressed. In this dissertation the community, although an important factor, necessarily will have to be treated as somewhat residual due to the nature of the problem under study. It will be used as a sample or field to discuss what happens within an organization located in its bounds. In this sense what happened(s) in the community helped(s) to determine what occurred(s) within the organization, although the reverse view is possible too. Extra-community factors are intervening variables between the independent, community variables and the dependent, hospital, organizational variables.

Format to be Followed

The format to be followed in the presentation of the rest of this dissertation will be broadly as follows. First, a general discussion of the overal dimensions of the problem and its significance, viewed first from the perspective of the community and then of the organization, will be presented. Then, specific references to prior theory and research bearing directly on the problems of studying organizations at hand will be made, and those aspects and approaches deemed valuable will be synthesized with those of the community approach into a model of analysis appropriate to our purposes. Next, the research design in terms of the specific methods used and the problems encountered in actually carrying out the empirical field work in the hospital and deriving theoretical conclusions therefrom will be spelled out. Following this, the analytical findings will be stated and considered in terms of future research prospects and theory. Although the findings of this study may have some practical or applied sociological implications, the concern throughout will be only with the theoretical implications it may have for establishing a link between organizational and community theory.

Summary

The thesis of this dissertation, succinctly put, is that policy- and decision-making activities in the general hospital studied are affected largely and immediately by informal power relations obtaining in the surrounding community, which have been carried into the hospital, and both directly and indirectly subsequently by authority, power, and influence networks initiated and evolved over time within the organization

proper and affected by conditioning forces from without both the community and the hospital. These latter forces are hypothesized to have less direct but nevertheless significant impact upon policy- and decision-making in the hospital. The actual study in the field, following standard procedures used in case studies with slight modifications (see Chapters III and IV for amplification of the methodology employed), covered a two year plus period from 1958-1960. No attempt has been made to follow up events within the hospital for a variety of reasons militating against such.

CHAPTER II

FORCES OF CHANGE IN AMERICAN COMMUNITIES AND COMMUNITY DECISION-MAKING

Warren on the "Great Change"

Roland Warren[1] points out that seven major changes (taken together making for the "great change") have occurred in American society in this century mainly, which have operated at different times and in different combinations to transform the structures and functions of American communities generally. These "forces" inclining to such changes are: (1) the increased specialization and division of labor both within and among communities; (2) the development of differentiated or specialized interests among local people who thus associate more often with others on the basis of these specialized interests than on the basis of merely living in the same place; (3) the increased interdependence within communities, with other communities, and with social systems within the larger society; (4) the increased bureaucratization and depersonalization of community life; (5) the entrance of many formerly local functions into the money-price-exchange market system; (6) the growth of large metropolitan areas with central cities and suburbs; and (7) the gradual change in many earlier cultural and social values which reflect the other changes just enumerated. Ample evidence of some of these change effects exists in the case of Mills Springs.

Underlying the "great change" in American communities, it might be added, have been demographic shifts (through in-migration or out-migration and/or natural increase or decrease) which, linked to overall societal changes in cultural values and economic trends, have led to the growth of some communities or to the decline of others, and physical as well as social transformations to accommodate these shifts have occurred. Both the physical and social transformations have been brought about in large part by the introduction of technological innovations and developments of an astounding variety into many communities. Among these developments, the extension of communication and transportation networks across the country serving as vehicles for the wide-spread and standardized diffusion of social and cultural values are noteworthy. Some communities have benefitted, others have not, from the introduction of various technological innovations and developments. Profound structural and functional changes have accompanied the resultant growth or decline of the affected communities. Again, some of these effects were felt in Mills Springs.

On the one hand, all of the above "forces" can be viewed as consisting at base of the conscious or purposive decisions made by individual citizens and public and private organizations working out individual destinies in a geographical area in response or adaptation to their social and physical environment. But, on the other hand, they may be, perhaps, better viewed collectively and cumulatively as the results of "mindless" ecological processes. In the mass it appears that such "individual" choices are gravely compounded very often and may affect the physical and social structure and functions of communities in a seemingly non-purposive, unconscious way. In either way, the

effects of these decisions is considerable.

A contrasting view holds that some community changes may result from self-conscious, collective actions of certain individuals, certain groups, and certain organizations which are directed at transforming or maintaining the status quo of their communities. It is to these latter kinds of actions or decisions of members of the C.P.S. that we will look for understanding much of the concerted and directed change in both the formal and informal aspects of the structure and functioning of our community and its positive or negative effects upon the hospital within its bounds. Actually, changes may be directed or not, and attempts at direction are attempts at controlling what has become undirected.

It will be necessary to repeatedly refer to the increasing and strengthening of external ties which bind this community to the larger society through this particular organization. Modern studies of both organizations and of communities demonstrate clearly that the educational, recreational, economic, governmental, religious, health and welfare units and their respective functions are increasingly being oriented toward standards set by district, state, regional, or national offices and less oriented toward each other -- i.e., more outside the community rather than inside. Although this may be true in more and more cases, such a generalization indiscriminately applied to all instances can be a dangerous overstatement and an over-simplification of the actual situation.

It is our contention that the community system in many parts of America is still very important and viable, or potentially so still, in affecting the operations of its local organizations positively or negatively. While it may be partially true that much of the decision-

making prerogative concerning the structuring and functioning of many of the aforementioned community organizational units or sub-systems of institutions has been transferred to the headquarters or district offices of such sub-systems themselves, leaving narrower and narrower the scope of functions over which the local units exercise autonomous power or control, many are still responsible in effect to the local community. The case for such a view for all communities and all organizations as powerless can be overstated and is subject to correction by pointing out the variant situations and the context within which they occur.

The particular unit, such as the community hospital, still is located within a community and largely staffed and maintained by community members who share community values as well as organizational values. Its continuity and very existence in the community, the formulation of certain key policies, the determination of specific behaviors, although not as subject to local control as once was the case in earlier decades, nevertheless all depend in many communities upon strong and often successful efforts made especially by the C.P.S. or elements in it to retain control over the unit for the community.

In the zeal to compensate for the over-emphasis placed by earlier community researchers[2] on locality orientation and upon a study of local behavior as though it were sui generis and independent of cultural and social forces from the larger society surrounding it (basically a social psychological cum geographical conception), an excess in the opposite direction has occurred in some studies. We must in an adequate and realistic description and analysis give what is due the local community influences, while at the same time relating

the community meaningfully to the rest of society.

In a very real sense, then, the community is a process. It is figuratively a prism which refracts the sources of social and cultural "light" (forces) passing through it from the surrounding society, and, given its somewhat unique, historically-developed composition, it projects a somewhat unique "spectrum" of its own "colors." Though "distorted," there are identifiable features with those of other "prisms" and their "spectra." A like analogy is useful heuristically to describe the particular hospital as an organization of a type or set of organizations.

Although it will be necessary eventually in the area of community studies to theoretically relate one type of community on a particular level of goods and services or functions to another type and to do the same with communities of different size, this difficult problem is not our concern. Besides, there is available, as yet, no adequate, systematic classification of these various types or levels and of interconnected behavior to allow for uniform generalizations to be made. The size problem has not yet received adequate treatment either, nor has the problem of geographical definition been resolved, as overlapping of communities in various institutional respects frequently occurs. Adequate theoretical resolution of these and other related problems awaits the gathering of more factual information than now exists.

One paramount difficulty in studying communities as social forms is that there does not exist a formal organizational chart for the community. A community, except possibly for that institutional segment legally and collectively representing it as an entity -- its government --

normally is not formally constituted or enacted. Conscious, coordinative functions or attempts to give to it an overall identify or social cohesion beyond that naturally obtaining in its informally interconnected components are usually appropriated by a set of leaders or a C.P.S., basically an informal group in its collective aspect and variously susceptible to change itself.

Warren[3] presents a community model which attempts to fill this gap, to approximate a basic form. So do Arensberg and Kimball.[4] These two attempts, although not entirely satisfactory, do afford us a comparative means of tying our analysis of organizational policy- and decision-making activity to the community's overall activities in this same regard. The former also allows the introduction of certain ideas of Form and Miller et al.[5] concerned with the C.P.S.'s functions as indicated above, sketchily, and below in more concrete and detailed terms. The relevance of viewing the C.P.S. as the main refractive component of the community "prism" will become clearer as we proceed.

For Warren and Arensberg and Kimball, the community consists of that combination of institutions and their respective social units which perform functions for the locality. Warren's five major social functions[6] having locality relevance are: (1) production-distribution-consumption, with all community institutions and organizations so involved in one way or another; (2) socialization, with the school system and individual families pre-eminent in socializing children, but with other organizations contributing to adult socialization in terms of occupational training and in other ways, we might add; (3) social control, with the government, the police, the courts, and family, and certain social agencies pre-eminently sharing this task; (4) social

participation, with religious and voluntary organizations more directly and formally, other units less formally and directly, involved; (5) mutual support, with primary groups (families, friendship groups, and neighborhoods) and local religious groups and voluntary agencies plus public health organizations contributing. All five functions, however, may be fulfilled also by extra-community associations or units.

The possible ways in which American communities differ from each other in structural-functional terms may be gauged roughly by arranging and comparing them along the dimensions of (1) local autonomy, (2) coincidence of service areas, (3) psychological identification with the locality, and (4) horizontal pattern, by which term Warren[7] refers to the structural and functional relations various local units have with each other. The various problems communities face and the ways in which they are solved or not are closely related to where they fit along these dimensions.

Using what he refers to as an historical, processual analysis and functional approach, Warren views social problems as the price paid for whatever advantages that a particular system of community living entails. Increasingly in modern times, the general problem facing communities is their inability to organize their forces effectively (let alone efficiently) to cope with their specific problems. There are various barriers to effective community action. First, the problems of the larger society, of which the local community is a part, may confront the local community and these problems are of such a nature that they are irresolvable at that level due mainly to the lack of adequate material resources to even attempt to do so unaided, given the general will to attack the problems. Of the many problems which fall

within this range, those of poverty and racial unrest or strife are prime examples. Second, the loss of community autonomy over specific institutions or organizations located within it, yet still closely intermeshed with the community's welfare, presents problems difficult to solve. Third, and in regard to problems which are potentially soluble at the local level, is the lack of identification many members may have with their community. This last barrier may be traced to various related sources: to the apathy of many citizens regarding community affairs, to specialized and divisive interests, to the large size of communities and organizations, to the lack of time for such pursuits on the part of many people, to the transiency of the population, to the alienation of certain segments such as the aged who feel, justifiably, that they have lost their place in society, to anomie (alienation from values), normlessness, and different subcultures with differing values. It is Warren's main thesis[8] that "the great change in community living includes the increasing orientation of local community units toward extra-community systems of which they are a part, with a correspondent decline in community cohesion and autonomy." Persuasive as this sounds, it is not the whole picture.

Rossi on Community Decision-Making

Turning now to the subject of community decision-making, the work of Rossi[9] in this area is pertinent at this point. Although he is interested in those choices or decisions made by communities which are directed at affecting community-wide institutions, his main emphasis is on restricting the concept of community decisions to formal choices made by an authoritative person or group. He defines a community decision as ..."a choice among several modes of action which is made

by an authoritative person or group within the community institutions and of which the goals are the change or maintenance of community-wide institutions or facilities."[10] This definition would appear to exclude all community decisions not made solely by authoritative parties within its institutions.

Community decisions which cut across community problem areas and which concern a community-wide institution are most often arrived at collectively and informally (in our experience) with no one official person, body, or institution ultimately responsible. Through a vote or otherwise, the wishes of the public are also heard when decisions of this nature are in the offing. Referring back to the point of Warren, Arensberg and Kimball, to the effect that no formal blueprint for the community exists: this can be extended to cover the fact that there are few community-wide institutions concerned with the whole of the community. Our modern institutions and their organizational units are quite specialized. Unless a C.P.S. is considered to be an institution, it is hard to accept Rossi's view.

To be fair, Rossi does leave the door open for recognizing these informal and collective aspects of community decision-making when he stresses that the legitimate and recognized right to make choices is accorded by law or custom, the latter presumably covering power structure activities in the sphere of decision-making. Nonetheless, in the main he underscores the provision that decisions must involve community-wide institutions, locally-oriented private associations and the like. In addition to excluding decisions made by non-authoritative persons or groups or by default, Rossi clearly rules out the myriad decisions not immediately community-oriented, such as state or nationally-

formulated decisions which may have a direct bearing or a very important impact on many community decisions.

Rossi's idea of "community issues" implicitly covers choices as to policy open to authoritative decision-makers. The particular issue in this view defines the relevant decision-maker according to rules laid down by law and custom. He is aware that more factors are ultimately involved than these in the process. The role of partisans and pressures from them, for example, may have a significant influence on decision-makers. Partisans, being persons or groups who are concerned to see that their particular preference is chosen by the decision-maker, are interested in particular issues and may, depending on the issue involved, range from the entire community to just one or two persons. The distinction made between community and non-community issues is an arbitrary and rough one in many situations, Rossi recognizes.

Warren also recognizes this difficulty of making a neat distinction, but he sees the increasing complexity developing in all communities -- large and small -- and the shifts in social participation from locality to specialized interests resulting in categorical rather than personal relationships, a lessening of local social control and weakened cohesion as complicating factors; and he points to the need for the community to find a means by which different interests and groups somehow receive their due in the process of collective decision-making.

It is our contention, following from Warren's point, that not all decision-making situations are clearly defined in terms of precedent law or custom. Decisons of a pressing and new order for the community may be made in a trial-and-error, random fashion outside the purview of community-wide institutions. Ad hoc groups may spring up.

The proliferation of large-scale organizations which are centralized impairs community autonomy and tends to blur the distinction between community and non-community decisions. Periodically, there may be an influx of experts and specialists into the community from the state and federal government, from private organizations and business or industrial companies bearing sad tidings in the form of certain demands or edicts for meeting standards and for making unpalatable choices for action.

Two important questions are raised by these extra-community ties, questions which relate to the problem of distinguishing community from other issues. "How can organizations or units, which exist in the local community but are at the same time integral parts of diverse extra-community systems, be sufficiently flexible so as to relate to each other at the community level in a harmonious fashion, to avoid conflict, to make available to the local people the services of the larger society?" The other closely related question is, "What types of decisions and what types of institutional control are appropriate for the local community level, and what types are more appropriate for the respective extra-community systems?" The answers to these questions requires empirical study and probably varies with the type, size, and influence of the extra-community system, as well as with the type, size, and influence of the community and nature of its power structure.

The extent of bureaucratic organization of the respective community units, which provides the structural and procedural vehicle through which various types of decision-making behavior can be deliberately administered rather than left to the decisions of individuals, requires study. The bureaucratic organization of units may allow for the separation

of the administration of the unit and the policy-makers (usually composed of boards of trustees or the like, the members of which are most often influential and powerful community persons -- the C.P.S.) and may enhance the rationality designed to favor the organization's own goals as opposed to the community's.

Social and cultural values underlie the decision-making process and give direction to the establishment of priorities in the different functions to be supported in the community and how much support in terms of resources the actual units fulfilling those institutional functions are to receive. Presumably, values are the underlying principles according to which people in organizations similarly make their choices. There can be a conflict between these two sets of values -- community versus organizational values -- or among values held by the different segments within an organization. It is necessary that such values be studied.

Williams on Values; Warren's Additions

Robin Williams, Jr.[11] has presented a four-point outline for appraising the relative importance of different values in a particular setting, which can serve us as a guide below. The criteria consist of: (1) the extensiveness of the value in the total activity of the system, (2) the duration of the value (the time factor is very important), (3) the intensity of the value as indicated by the effort, crucial choices, verbal affirmations and reactions to threats on the value in question (sanctions), and (4) the prestige of the value carriers. According to Williams, the outstanding values which appear to permeate all aspects of American society are freedom, individualism, democracy,

practicality, pecuniary evaluation, success, education, science, progress, happiness, humanitarianism, and conformity. Since values are so abstract in nature and amenable to varied interpretation, in specific contexts they may well conflict with one another and/or be inconsistently applied.

In this vein, Warren[12] sees the gradual acceptance of governmental activity as a positive value in an increasing number of fields at the federal, state, and local levels. There appears also to be a gradual change occurring from a moral to a causal interpretation of human behavior by more people in more situations: a shift from sacred to secular values. A value change is becoming more evident in the community approach to social problems from a stress on moral reform to that of planning. A change of emphasis from work and production to enjoyment and consumption is another shift in values. One must, however, be aware of the powerful resistance to these trends which may result in community conflict on the local level. This factor of values and conflict between values will play a big part in this dissertation at the point of linking the various systems: of the community and the hospital (along with its sub-units) and both of these to the larger system of society and unit organizational systems.

There are identifiable instruments in communities generally which contribute, to a greater or lesser degree, to the maintenance task of integration or cohesion of the community and which serve as the social vehicles of the various cultural values produced or expressed there. Although they are all subject to certain imperfections and to the limitations often imposed upon them by pressures from specialized interests, the vehicles which so fit into the picture are:

the local political and governmental sub-systems; the local press which purportedly communicates the broad community viewpoint; organizations specifically instituted to effect a horizontal (intra-community) integration of community-based units, such as community or citizens' councils (these appear to be weak and notoriously unstable generally); the churches and schools or other special units may form associations in their particular spheres of interest addressed to community-wide problems of social integration. The family is the traditional institution, one function of which is integration via social placement in this respect. Because of the considerable specialization in our society, however, the effectiveness of these instruments or vehicles in serving the integrative function has been lessened tremendously. More significantly and effectively serving this function, we feel, are the social class structure, power structure, and other associations.

Internal and External Systems

A number of theorists have been concerned with the problem of relating the external and internal patterns of activities in the community and whether they can be clearly differentiated. It is most difficult to locate a community structure which corresponds to the external pattern discussed by Homans, Loomis, Parsons et al.[13] It is relatively easier to locate a community structure corresponding to the internal pattern of which they speak. Both tasks tend to be supervised or handled by the power structure in small communities. Larger cities are more problematical and not our direct concern.

Warren's notions of vertical pattern and horizontal pattern roughly correspond to the distinction made by Homans[14] between external and internal systems viewed from the perspective of the community. The former refers to extra-community structural and functional relations; the latter to intra-community structural-functional relations. Task performance by the community's sub-systems tends to orient them toward external or extra-community systems, while maintenance functions are internal and cut across sub-systems of the community.

Characteristics of Decison-Makers

One type of research in community decision-making has been mainly concerned with the characteristics of decision-makers.[15] It has related the social and personal differences among decision-makers to the kinds of decisions made. The techniques used have ranged from the analysis of detailed case histories (sometimes of a quasi-clinical nature) through the analysis of official biographical notes. A second approach has been centrally concerned with the partisans of issues. In such studies the "ultimate" determinants of the outcome, of the decisions or the resolution of issues, has been sought in partisans' actions vis-a-vis the decision-makers. Power structure studies, pressure group or propaganda research fall into this category of research designs. A third variety of research in this area deals with decisions directly, seeking to understand the choices of decision-makers as the outcome of relatively complex processes. Interviews with the decision-makers are used to obtain retrospective accounts of the decision-making process in some of the studies. In others, contrived problems of decision-making have been studied in small group laboratories.

In our previous study of Mills Springs (and herein) a combination of the first and second approaches (with the appropriate techniques) was used. The parties to the various decisions were located and certain of their basic characteristics ranging from the relatively simple ones of age, sex, occupation and education to the more complex attitudinal and valuational data supplied by in-depth, detailed interviews were identified and compared with the rest of the Mills Springs population. The decision-makers were found to differ from the general population of the community in various ways. The ways in which they differed -- unlike in most "pure" studies of this sort which use the differences to make inferences about the types of decisions decision-makers are thereby disposed to make -- were linked directly to actual decisions and issues in which they were involved. The differential recruitment of decision-makers has been most strongly established in these studies of decision-making. Those findings, as did ours, tend to show that decision-makers as a group are consistently and disproportionately drawn from the ethnic and religious groups with higher status, from the higher socio-economic classes, and from the older age groups. The differences between decision-makers and ordinary citizens are more marked as the authority level of decision-makers rises.

Rossi[16] questions some of the inferences made in such studies concerning how decision-making is affected by these differences. This approach, he feels, has had the greatest success when applied to mass voting behavior wherein clear divisions are discernible along ethnic, religious, class, and regional lines. There are not always clear and consistent differences among age levels, religious, ethnic, or class

levels, etc., on many issues when a set of decision-makers of radically different backgrounds is substituted for another. The assumption that there is a close association between an individual's background and personal characteristics and the behavior he will exhibit in office exists may not follow. In the general population, class position has been found to correlate with opinion, but at a low level, so that deviants from the majority opinion may be elected. Popular support of the lower levels of a community's social strata may go to these deviants at the upper levels. On this basis, Rossi believes that among elected decision-makers social background may be a very poor predictor of decisions made, particularly on class-related issues. Using social background and personal characteristics as the major explanation of behavior in a decision-making role denies that given individuals may act differently when placed in different roles.

Higher-level decision-making roles ordinarily are rather well-defined in both law and custom of the community and each role involves its occupants in a formally and informally defined pattern of behavior and a set of structured relationships to other roles. Professional roles require special training enabling persons to fill their positions. Role expectations of a distinctive nature will probably be important determinants of decisions in such instances. The decision-maker, however, does not operate in a social vacuum but is subject to the influence of partisans on many issues so that this factor, above and beyond predisposition and role, may be crucially important in the outcome of many issues. In each instance, empirical testing rather than assertions is indicated.

Community Power Dynamics

In the "partisan approach" power and influence are seen as determinants of decisions. Both are relational terms used to describe relationships between persons and/or groups. Power implies that sanctions exist which may be used by A to compel B to do his bidding, whereas influence is behavior effected by A from B without recourse to sanctions. Although the general form of the relationship is the same, the process is different. It is often difficult to empirically distinguish between the two. Three basic research designs[17] have been used to investigate these related phenomena. There are the studies of the potentials for power and influence, in which inventories of persons and organizations in positions to apply influence or power in a community are produced. Another set of researches deal with reputations of power or influence or on what the community members consider the influence or power structures to be. Research on actual power or influence, studying of particular issues in progress in which these factors have played a part in the determination of the outcomes, constitute the third subtype.

The first of these approaches has been more extensively used than the others due to the difficulty which exists often in directly studying these types of social relationships. The lack of access is a prime obstacle. Some of the researchers have produced inventories of community positions which contain the necessary attributes for the wielding of influence or power. Many such studies of power, for example, have tried to document who within a community controls significant amounts of economic resources. Such persons -- called economic dominants -- are in a position to wield economic sanctions

over decision-makers. Persons who are heads of various private associations or who occupy important offices -- called leaders in influence studies -- are seen as able by virtue of their positions to have effects on the opinions of their followers on a variety of issues. These sorts of studies implicitly assume that the potential for power or influence will be used. In fact, economic power often is used; such potential power can make a big difference whether actually employed or merely threatened (not used); and potential for influence is often regarded as equally effective regardless of the issue or topic involved or the special competence of the influential leader and, when used, influence results in a different combination of opinion among the public than would have occurred in its absence.

Employed in communities of small size, the sociometric techniques which are often a part of the studies of reputational power or influence allow for a literal mapping of these relationships within and between groups of such prominent people. The reputations are accorded to individuals and/or groups by a set of judges or a panel of strategically located persons in the community most often. Studies of reputational power and influence have established that some key individuals with considerable economic strength can and do exercise more than ordinary influence over decision-making. It has been found, moreover, that this sort of control is especially effective over decision-makers in civic associations dependent on voluntary financial contributions. Informal opinion leaders appear to exist on all levels of community and on occasion affect the opinions of the mass of citizens. These opinion leaders do not necessarily overlap with the official public and organizational leaders of the community.

Warren is also concerned with how, where, and by whom decisions in the community are made, although he is more concerned with the policy decisions. In his view,[18] there are a number of different auspices identifiable, under which policy decisions are made, both formal and informal, community-oriented and unit-oriented. (There are certain issues which contain mixtures of these attributes.) The need for delegating authority to make decisions is recognized by Warren as a practical necessity, even though democratic values abstractly would seem to call for decisions to be made by those who will be most directly affected by them. Some types of decisions require special knowledge appropriately confined to individuals or groups with special qualifications, according to the criterion of relevance. On the other hand, the criterion of prerogatives, indicating that some community people have a greater claim to a voice in particular decisions of a unit than do others, encompasses legal, customary, and other claims such as power and influence.

In voluntary associations the formal decision-making authority over policy determination resides in a board which may either be self-perpetuating or elected by a larger membership body and which is responsible to it and/or to the community. The board usually exercises broad or even exclusive powers, but its sphere may be restricted to relatively narrow powers. Boards are made up predominantly of upper and upper-middle class people in the community, holding important positions in the business or industrial world or governmental hierarchy or people who "speak for" or "represent" them.[19] It is such people who are in the position to found organizations or associations or whose material support and advice in so doing is avidly sought.

There is a similarity in form between private corporations and voluntary organizations. It would appear that the former have served as models for voluntary associations because the board, which has ultimate authority and establishes policy which affects other organizational decisions, is composed of interchangeable members in this sense.

An important point stressed by Warren has to do with the nature of community controls over various units and with the various types of auspices which directly affect the decision-making process.[20] Local governmental ordinances and other legal regulations are one form of control over unit functions. Control functions of state and federal government over aspects of local community units and their functions are another. Informal local and extra-community control exercised through public opinion, gossip, praise, blame, etc., and local customs or norms operate more or less directly on parties authorized to make decisions. Voluntary associations are especially subject to these various pressures.

Voluntary or civic associations mainly depend on gifts in different forms for capital and for current operating expenditures. Control -- often quite considerable -- is effected through the making or withholding or re-channeling of gifts by community members. Whoever controls this pattern of contributions essentially controls the fate of the organizations so supported. Control through patronage, local labor supply, and customer behavior bear on organizational units of this type also. The actual extent to which an impact on the behavior of a unit can be made by the local community through these various control mechanisms probably is greater in smaller than in larger communities. At any rate, it is an aspect needing empirical study.

In terms of a voluntary, non-profit association such as the hospital, it is pertinent to find out what control community people have over it through their gifts (donations, pledges, etc.) and through the effects of their patronage or "business" of the patients. Would the decline or choking-off of gift-giving mean the decline or demise of the hsopital? As for patronage effects, actually most community lay people seem to give a high valuation to the performance activities of a hospital (or like voluntary organizations) because of the vital function it fulfills for them, without their having a detailed knowledge or understanding of the effectiveness or efficiency of the unit in performing this function. Since it is very difficult for most people to judge the extent, quality, and efficiency of such a unit, an emotional appeal to the "cause" influences gift-giving and patronage. Appeals to "community spirit" for supporting such units is not uncommon. The facts for an intelligent or rational decision about voluntary associations are usually not widely available.

Social institutions, and their respective representative units, are intended to supply recurrent and vital human and community needs. As such they have a peculiar staying power and toughness that appears to defy dissolution. For them to be viable, it is not in fact necessary that they be efficient. It is not even necessary, apparently, for its personnel to have any clear idea as to the unit's raison d'etre.

Not only is there less rational control on the part of the community or its representatives on the boards of such units, as opposed to boards in business/industry,within the internal administration of the hospital, for example, there tends to be less rational

control over the allocation of the gifts and other financial input through a budgeting system. There is little evidence that money will go where it is most needed rationally in organizations of this order; rather, the allocation is subject to internal cross-pressures and ad hoc needs. This seeming disorder in procedure, this maladaptation of means to ends, these sudden tacks and turns of policy noted by some researchers in organizations governed primarily by top-notch business-industrial people, has been contrasted with their behavior in their usual, vocational lives. In terms of the hospital, one might well ask whether such an organization can be operated otherwise, since it is a normative organization with life-and-death concerns at its core -- concerns which are scarcly amenable to thoroughly rational, business-like or bureaucratic techniques, except on a most superficial level. It should not be too surprising that the behavior of businessmen in policy-making positions on the boards of profit-making corporations may be markedly different from their behavior when sitting on the boards of non-profit associations.

Yet the board form of organization is ideally designed to apply the principles of rational, bureaucratic organization to a pattern of gift-giving and gift-distribution which would otherwise be left to the free operation of the "gift-market." Tensions generated by such a basic conflict in purposes and values structurally built into the hospital organization will take a prominent place in our detailed analysis to come.

Warren[21] discusses the nature of other community auspices in some detail, which we need not pursue. Various types of functions, or the same functions, can be performed by different types of community

units or under different auspices. The first hospital in Mills Springs, for example, was a proprietary one, owned and operated by a local doctor and his partner, a practical nurse-supervisor, for profit. The major source of funds, the formal locus of decision-making, the ultimate authority and responsibility and community controls over performance of similar functions should differ systematically under the various auspices.

In the absence of other clearly defined and measurable criteria, the ability to make a profit or to perform a function at a low financial cost tends to become the sole criterion for evaluating the efficiency of the operation, regardless of under which auspices the function is performed. Community controls over the performance of health and medical care functions for the community are made especially difficult by the absence of adequate standards of evaluation or by the application of profit or cost criteria to functions to which such criteria do not properly apply or are irrelevant.

Whereas Warren[22] succeeds with some voluntary associations in attempting to delineate the reciprocal functions which local units of an extra-community system and its headquarters perform, he fails to satisfactorily apply his scheme to the case of the community hospital. It is more accurate to say that he implies that this fit is proper, but from our experience the fit is poor. When dealing with community hospitals in America, it is difficult if not impossible to define such an extra-community system to which the local unit belongs, although it is possible to do so in the cases of state mental, T.B., or other hospitals and V.A. hsopitals and the like. For American community hospitals, however, there is no real central headquarters or bureaucratic

organization as in certain foreign countries where such hospitals are tied in with national, regional, and local divisions under a central ministry of health or the like. Only in a very loose sense does an equivalent state of affairs exist with the national Department of Health, Education, and Welfare. No real headquarters as exists for an industrial or business corporation obtains.

The community hospital does not usually make a product or provide a service which is fed into an extensive extra-community system; nor does it sell products of the larger system locally; nor does it participate directly, fully, or wholly in the decision-making process of the extra-community system. The A.M.A., state or county medical associations and other advisory, evaluatory, or participatory professional and semi-professional associations do offer a rough set of equivalents, nevertheless, but through members of sub-units of the hospital. The last of these functions -- participation -- is fulfilled by the local unit's members in their respective specialty organizations.

The functions that the "system headquarters" (in the above sense) are supposed to perform with respect to its "local units" are also moot. In clear-cut cases of voluntary organizations (other than the community hospital) these functions are to provide a system product to its system units for use or local distribution by them; to provide formal-structural, administrative direction and co-ordination, and other advisory or evaluatory services to the system units; finally, to provide services such as information about the system to people or organizations outside the system.

Power and/or influence may be exerted by system headquarters through the provision of services to the units with rational, pragmatic

authority -- especially in terms of personnel training programs or the certification of same, through special district or national meetings, through informational communications (such as journals), or through pragmatic suggestions. The power of the system may be exerted through personal contact and through the channels of influence extending beyond the system's formal structure and basic charter. Similarly do the specialized, professional and semi-professional hospital organizations exert power and influence on their constituent members.

Reciprocally, the local unit's power may be exerted in the relative autonomy its employed bureaucracy may enjoy from the system headquarters. Informal influence may accrue if only through the difficulty subordinate units may have in implementing the system's policies at the local level. These observations find but tangential application in the case of the community hospital because it is not linked bureaucratically nor is it organized into a national, state, or county system of medicine. The looser set of links mentioned above does exist and these will be treated below. For now, a more relevant set of considerations treating the unit-system input and output exchange is a more fruitful way of establishing the general connections of a community hospital with its extra-community systems or organizations and the community.

With regard to the input of the hospital into the community, the following questions need to be posed and answered. "What kinds of things, processes, or effects are brought into the community through the extra-community ties it has? Are any capital or operating funds for the operation of the hospital brought in from outside the community; if so, from whence and are any strings attached? What is the nature of the services given to the hospital? Is a program of objectives and

procedures for the unit externally applied? Is personnel for the operation of the local hospital so furnished? Are products or services for distribution within the community sent in? Are provisions of employment opportunities to local people made from the outside? Are certain skills, techniques, knowledge, and social attitudes poured in?"

The output of the local unit into the extra-community system may consist of raw materials and sub-parts, funds, innovations in the form of social inventions or mechanical processes, "trouble," and adjustments to policies of the larger system in the form of expressed reactions. In the case of a small community hospital, its contribution in this regard is quite limited since it is usually un-noticed, insignificant or not too important. Its output and impact are usually limited to the local community. It gains more from the various extra-community systems and ties than it gives in return.

The impact of selected aspects of the wider culture on the local community is often made through the local unit by means of administrative and professional diffusion of specialties and alternatives created elsewhere. In this way certain patterned modes of behavior which local people share with other communities of a larger cultural area are brought about. Usually the larger communities and organizations so affect the smaller ones, although the reverse is sometimes possible. Managerial innovations, altered professional and semi-professional standards, personnel training, consultative services, new products, educational material for the general public, sales promotional material, and so on are so diffused.

Cultural specialties, according to Linton,[23] are "those elements of culture which are shared by members of certain socially recognized

categories of individuals but which are not shared by the total population." People who transmit cultural specialties usually share a special subculture and a set of values and are organized into professional or semi-professional organizations and other special interest groups. They may also form a category of local residents (such as newcomers to a community or cosmopolitans) predisposed toward welcoming cultural innovations into the community on many fronts. Innovations are customarily introduced through certain of the specialist groups as a part of the normal exercise of their calling or profession. It is more likely that such innovations are supported by other professionals or kindred persons, even though they may not be directly concerned vocationally.

Another type of diffusion -- in part administrative -- is that of cultural alternatives[24] which are traits of mass culture diffused to various publics by means of the media of mass communication primarily. These cultural traits are those shared by certain individuals but which are not common to all members of a society or even to all members of any one of the socially recognized categories. This is the broad area of free choice wherein values of taste, opinion, and material possessions are diffused. To the extent that people are affected by these values in the area of health care, this sort of diffusion becomes germane.

The reciprocal functions of local units and the community system are most germane to this dissertation. One can respond to the question, "What does the hospital as a local unit do for the community system and vice versa?" that the hospital performs the very important function of supplying the bulk of serious and prolonged medical care for the

community. It provides employment and income for a significant number of community members. It provides well-defined links between various of its sub-units and individuals in the community and cultural and social system of the larger society beyond the community's borders. As do other local units, the hospital provides channels through which impacts tending to change are brought to bear on the community from various extra-community systems and vice versa potentially.

The local community may be viewed as a field in which units interact with each other on the local scene, maintaining a continuous but constantly changing pattern of interaction -- sometimes competing, sometimes co-operating. The community system provides a market place for the local unit's product or service, as well as a labor market. It provides the functions necessary for the unit's continuing operation such as police and fire protection, transportation and communication facilities, utilities, and consumers.

There has developed in many communities some degree of formalization (amounting to bureaucracy in large ones) in the horizontal patterns to hold things together on the local level, to as equitably as possible relate and regulate the various activities of their local units and to supply their needs. (In the later stages of the "great change" this attempt has become quite necessary.) The Community Chest is a good example. This development in large part is an attempt at deliberate community administration, planning, and rationalization of the relationships of competitive local units.

Bearing study is the relationship of unit status-roles to the community system. Although the positions in the various local units are less clearly related to one another either in a functional way or

in terms of the authority they carry -- i.e., the formal relationships are not clearly defined vis-a-vis superordination-subordination, prestige, or responsibility -- nonetheless gradations and links do exist. Positions in various local units carry implications of prestige and power in relation to the horizontal pattern. They are more important with respect to the relationships of top administrators or policy-makers to the pattern of local power distribution, but the implications may also apply to positions in the unit structure's lower echelons. In this vein, Warren tends to oversimplify the nature of behavioral expectations in the organizations as opposed to those obtaining in the community system. He cites as appropriate behavior in status-roles in local units expectations such as "following the rules," "categorical," "impartial:" these are vertical, unit expectations. For horizontal, community expectations he cites "making exceptions," "being human," and "permissible variations."

In an organization such as the community hospital, however, the latter expectations and values, goals or objectives are part and parcel of its normative type of subculture. As a matter of fact, not all organizations of other types, let alone normative ones, are all that rational, bureaucratic or universalistic. On the other hand, neither are all communities as particularistic as he states or implies. Nevertheless, since there very well may be values, goals, and objectives of the locality imposed upon the local unit, which may be a different set of demands from those of the extra-community system or other sources, these should be carefully studied. Pressures for a certain political party affiliation, religious membership, or service club activities may be expected for full participation in the halls of

community decision-making and to ensure the particular top administrator favorable treatment for his unit. Considerable civic participation may be expected of certain positions--especially of those developed or dependent on gift-giving as outlined above. A hospital administrator and his family may be expected to take an active part in the activities of the community and an informal network of reciprocal obligations and "neighborly" exchange of favors among the leaders may develop. This is quite evident in smaller communities. Of course, the individual's own value system and predispositions are important as to whether he is an "organization man;" in this context the useful distinction between locals and cosmopolitans is a relevant one.[25]

The community system has certain controls over the local unit at its disposal. Basically, these include governmental ordinances such as zoning, health, and building codes; otherwise, there is little actual local governmental control. Co-ordinative units such as Chambers of Commerce, Community Chests, United Appeals, Citizens' Councils, etc., usually have little authority, but they may exercise considerable influence and some power through informal means such as praise and blame, favors, and income pressures. In this regard the common, middle-class, professional or occupational norms and the approval of one's peers may be at work on a unit's administrator. Civic associations, such as the League of Women Voters, may have some effect on public opinion, but, by and large, their influence is not decisive.

The most important instrument for control available to the community is its power structure, we contend. It, more than any other component or factor in the community, brings local community considerations

to bear upon specific community units. A C.P.S. need not be monolithic to be effective in applying pressures or maintaining control; its form often varies with the community type and size, region, and may vary over time within a particular community.

Many C.P.S. studies have found the general existence of concentrations of power over decision-making in every segment of community life. In smaller communities, especially, there may be various degrees of overlapping among these different concentrations of power in specific groups of people or individuals. In larger communities power so wielded appears to be more diffuse on issues related. The point to be made is that the C.P.S. is a major channel through which conflicting or competitive interests in the community, and this of course includes unit interests, become balanced or, as in issues, resolved or at least accommodated. It is the most important single channel through which influence from the various segments of community life can be concentrated and applied to a specific unit so that its operation will satisfy, at least minimally, the interests and needs of the widest variety of the community members and units.

A more diffuse, though not unimportant, control feature available to the community is its market behavior. A community or a substantial part of it can refuse to patronize a particular unit not fulfilling minimal expectations and through negative public opinion and the networks of informal association bring more diffuse pressures to bear on the unit toward altering its operation. The communication media are a means of local community control. There may be liaison persons in the local community with direct lines of influence to higher-ups in the extra-community system or elsewhere who can pull

strings and place effective pressure on recalcitrant local units.

Local unit controls over the community system by such units as the hospital are less effective than for other kinds of units (such as industrial corporations) which may have the strong backing of their state or national organizations in pursuing goals and developing operations in the community. Such state or national organizations may lend considerable support to their local units in following policy not satisfactory to other community units or members. The local unit's policy may be determined elsewhere, and the basic charter or law may not permit concessions to local policy. Actually, things are less clear-cut than this because policy developed elsewhere still must be implemented under local conditions. But the access of the local unit to system headquarters or to other extra-community sources is a forceful means of exerting pressure on the local community. The more autonomous industrial or other unit has at its command the threat of withdrawal of the facility itself or its services which means often a considerable loss to the community. With regards to the hospital (or other voluntary unit), however, it does not have available this means of control. It does have an important means available to influence the horizontal pattern through the positions its leaders occupy in that pattern (especially the C.P.S.), and through which they are able to exercise some influence or power and to communicate their needs for community action. A large share of decision-making takes place informally among the leadership group(s) (the C.P.S.) who pass or veto projects, then have these decisions implemented in the community's formal organizational structure.

The unit-community system input-output exchange parallels the unit-extra-community system pattern discussed above. The reciprocal kinds of functions, services and impacts are essentially alike, the one's output being the other's input. Community system inputs into the unit include: (1) certain general services which constitute the "products" of the other units in the locale; (2) more specific services related to the actual operation of the unit; (3) a labor force; (4) capital and operating funds; (5) cultural traits and values from the locality, such as pertain to working conditions; (6) social pressures of various types usually informal and channeled through the C.P.S. members on the board of the unit; (7) goodwill; and (8) impacts caused by the action of other local units. The major local unit inputs into the community system are reciprocally (2), (3), (5), (6), (7), and (8).

It is an exaggeration, if not a fallacy, to consider the local community as merely the end of the line for a congeries of extra-community systems. One must be cognizant of the distinctive modes of local interaction realized in the areas of social stratification, intergroup relations, and at the level of economic activity, which have both local and extra-community ramifications.

Background Factors in Mills Springs

The following section of this dissertation briefly outlines the evolution of the community of Mills Springs with respect to the significantly related changes observed: (1) in its economic base, (2) its form of power structure, and (3) its modes of making decisions and resolving issues -- as all these aspects were affected by the particular

social and cultural impacts (discussed in general terms above) which it had experienced at various stages in its history. (Participant observation, interviewing of key informants, written local histories, documents, and newspaper files were all used to generate this account.) The overall evolution of this small town has resulted in a basic transformation in its identity from what had been a traditional and very conservatively-oriented one-industry town and rural trade center early in this century into, at present, an uneasily modern satellite town.

Particular attention has been devoted to tracing the evolution in the power structure and decision-making activities of the community as related to changes in its economic base because there is compelling evidence that such major shifts are strongly correlated and have consistenly played a key part in the transformation of many American communities. A more complete explanatory picture than that afforded by more limited functional approaches to community decision-making is possible by depicting the parallel developments in community decision-making and power relations to the external factors previously discussed as well as to the internal or immanent changes also observed: specifically in the stratification system, the redistribution of economic dominance, the types of problems and issues that arose, and the patterns of resolution of issues occurring in each historical stage.

The mushrooming spread of social problems in recent times on the local community, state, and national levels of our society is one of the most serious effects produced both suddenly and/or cumulatively by the impacts of the combined forces of population growth or decline, technological innovations and developments, the spread of communication and transportation networks, and the increasing centralization of

governmental, business-industrial, and other activities: all accompanied by changes in many basic values. To list only a few, these problems include: troubled racial relations; the need for more and adequate housing; technological unemployment; the need for extended and improved education, medical care, and welfare; crime and juvenile delinquency, etc.

On the local level, the impact of these and other social problems has often been acute and usually it has been expressed in the form of social issues which have revealed community tensions or conflicts over deeply polarized cultural values, and have involved, overtly or covertly, power struggles in the attempts at their resolution. Oftentimes, these problems and their implications for reform have been unrecognized or ignored by community leaders until their dimensions have grown beyond the capability of the community to handle them alone. The blindness to the existence of social problems and the lack of adequate preparation or planning for solving them on the community level have been further complicated by the reluctance of certain powerful interest groups or associations to resolve the social issues confronting them and their community, even when the means and knowledge were available to do so. The desire to maintain the status quo and the fear of change are the two sides of the same coin.

Mills Springs has faced three major issues in the last quarter century resulting from problems involving industrial labor relations, medical care, and education. In all three issues, stability versus change was basic and community opinion was clearly divided, with the first and third issues resulting in overt conflict. As previously mentioned, these issues were interconnected and made up a pattern of contrasting values.

Conflicts or tensions over the resolution of the problems contained in community issues have often been fed by demands from other levels so that conflict or tensions between the local and state or national levels have been produced. Especially pertinent in the case of Mills Springs have been those existing between the state and local community levels of government and education.

Since World War II, there has been an upsurge in the legislation of federal and state laws which have had the effect of forcing reluctant communities to establish certain functions and/or to maintain certain existing services at levels of adequacy -- to comply with standards -- which they would not have done without such external compulsion. Both state and federal agencies are increasingly in a position to exert sanctions to get compliance. Such was the case in two of the issues studied in Mills Springs: there was constant state pressure brought to bear both in the hospital and school issues. There were some prominent community members who were more receptive or positively inclined to accept the changes made by the state departments' making demands for reforms in the areas of health and education.

The analysis of community power and influence relations used in this study is rooted in the pioneering theoretical works of Max Weber and Karl Marx, and is based more directly upon the themes found in the various works[26] of C. Wright Mills, W. H. Form and D. C. Miller, F. Hunter et al., who have followed the lead of Weber and Marx.

By studying how policies are formed, how projects are initiated and carried out, and how issues are generated, developed, and resolved through community decisions, one can arrive at an explanation of the

dynamics of community power. In this connection Form and Miller[27] have developed a suggestive typology, consisting of four basic models, which greatly aids in the attempt to isolate the dominant features of various kinds of issues and their modes of resolution. These are: (1) the Economic Interest Model which applies when community issues arising in any institutional sector are basically translated into economic terms, with various groups aligning themselves pro or con in accord with their economic interests, either generally or specifically; (2) the Public Welfare Model which applies to issues in which the general welfare is considered to be more important than the separate economic interests of groups in the community; (3) the Community Hostility Model which applies in cases where a community or segments of it are arrayed against private economic interests and primitive measures are instituted to change the latter's goals and methods; and (4) the Status Contest Model which applies in cases in which the functional groups of a community struggle not so much over the ends of community action as over the leadership, prestige, and methods of achieving common objectives. Pertinent to this case study are (1), (2),and (4). Common to all of these models is the notion that ongoing, institutional or organizational activities and relations in the community are challenged by problems, events, or projects which may become community issues and that community-wide decisions are called for which may involve drastic redefinition of existing relations and/or pose real threats to certain status quo positions through such potential or actual changes.

Community power in this context refers to the whole network of potential and actual influences, power, and coercion reciprocally brought to bear among persons, organizations, and informal groups

involved in community projects, issues, and decisions. Several components of community power are defined and elaborated by Form and Miller.[28] Given the particular community circumstances, certain of these components may or may not appear, or may appear in different guises and combinations, thus resulting in various types of C.P.S. Three of the components are of particular interest and use herein. They are as follows: (1) the Community Power Complex which is a power and influence arrangement composed of individuals, permanent or temporary organizations, special interest associations, and informal groups functioning outside the purview of the local institutions and emerging during specific community projects and issues to press for their points of view. (In Rossi's terms, these are the partisans who may apply pressures on the certified decision-makers); (2) the Institutionalized Power Structure of the Community is the term used by Form and Miller to connote the relative distribution of authority or legitimate power vested among the various societal institutions and their organizations on the local level; the component labeled (3) Top Influentials refers to the aggregate of community persons who are reputed to be of most influence and power in decision-making, and (4) the Key Influentials are acknowledged leaders among them. (These may be formal leaders, but most often they are informal leaders.) The C.P.S., then, consists of the various informal and formal components of community power which may be activated by a community problem, issue, or project. In the Mills Springs case, and in its three major issues, the informal components were equally if not more important than the formal ones.

Decisions which are not brought to a vote of the community are made by the influentials or authorized parties in consultation with

them. Policy-making is the province of the former, execution that of the latter most often. Key influentials and their front men, the top influentials, may so manipulate the form and manner in which issues or projects are presented to the wider public so as to effectively preclude some choices of action ever seeing the light of day. Veto power is part and parcel of this.

Dealing with the types of structural arrangements that may stabilize among the key and top influentials making such key policy decisions or exercising veto power, Form and Miller[29] present four possibilities which may vary from community to community or in the historical development of a particular community. The Exclusive Elite type refers to an arrangement in which a restricted group of key influentials hold and exercise exclusive decision-making power on all potential community projects or issues. A second type is the Core Elite in which a larger elite group of key influentials, surrounded by a relatively larger number of top influentials, make the decisions on most projects or issues. The type known as Fluid Influentials refers to a stable, small, elite group surrounded by other core influentials but who are differentially structured and drawn into decisions according to various projects or issues to which they are felt (by the stable core) to be able to contribute their special skills or competences. The Democratic type is an arrangement in which individual and representative influentials of all community members party to a specific decision participate on a relatively equal basis in the decision-making.

As we have said, in its history a particular community may evolve in its power structure from one type into another, and this evolution is correlated closely with the aforesaid factors. Such was

the case in Mills Springs. The specification of these various types is a clear and notable advance over earlier or even some present work accomplished in this area.

James C. Coleman[30] offers additional leads in the delineation of the general social conditions underlying various types of social issues, based upon a comprehensive survey of a range of empirical studies. He delineates the various settings and initiation of community controversy, its dynamics, and the various factors affecting its course. The degree of community involvement in the issues, the social strata involved, the type of event, the kind of community in which it occurs, and its economic base are the factors used to explain the various patterns of community conflict. The source of events and incidents, whether internal or external to the community and their relative importance, are stressed. The contents of issues are related to economics, power or authority, cultural values or beliefs, and attitudes toward particular community members or groups: all of which are important as bases of response to issues.

Brief History of Mills Springs

Mills Springs was founded in 1836 by a group of pioneers (native-born Easterners of Anglo-Saxon origins, mostly) trekking westward who had stopped and settled there. The site had been for some years previously a watering stop used by many westward-bound homesteaders. The group which eventually settled did so because they felt they could exploit the area's rich natural resources and especially its ample water supply and sell supplies to the pioneers constantly passing through. The site was seen as particularly favorable for developing a lumber trade, and a sawmill was soon built plying a profitable but

short-lived, heavy, lumber trade until the surrounding forests gave out. In the 1860s several springs were discovered and put to use lending the budding town some fame as a health resort for about a decade until a series of disastrous hotel fires wiped out this lucrative enterprise. During the five decades following its founding, Mills Springs slowly but steadily became a modest, rural, agricultural trade center.

Mills Springs is located one hundred miles from the largest metropolis in its state and within easy commuting distance of several larger cities and towns in the vicinity. It has become increasingly dependent economically and culturally upon the state capital, a city of over 100,000 people located some fifteen miles away. Although it has lost steadily in its retail sales activities to this city, Mills Springs still actively maintains a rural trade area with a ten-mile radius serving approximately 7,500 people.

There are at present eight manufacturing plants in the town, employing approximately 600 persons. Light fabricating and stamping, paper packaging products, dairy production and sales, cucumber and vegetable pickling, and woolens manufacturing comprise the main industries. Agriculture was, and remains, an important form of livelihood to a number of local and surrounding inhabitants. The chief forms of farming include dairy, livestock, poultry and poultry products, and field crops and feed.

The population of Mills Springs is unofficially estimated at a little more than 4,500. In the census of 1940 its population numbered 3,060; in 1950, 3,509; in 1960, a little over 4,000. The highest percentage of increase was 17.7 -- between 1940 and 1950. Less than

one percent of its population are non-Caucasian. Ninety-seven percent are native-born whites; three percent foreign-born. Of the ninety-seven percent, the great majority of people are of Anglo-Saxon stock. Thirty-five percent of the population are in the under 20 age bracket; fifty-two percent are in the 20-64 bracket; and thirteen percent in the 65 and over age bracket.

Approximately seventy-five percent of the Mills Springs labor force commutes to work in the larger, outlying communities, with the capital employing most of them. Most newcomers, with the exception of professional and semi-professional people, have retained their out-of-town employment and many native-born workers sought employment outside the community upon the failure of the major, local, woolens manufacturing company. Many of these commuting male and female workers are employed by the state; a larger number also work in the automobile plants in the capital. It was with the extensive development of the highway systems in the state that these people were enabled easily to seek outside jobs. Much of the increase in the community's population since World War II is due to the in-migration of younger newcomers from the larger, surrounding communities basically, but also from farther afield to a lesser extent. Most of the newcomers, in addition to some seeking better job opportunities, have moved into town to enjoy the small town atmosphere and to enjoy lower taxes and living costs. The close and friendly relations possible in a small town were much stressed and appreciated characteristics of Mills Springs, as well as advantages hinging on these for their children growing up in such an atmosphere.

From the 1880s until the 1930s, Mills Springs was primarily noted regionally, and nationally to an extent, for its woolen industry and for the Sampson Mills especially. For some five decades it was a nationally recognized producer of quality goods and it enjoyed an extensive distribution of its products. Blankets, yarns, coatings, automobile robes, and upholstery fabrics were its main products. With the development of synthetic fibers and fabrics and technological improvements and changes in automobile design involving the use of such fabrics, this company steadily lost its ability to compete inter-industrially and lost its intra-industrial position. Now it is no longer involved in manufacturing; only one of the other two, derivative, woolen mills still engages in the production of wool and merino yarns.

In the past there existed two other major industries in Mills Springs: one manufacturing oil and gas furnaces, blowers, and filter package units; the other, industrial fabrication of steel flasks and light equipment for the foundry trade. The one industrial plant moved out of town, while deaths in the family owning the other industry led to its closure.

The governmental and general social organization of this town resembles that of the usual, Midwestern, small town. The commission system prevails with a mayor and ward councilmen elected. Local politics is not partisan, although politics is rabidly partisan when the community votes on the state and national levels. The town votes consistently conservative Republican. The town owns the library, distributes water and other utilities (excepting telephone), and operates a fairly new sewage disposal plant. There are one high school with a manual training-agriculture division, two elementary schools, a

lighted athletic field, and a centrally-located park in which weekly band concerts are presented during the summer season. Recreational facilities include a small motion picture theater, a bowling alley, and a youth headquarters. Of the ten denominational churches in town all but one are Protestant -- it being Catholic. There is the recently constructed hospital. A weekly newspaper publishes community and area news predominantly. Mills Springs has its fair share of fraternal organizations and service clubs which appear to offer a high degree of social participation to all levels of the community membership.

The evolution of Mills Springs in terms of its economic base, stratification system, C.P.S., types of issues and their resolution, and the social conditions underlying them was found to fit into four historical stages.

Stage One (1836-1870s): Pioneer Settlement. This was the period of early settlement and development. This stage, clearly subdivided into two parts, (a) and (b), is the most difficult to reconstruct due to the paucity and unreliability of historical records and documents. Few knowledgeable informants remain from that period. The economic base of (a), the pioneer settlement, depended heavily upon the trade in water, agricultural foodstuffs, and hardware. With proceeding settlement, the town was more fully formed and became more complex. It became basically (b), an agricultural trade center. Continuing retail trade was joined shortly by sawmill and grist mill operations; lumbering, grains and fruit growing waxed and then waned; finally, the mineral springs resort period had its inception, highpoint, and ended abruptly.

The stratification system of (a), the early part of Stage One, was inchoate, although the pioneer settlers appear to have been predominantly of lower-middle class origins (translated into modern terms). Strata soon appeared especially in the later (b) part of this stage, with the upper class consisting of the prosperous merchants, bankers, and farmers -- a very small group it seems. The middle class contained the few skilled craftsmen, artisans, and workers -- a somewhat larger group. The lower class consisted of farm and manual laborers -- this unskilled and semi-skilled group being largest in number.

The power structure was, again, inchoate in the earlier part of this stage (a); only in the later part of Stage One (b) did a loosely-organized coalition of interests (of prosperous merchants, bankers, and farmers) form with a weakly-organized group of less prosperous farmers and unskilled workers in dilatory opposition. Given the simple nature of the community and its then underdeveloped institutional functions, no clearly identifiable Community Power Complex was formed and the Institutionalized Power Structure was not extensively developed. No reliable data was available to deal adequately with the types of issues or their resolution at this stage.

Underlying social conditions at this point in time [(a) & (b)] in the local community (but also obtaining at the state and national levels to a great extent) consisted of: a steady population growth with an increase of in-migration taking place; a decentralized system of government and business; a self-contained and locally-oriented value system; a meager industrial development; and relative isolation due to poor transportation and communication facilities.

To sum up: during the period from 1836 to the 1870s a local stratification system had gradually crystallized with the economic dominants of this period situated at the top and with these same people forming a loosely-organized coalition of interests and power. There was, however, no discernible Community Power Complex as such. The Institutionalized Power Structure was not extensively developed either, due to the simple nature of the community and its functions.

It was in Stage Two (1880s-1930s) that the essentially predominant form of the modern Mills Springs power and influence system was determined; long-lasting, a series of reactions to it have triggered changes of considerable magnitude.

Stage Two (1880s-1930s): The Woolen Mills Dominant. In the 1880s a burst of sustained industrial activity took place which was to shape Mills Springs' economic and social destiny for over fifty years. In those years the Sampson Woolen Mills began and developed its operation as the one of several family enterprises which was to become the largest and most powerful concern in town -- its industrial and economic cornerstone, employing at its peak as many as 500 townsmen, a fourth of its population for years. With its rise in the textile industry nationally and its considerable economic growth and dominance locally, the Sampson Mills family and its key employees-representatives soon rose in local social and political importance, and later, at its height, in the state as well. For all intents and purposes, Mills Springs had become a one-industry town operated by the Sampsons and closely-allied interests.

For approximately the first three decades of this period, the Sampson family itself and its closest colleagues and allies formed an

Exclusive Elite power and influence structure. No public issues were allowed by them to develop. This economic elite monopolized the Institutionalized Power Structure which had become somewhat more developed during this period as the community, along with various of its functions, had become more complex.

In the latter part of the Sampson reign, while still retaining control and influence over the community's voters due to their overwhelming economic sanctions, the offices in the town government and other institutional sectors and the authority vested in them were in a real sense delegated to their trusted (though further removed from the core) allies of merchants, bankers, prosperous farmers, professionals, and semi-professionals. These "front" people were the nucleus of the slowly germinating Community Power Complex. Property assessments, taxation, local laws and regulations: all favored these combined vested interests. To insure the status quo, in-migration of "foreigners" was actively discouraged and the ban was successfully enforced for a long time by this "Old Guard" by direct economic and other pressures placed on the realtors who did not sell or rent to "outsiders." Restriction on change was the order of the day.

No matter how much these entrenched interests wished to maintain the status quo, however, conditions external and internal to the community were to force its power and influence pattern to alter. Toward the end of Stage Two, during the 1930s, the local woolens industry was facing increasing stresses and strains resulting mainly from outside inter-industrial competition (with the automotive and related industries mainly) and from radical developments in fabrics technology. Competition over a labor force with automobile, metals,

and fabricating industries in the area, which were all able to pay higher wages than Sampsons', increasingly forced Sampsons' concern to curtail its operations. It was faced with the problem of synthetic fibers and products which had displaced many of the goods and products it had previously supplied the automobile and other industries. These two closely-related technological and economic problems were major factors contributing to Sampsons' eventual and total collapse. Here, external and internal distinctions are really but two sides of the same coin.

Also contributing to the eventual industrial demise of the firm were two clearly internal factors. The company was either unwilling or unable to modernize its plant, latch on to technological innovations, and diversify its production. The third generation of the family had no interest in continuing, let alone expanding, business operations. The creative capital of the family, it appears, had been spent by the third generation.

The crowning blow to the local socio-economic power and prestige of the Sampsons and their allies, however, was the strike-unionization issue of 1937 which occurred as part of the general and turbulent state and national scene.

The Strike Issue:

The Sampson workers -- for a long time silently enduring but increasingly loudly restive about their low economic status, poor working conditions, and a proposed company union for key workers -- struck in 1937 in an abortive effort at complete and independent plant unionization to rectify conditions and seek redress for their grievances. Their action (completely unprecedented in Mills Springs'

history) was considered to be "rank disloyalty to the community and to the Sampsons" by the ruling interests because outside help and "foreign" leadership of the U.T.W.-C.I.O. labor organizations was offered and accepted by strikers.

During the long and bitter struggle that ensued, three ultra-conservative groups consisting of certain businessmen, farmers, professionals and semi-professionals were organized into a vigilante body by a prominent and reactionary lawyer against the striking workers, and by threats and intimidation plus boycott defeated them. This vigilante body was made up of a large part of the influential and powerful members of the community. The defeat of the workers effectively halted any further attempts to unionize the Sampson plant, failed to improve the lot of the workers, and set an enduring standard for dealing with labor in Mills Springs. To this day there are no locally-owned industries or businesses that are unionized; of the town's eight industries, only the two with outside ownership are unionized. Seasonal industries, such as foods pickling and two minor storm-door and sash plants, moreover, have moved into town to escape union difficulties they had had in other areas of the country.

Notwithstanding the seeming success of the Sampson and allied interests in defeating the workers by breaking the strike, this key issue was the first clear indication that external events beyond local control and increasing internal discontent, funneled into one stream, were to lead to eventual change in the balance of power in Mills Springs. It signalled the first serious "crack in the wall" for forces flooding in from the wider society. It was at this time that the most disenchanted of workers in significant numbers sought outside employment.

We have seen that in Stage Two Mills Springs had been transformed into a one-industry town essentially, although retaining its status as a rural trade center. It was basically still a self-contained and locally-oriented town, however. The woolens mills were dominant (Sampsons' being the kingpin); dairying superseded grains and fruit growing; and there was slight and intermittent development of specialized light fabricating. An Exclusive Elite type of power structure developed, closely correlated with the socio-economic makeup of the community. It was composed of the Sampson family and representatives exclusively reigning at the first, and then, through delegation, trusted allies in dairying and the other woolens industries, some merchants, farmers, and professionals were admitted to a share of power. Paternalistic and patriarchal power was the keynote early in this period. No Community Power Complex worthy of the name existed at this time. The stratification system faithfully mirrored this situation with the woolens family and closest allies in dairying and minor woolens production making up the bulk of the upper class. The middle stratum consisted of the smaller businessmen, merchants, bankers, professionals and semi-professionals and prosperous farmers. The lower stratum was made up of skilled labor, unskilled manual, and farm labor. In the latter part of Stage Two (1920s-1930s) a germinating but weak Community Power Complex composed of the businessmen, merchants, professionals and prosperous farmers was developing. For the first time, community issues saw the light of day. The strike-unionization issue is an example par excellence of the Community Hostility Model. The key protagonist for the status quo and Sampson economic interests was the aforementioned lawyer-activist. The workers were antagonists and

out-of-line as far as many of the community's upper and middle class strata were concerned. The issue was resolved equivocally in favor of the status quo interests with the organization and legal advice and action provided by the reactionary activist (of whom more later). It was he who instituted the company union, prosecuted a court injunction, and formed the vigilante committee. The general conditions of the community in this period contributed to the success of the status quo. For decades in Stage Two, Mills Springs had an enforced population stability -- in-migration being controlled -- and a stratification system and power structure which brooked no "disloyalty."

Stage Three (1940s): The Winds of Change Blow Harder. Stage Three saw the complete ascension of the "city group" to power, replacing the Sampsons completely. In the early 1940s the economic base of Mills Springs was undergoing a gradual diversification, but with the steadily declining Sampson Mills and two other viable, though smaller, woolen mills and an expanding dairy-farm enterprise in the aggregate remaining the largest local employers. Apart from these people, there were concerned, though conservative, businessmen, merchants, and professionals led by the reactionary activist-lawyer, who had by now become fully established as the community co-ordinator, trying to attract "suitable" enterprises from outside and to start new industries locally, without much success. The certain demise of Sampsons' was evident to these close allies by now.

World War II temporarily resuscitated the Sampson concern, but the long-term need for new and viable industry remained. Several locally-owned, metal stamping plants (only one of which remains in

business) were started during the war period with capital loaned or procured by the activist and through the efforts of the city group under his leadership.

The power situation in Mills Springs during this period was at first characterized by a definite slack left by the vacuum created by the Sampson decline and withdrawal from community affairs, but the slack was aggressively and rapidly being taken up by the activist-co-ordinator and his cohorts. The type of power structure developed was a Core Elite. The mundane projects and minor problems that arose during this period were effectively handled either informally and directly by the city group or by the institutional or organizational representatives in whose province they occurred, under the city group's general supervision. No issue of a major nature, requiring total community involvement, seems to have occurred in this period. The status quo and continuity were being maintained.

However, population increases, occasioned in part by the small rise in local birth rates and in greater part by the increasing in-migration of newcomers during the war, and shortly after, were beginning to place heavy strains on the traditional "pay-as-you-go" philosophy and prevalent day-to-day method of maintaining community services; and this cumulative pressure increasingly required long-range planning and the establishment of new projects and services demanded by increased numbers of people. Many of the newcomers, being more sophisticated urbanites, with different values and used to the amenities of life, after a bit were vocally applying pressure. One instance in the late 40s involved the construction of a long overdue sewage disposal plant which was finally but reluctantly built only as a result of considerable

state pressure, and then an ultimatum, although there was some internal community pressure as well. A full-blown community issue over this sorely-needed project was avoided by its semi-public handling by the city group in conjunction with the by then firmly-established Community Power Complex.

During the 40s considerable decision-making authority and power in Mills Springs became vested in the town's governmental group -- the city group as indicated. The Sampsons' influence remained, but they declined in status and power concomitant with their economic decline and eventual demise. (With the war's end, the firm went out of the business of producing woolen goods, retaining only a local retail outlet for a limited line of blankets and mackinaws produced by other companies elsewhere.) This city group had been informally-led and dominated by the lawyer-activist for some fifteen years. His many strategic offices held at one time or another (both in local and county government and in virtually every major institutional sector of the community), his extensive landed property, his major share holdings of bank stock and property mortgages, his wide and influential law practice, and his personal aggressiveness and shrewdness have all helped to consolidate his tremendous influence and power in the fifty years he has been active in community affairs.

The group's other members and supporters have consisted, primarily, of the ultra-conservative businessmen, professionals, and farmers who were sympathetic to the Sampsons formerly and who continue in sharing those basic values and philosophy. (These people are rapidly dying out in numbers.) They believe that <u>all</u> projects should be on a strictly pay-as-you-go basis and that none should be launched

until absolutely necessary. No "frills" for them. Bonding issues, until lately, have been anathema. The members of this old and powerful group are not alone in these sentiments, however, since there is still substantial support in the wider community for this ultra-conservative value orientation. Above all these people want low taxes.

Members of the city group have developed an intimate and informal organization within the formal framework of town government, which has come to include at its core: the activist, a former mayor, several past and present city commissioners, the city clerk, the tax assessor; and other lesser town officials, employees, and political "cronies" on the fringe.

The Community Power Complex:

This clique's new co-ordinator has largely taken over the leg-work activities once performed by the activist. (Veto power still largely resides with the latter, however.) The new co-ordinator now meets with members of the various community interest groups and cliques at informal coffe-klatsch meetings during the day where he sounds these people out as to their opinions and ideas on various town projects and issues. He tries to balance and integrate the socio-economic interests of these individuals, groups, or (as lately) factions in terms of city group policy. (All of these people are top or key influentials.) The groups are: (1) the industrial clique, (2) the bankers, (3) the realtors, (4) the merchants, (5) the "substantial," retired people, (6) the important or relatively prosperous farmers, (7) the professionals, mostly doctors and lawyers, and (8) certain "politicians." In the recent past, most important projects and issues (those requiring funding

and/or involving controversial values) were discussed informally among these people before they were ever brought up formally or informally at meetings of the three service clubs or as business in various formal organizations, but this situation of close monitoring or supervision by the city group has changed somewhat of late.

Although the city group has been dominant in Mills Springs' power and influence system in Stage Three and has continued to be viable even into Stage Four, there have been a number of serious challenges to its vaunted position. In a number of such recent power struggles, as well as in the more distant past, the activist has alienated certain influential businessmen, professionals, and farmers by his attacks on their personal motives, integrity, honesty, and morality. By threatening yet others with certain confidential and damaging information about them at his disposal, he has made additional enemies. As a result, these people have increasingly tended to band informally together in opposition to any project the activist has pushed or supported. He has aroused intense, personal animosity by his methods. The opposition is still in the minority, however, for the activist has a large fund of community respect and gratitude to draw upon. Still, in many ways he is out-of-step with the times and developments in his own community.

During the 1940s Mills Springs was in more rapid transition. It was on the way to becoming a dependent satellite town. It was no longer so self-contained and its local-orientation was begrudgingly weakening. During the war Mills Springs' industry contributed modestly to the war effort and Sampsons' was temporarily resuscitated. Post W. W. II, the war industry having evaporated, industrial activity gave

way to minor fabricating and seasonal industry. Dairying, in the form of one large ice cream firm, and a minor woolens production company remained as the mainstays of local industry. Family farming was on the way out. Business generally was beginning to feel the heavy competition of larger surrounding communities. A Core Elite type of power structure had supplanted the Exclusive Elite. It was composed of the lawyer-activist as leader of the city group hard core and a rapidly forming Community Power Complex of businessmen, farmers, professionals et al. -- all key or top influentials -- on the fringe.

The one serious issue which had come to the surface during this period involved the building of a sewage disposal plant. The form of the issue fitted the Public Welfare Model. It had both external (state pressure) and internal sources. State pressure in the form of an ultimatum from the department of health was necessary before action finally was taken. Most projects were minor and were privately handled by the city group and the C.P.C. or by the respective representatives of institutional segments or units, if it was their routine business. Population increases occasioned by wartime and post-war in-migration and a slight increase in the local birth rate led to new problems and demands and the beginning of a challenge of the traditional values by the newcomers.

The stratification system was in transition as the new people were being integrated reluctantly into the Mills Springs community system according to their previous socio-economic status. The upper class contained the families of the older, viable concerns, the Sampsons, some merchants and long-established professionals, and new industrialists. The middle class consisted of other professionals, semi-

professionals, prosperous farmers, and smaller scale merchants. The lower class consisted of the local skilled, semi-, and unskilled laborers, commuting industrial and auto-workers, clerical workers, and miscellaneous semi-skilled and unskilled workers.

The community was now really feeling the effects of more centralization of government and of business; better transportation and communication facilities and technological innovations, developments or improvements were breaking down the insularity which had been a dominant feature of the community and especially of its leadership.

Stage IV (1950s-present): What Now?

The present economic base of Mills Springs is best characterized as that of a dependent satellite community. In addition to the ordinary, tertiary, commercial and other services, the community now possesses a number of small and light industries -- such as two specialty woolen mills, a stamping plant, a cardboard factory, and an aluminum storm door and sash plant, and a food pickling plant (the latter two presenting only seasonal employment opportunities). The livelihood of most of its employed people is earned elsewhere. Family farming is definitely on the way out, it seems. The Smith Ice Cream Company operates eleven dairy farms.

The top of the stratification system today is showing increased signs of the encroachment of some aggressive newcomers in the professions and business-industry and the rise of some younger, locally-born businessmen, merchants, and professionals. Some of the "Old Guard" have relented and are willing to admit these people to the halls of power, primarily because they are related familially or associated in

business and they realize that age and death will soon enough take its toll and replacements are needed. Others, such as the city group and their followers, are not so prone to allow this.

In Stage Four a situation exists in which the C.P.C. -- having been steadily invaded by the younger managerial and professional newcomers and formerly subordinate natives mutually attracted to each other and formed into an informal "liberal" opposition -- is divided along basic economic interest lines as well as in terms of value orientations. But the situation is one in which previously historically-determined alliances are changing too, with some formerly consistently ultra-conservative family interests showing signs of liberalizing their views and attempting to take neutralist positions to cushion the negative effects of the community conflicts which have resulted from two recent issues.

The present power and influence system may be best characterized as in clear transition from a Core Elite to a Fluid Influentials type. The growing socio-economic strength of the newer industrialists-businessmen and the knowledge of the professionals has allowed them a louder voice in specific institutional areas or scopes for power such as the school and the hospital. Similarly, rural residents of both stripes -- liberal and conservative -- have found increasing opportunities to exercise influence and power within these scopes. In both cases of the school and the hospital issues, wider appeals for financial contributions and political support were made by both camps in more than just the immediate community of Mills Springs, and decisive votes involving consolidation and annexation and taxation for renovating and supporting the schools involved the wider community in this sense.

In the not too distant past, many of these by-and-large younger people -- including newcomers and disgruntled natives -- have been apathetic to local political affairs because they have not been allowed to, or have been unable to, exercise their influence or power. But because both of these groups have young children in the schools, while the "Old Guard" have not, they or their representatives have been elected (sometimes by default) to the school board and have been strongly supported or have supported an independent school administrator, certain teachers, and the P.T.A. This faction is socially respectable and "belongs." In general, it is "liberal" in a still traditional Mills Springs, and it is for opening up the town to change on many fronts. It pushed strongly for consolidation and annexation of the school districts and for bonding issues on new school construction and renovation and other needed community projects. The development of this basic community division into "old" and "young," "progressive" and "conservative" was clearly revealed in the hospital and school issues.

Hospital Issue

The issue over building the new community hospital officially began in December, 1953 when the Kiwanis Club was informed by a prominent local physician (a newcomer) that the State Fire Marshal had condemned the old Morton Hospital owned by a group of doctors practicing together. Extensive repairs and renovations and an immediate series of fire prevention steps were necessary if the hospital was to be allowed by the state to remain in operation. The total expense was more than the Morton organization could afford. This doctor, a coming

key influential, personally felt that it would be an unwarranted expense to put so much money into an inadequate structure 83 years old, even though he was a member of the medical group practice.

Presented with this problem, the Kiwanis Club appointed a committee to study it and, on the "suggestion" of the ubiquitous activist, this committee was empowered to study the possibilities of building a new community hospital (his long cherished dream and enduring memorial to the community). Some members present, however, were tacitly for renovation, and these initial alignments had latent consequences for the resolution of this issue and the concurrent school issue, which lagged behind in resolution even though its inception was prior.

That evening the Lions Club was also informed of the Fire Marshal's edict, and it, too, appointed a fact-finding committee. These two committees subsequently met to form one committee. At this combined meeting the activist again suggested constructing a new hospital which should be divorced from the private control of the doctors' group. No explicit opposition to this suggestion was voiced. Presenting a series of other cognent and practical reasons for his suggested course of action, the activist offered to contribute a large parcel of land for the new site "to get the ball rolling."

The joint committee, consisting of a few key and more top influentials, tentatively agreed upon constructing a new hospital, pending further investigation. Subsequently, a non-profit corporation was formed with provisional officers elected to serve until the necessary articles of incorporation were to be approved by the state. With aid from the other service groups, this "board" made a survey and tentatively estimated expenses for the new hospital facilities.

In March the temporary board announced, however, that it was having difficulty in determining what ought to be done and in arousing sufficient community interest. The board doubted that enough money could be solicited after a disappointing show of community support was revealed in widely distributed questionnaires seeking pledges.

The temporary board announced that it had decided to offer the alternative of an annex to the Morton Hospital, after finding "apparent apathy" toward a new structure. They asked to be relieved of further responsibility for the drive.

The composition of this board was very enlightening in the face of further developments, however, because it consisted of a majority of members tacitly committed to renovating the old hospital, who "just happened" to be very close friends of the older doctors.

These board members had, in fact, previously, and "secretly" met at a board member's private offices and had decided there to abandon the new hospital project. The activist was incensed when he subsequently found out, especially since he was a board member and, with others of his persuasion, had not been invited -- for obvious reasons.

At this point, only part of the Community Power Complex and community-at-large were actively involved in the issue. Nevertheless, a division into two unstable factions for and against the new hospital had been clearly developing. The older doctors and their allies were for renovation; the activist, a young doctor, a small woolens mill representative, the new co-ordinator and certain businessmen (the realtors especially) were for constructing the hsopital. The wider community and rural environs were uncommitted as yet.

As a counter-move to renovation, the activist, the co-ordinator, and the woolens representative met informally together, at which time the activist informed the others that he personally would donate $25,000 if 25 other community members would match his offer with pledges of $1,000 each. This offer, in addition to the plot of land, had "sweetened the pot." The challenge was accepted and within days this offer had been matched and surpassed by 12 pledges.

A new board was subsequently elected by the members of a newly-formed hospital association with a neutralist, local, automobile dealer and key influential as chairman. At the next meeting, the pledges were made public. Strong support for the new hospital had crystallized as a result of this re-organization.

Without further detailing the involved series of events leading to the overall power alignments in the hospital issue, here they are as they existed at the point hospital construction got underway: the Morton group of doctors remained split as to what should be done, with the older doctors still very much for renovation of the existing plant; the younger partner was for a new building. Evidently the older doctors feared losing their personal control, as well as their economic and medical monopoly by such a step, since a capable young osteopath was already making heavy inroads into their medical practice. Later, an unpleasant incident involving the refused admittance of one of the osteopath's critically-ill patients to the newly-built hospital almost resulted in stagnation of the hospital drive.

The dairy interests and Sampsons were initially for renovation, but shifted sides in the face of increasing community sentiment for a new hospital facility and its demonstrated economic feasibility.

Conservative recalcitrants eventually acceded to community pressure when their support decreased in strength.

The wider community's primary interest seemed to be in terms of health and medical care values in this issue, to which values the dairy interests, although very close friends of the older doctors, were more ready to accede because of their long-time interest in this area, and because their long-time, private, financial support of the old hospital was viewed by them more as a community service than as a personal favor.

The initially uncommited bulk of citizenry was gradually rallied to support the new hospital through appeals for community solidarity, neighborliness, and the very real need for adequate health care facilities. A small segment of the community -- mainly patients of the osteopath -- at first for the hospital, withdrew their pledged support following the incident mentioned above. Two top influentials withdrew their support, but voiced only muted disapproval or disappointment.

On the whole, this issue was without prolonged rancor. The "fighting" that took place was more or less effectively screened from public view and the sub rosa tilt between the doctors and osteopath was resolved by the latter's eventual withdrawal of his practice from Mills Springs. The doctors continued their medical monopoly, but the hospital was now under the direction of a board of trustees elected from among the prominent citizenry. In the hospital issue it is clear that the old doctors were still hewing to the traditional concept of charitable donation by prominent families to supplement financial support of their medical domain. The young partner was not. The new industrialists, among others, prompted by the old doctors' lawyer,

supported the elders. The city group and its supporters, however, were able to mobilize a larger part of the uncommitted citizenry behind their position which was expressed in terms of the wider community's welfare. The resolution of this issue resembles that of the Form-Miller Model of Public Welfare. In this case some of the "conservatives," paradoxically, were the "liberals," while some "liberals" deserted their usual stand because of basically selfish interests.

School Issue

The school issue in Mills Springs was the most recent and spectacular of the three studied due to the extent and concentration of community conflict. It was "won," temporarily, by the liberal school faction when annexation of several rural districts with that of Mills Springs took place.

This issue also had both internal and external sources for dispute. The crowded and inadequate physical conditions of schools in Mills Springs were but two facets of a common and cumulative problem due to population increase. Complicating this internal situation was the increasing external demand of outlying districts (also plagued by population increases) on Mills Springs to expand its tuition-paid high school services. The problem was further aggravated by an immediate need for a new elementary building.

But the situation was really made critical by the state's policy compelling consolidation or annexation of these rural school districts in the county to three for purposes of efficiency and effectiveness of operation. Just as in the hospital and several other issues that have come up, an external state governmental pressure

was necessary to bring community action to bear on a serious internal situation. External pressure in this case germinated internal seeds of conflict sown both before and during the hospital issue. The cleavage between the two factions in town led to the formation of alliances with different rural segments as the issue unfolded.

The activist and the school superintendent, a top influential, had been at loggerheads for some time over a personal altercation they had had long before the problem of consolidation or annexation ever came up, which was to feed the school issue and draw adherents to one faction or the other on a personal basis as well as on other bases of response.

The matter of annexation or consolidation touched upon many criteria important in the development of a controversy. It touched upon the education of the community's children and those of nearby districts, taxes, and the fears on the part of various citizens in the reluctant districts over losing home rule if they consolidated or were annexed. Each faction attempted to win over the uncommitted members of the community to their values and solution of the problem.

The division along economic lines was as follows. The conservatives -- the "solid" old residents, the pensioned and retired, the childless, and certain farmers -- were against consolidation or annexation because either would have meant an increase in their tax assessments via a proposed five-mill tax levy. These people felt they received no direct benefit from school improvements and were banded together by the ubiquitous activist on this basis. The school faction liberals -- the younger, relatively property-less people, the parents of school children, and certain liberal rural residents -- were for

consolidation or annexation. They were willing to pay the tax increase because they benefited directly or indirectly.

In the area of cultural values, we find that the rural sentiment for the "little old red schoolhouse" was strong. Coupled with this was the old-fashioned philosophy of education stressing firm discipline and the three "Rs" which was espoused by the activist and shared by many of the older people. His injection into the issue of intimations of communism and socialism at work in the local school found adherents among members of certain local and rural education groups, such as the county Association for Rural Education. However, it found just as many opponents who claimed that the charges were ridivulous and calculated to be inflammatory.

The school faction stressed the values to the community of up-to-date and adequate educational facilities, better teachers and curricula, the children's welfare, the need for continued and reciprocal neighborliness with rural residents, and community growth and progress through modernization. With most local and rural people, these values were to win out in the end as far as annexation was concerned.

The power complex's interest groups were basically divided on the school issue with the city group at first adamantly against both consolidation and annexation. The activist exerted considerable pressure on his hard-core colleagues to gain support for his position. The city clerk was against the proposed five-mill tax levy because collecting taxes would neither be pleasant nor easy. As the issue progressed, enmities intensified and the group's peripheral members tended to take more neutral stands, and some tacitly supported the school faction. The activist's closest allies were finally forced to convice him to

curb some of his excesses when they realized that he was alienating a considerable number of the community's uncommitted citizens by his tactics.

The significance of changes in power scopes is clearest in the school issue. It was here that a considerable slack in power had developed. In the past, school board members had been regularly elected from among the representatives or supporters of the dominant families, and, later, the city group. But with the "careless" appointment of a new school superintendent shortly after the war, the composition of the board changed as newcomers and formerly powerless natives were tapped and filled these positions. The superintendent was mainly responsible for this state of affairs, and he organized a new school order. He made himself available to the power complex and community-at-large by joining the two major service clubs and by serving on various committees of community projects. He also brought in county and state education officials to help re-educate the members of these groups and to expose the wider community to new values in education through talks and newspaper articles. The superintendent was aided in accumulating influence and a modicum of power by the efficient manner in which he attacked the very real problems that had piled up in the school by the old practice of letting well-enough alone. He was early viewed by the activist as a threat not only to his personal prestige and power, but also to his cherished, ultra-conservative values. The personal altercation and vituperative behavior during this issue, therefore, may be better explained by placing it in the wider socio-economic context in which it occurred rather than dealing only with the psychological surface.

The "conditioning" factors (our forces) of increasing population pressure, the mounting developments and expansion in technology, and the spread of communication and transportation networks are most clearly recognized to be most important to the development of local problems and at the very root of the present and developing Mills Springs issues by the liberal school faction.

These people recognize that other community problems will develop as these factors or forces bear more and more directly on Mills Springs. Suburbanization and its tendency to make communities economically and socially dependent on larger cities is of particular concern to these people. They realize that, if they are ever to escape the fate of a "bedroom" community, they must build a relatively self-sufficient community again, but it must be modern. They must attract new industry and business. And if they attempt to do so, the type of industry they bring in (if it is to fulfill these expectations) will be primarily attracted by the community's resources and advantages. They must offer not only an appearance of community progressiveness but the substance as well.

A bonding issue must be voted if the schools are to be brought and kept up to date. Water resources, sewage disposal facilities and utilities services must be modernized and expanded. These improvements will mean increased taxes, but they are unavoidable. They must reckon the cost of not doing these things. Charter revisions, city re-zoning, new building codes, increased and adequate housing, hospital expansion to take care of the already overcrowded conditions, better recreational facilities, and other changes are necessary.

Some think a city manager plan should be adopted so as to enable a comprehensive program of action to be drafted. In the past, too many issues or projects were handled on a hand-to-mouth basis. Progressive planning is needed.

To accomplish these changes will require a realignment in power, but we think our data show this to be happening. Some members of the city group are also awakening to the realization that the community desperately needs these many changes. Already a new water tower has been built with the help of a large bond issue.

CHAPTER III

ORGANIZATIONAL THEORY AND RESEARCH

The contributions[1] of the sociologist Amitai Etzioni stand out as among the most impressive and satisfying of recent attempts at defining comprehensively the study of associations or organizations. In attempting a synthesis of the various results of previous and current theory and research in the area into a semblance of consistent, unitary, middle-range theory, he excels, as he does in clarifying the significant and thorny problems requiring further treatment. The works of Theodore Caplow[2] and Haas and Drabek[3] in this area join that of Etzioni in being considerably more advanced, sophisticated, comprehensive, and successful than that of other scholars. Taken together, these works introduce a necessary conceptual order and a theoretical comprehensiveness approaching or nearly meeting the criteria for a scientific strategy and tactics outlined above.[4] Although their approaches and some of their emphases differ from one another at certain points, nevertheless their combined work is remarkably complementary. Etzioni, Caplow and Haas and Drabek seem to have avoided the plague of partiality and the ideologically-tinged results produced by some sociologists and other scholars working in this area. Their work also allows for a particularly neat and comprehensive way of integrating community with organizational research.

Etzioni's Definitions of Organizations

Etzioni has defined organizations in various places as: "... social units devoted primarily to the attainment of specific goals;"[5] "...social units which are predominantly oriented to the attainment of specific goals;"[6] and as "...social units (or human groupings) deliberately constructed and reconstructed to seek specific goals."[7] Each of these definitions has stressed the striving of an organized set of groups of people to attain specific goals, or, in other words, have viewed the organization as a process, while the last definition allows for the possibility of a change of direction in this collective striving to attain specific goals. This emphasis on process in organizations is very important and complements nicely our stress on the community as process.

One of the key characteristics of organizations for Etzioni is that they are social groups deliberately planned (or enacted) to enhance the realization of specific goals. Etzioni focuses on the divisions of labor, of power, and of responsibilities for communication as prime characteristics of organizations.

His emphasis on power as the prime organizational factor renders his contributions particularly germane and valuable to this dissertation. He is keenly aware of the functions which one or more power centers perform in organizations. They control the concerted efforts of the organization and direct it toward its goal; they must continuously review organizational performance; and, where and when necessary, they must re-pattern organizational structure and functions to increase its effectiveness and efficiency. The substitution of personnel is another organizational function controlled or supervised by the various power

centers. Unsatisfactory persons must be removed and replaced and a recombination of personnel through transfer or promotion must be effected as the organization develops and as its needs change at various stages of its development. These organizational functions are among the key ones of concern to policy-makers and decision-makers in the community hospital (as in all organizations) and in the community.

Etzioni[8] cites certain synonyms which have been erroneously used (and, unfortunately, continue to be so used) for the term "organization." "Bureaucracy" is one such term. It has two clear disadvantages: (1) it has certain negative connotations for the layman; and (2) it implies that a social unit pursuing specific goals is invariably organized according to Weber's principles for bureaucracy, yet many modern as well as past organizations are not bureaucratic in the technical sense -- i.e., they do not have one center of decision-making or policy-making while bureaucracies do by definition. We shall return to this point below.

"Formal organization" is a term often used imprecisely and synonymously with organization. Such usage is to be avoided because the word "formal" describes but one set of characteristics of organizations and not the organization as an entity. (Following Caplow, it is better to use the term "formal elements" of organizations to signify this dimension or characteristic of complex organizations.)

Still another term, "institution," is used synonymously and erroneously, in a conflicting and confusing sense. Sometimes, it refers to certain types of organizations or even to an individual. On the other hand, the term "institution" is used to refer to a normative principle that culturally defines behavior such as marriage or

property. It is best to use the neutral term "organization" instead in a more restricted sense, and where indicated and when necessary, to use modifiers such as complex, large, small, etc., to refer to generic types of organizations.

Confusion in usage often results when the terms "social organization" and "social structure" are used interchangeably as when both are applied indiscriminately to the phenomena of general patterning and/or control structure. The latter term is more appropriately suited to express this meaning, reserving organization for the above sense, and dispensing with social organization altogether.

Caplow's Definitions of Organizations

Caplow also explicitly confronts the issue of conceptual usage in the study of organizations.[9] He complains, justifiably, that the language used by many scholars in this area is often imprecise and often fails to specify whether the groups under study are composed of people, behavior, or relationships, or combinations of these. Analytical categories are created by an observer to refer to verifiable events, whereas the classification itself remains unverifiable. In too many instances, it is not clear whether two observers, having used the same analytical categories, have actually used them in exactly the same manner. Although there is a wide choice of frames of reference available in sociology as a whole, fortunately the choice of observational categories is narrower in the area of organizations and becoming narrower still. Students with dissimilar assumptions are increasingly being forced to take into account certain phenomena or data which they had ignored so that a slow but steady convergence of viewpoints has been developing.

Caplow's approach to organizations contains certain basic assumptions which are certainly highly plausible, even if they cannot be agreed upon by all nor subjected to ultimate demonstration in all cases, as he claims. He asserts, firstly, that all human organizations belong to a single class of a natural kind, regardless of time, place, or cultural setting. He assumes, secondly, that organizations have certain features which do not occur at all in other collectivities. Thirdly, organizational events are orderly and regular, he claims, with certain antecedents always leading to certain consequents, regardless, again, of time, place, cultural setting, or the personalities of the participants. (On only the most abstract or general level do we agree with these assumptions or the one following.) The fourth basic assumption is that organizations are subject to a double principle of limited possibilities: by which it is meant that there are only a few ways an organization can be structured to achieve a given purpose. Once provided with a structure, an organization can perform only a limited number of functions in a somewhat circumscribed way. There is a limitation of possibilities inherent, it seems, in the mutual dependence of organizational form and function.

Preliminary to a more detailed discussion of the nature of organizations, Caplow makes a number of general observations about organizational structure, making much of the factor of status. He is as aware as are others in this area that tables of organization, which represent status in part, should not be confused with the actual workings of organizations -- that they only tell how organizations are supposed to work. All organizations, for Caplow, are pyramidal at the top and status schisms or formal discontinuity between the upper and lower

segments of an organization always obtain. In simple organizations, however, there is a single status system with a single network of communication between line and staff members ("line" and "staff" referring, respectively, to the upper and lower organizational segments). In compound (or complex) organizations several status systems obtain and there is restricted communication among or between the status orders.

For Caplow an organization includes persons who are its members and who can be placed in categories called positions (the incumbents of which are expected to act and interact in explicitly prescribed ways peculiar to that category). Positions can be combined and divided in various meaningful ways. Two particular positions or more, therefore, may interact in a patterned fashion based on certain criteria.

Positions are named and identified according to three elements: (1) the activity or work done in an official capacity, (2) status or location in the rank order of relative influence prescribed, and (3) location or the geographical part of the organization's positional functions. An organization's status order of positions is claimed to be unequivocal, transitive, and inclusive: meaning that there are no statusless positions and there is a definite place for all positions in the rank order. The organization is basically an array of positions with various status implications, in this view. Sometimes, strategically-placed individuals are able to exert influence far out of proportion to the positions they occupy. Examples of such individuals are alter egos of superiors or very popular persons. (This occurs most often in unstable situations.) Equally ranked positions exist and they are the basis for the important peer groups and their activities.

Compound organizations tend to separate their status orders into their major components. Possible complications exist since conflicts over status are frequent and bitter in organizations. Often, there is some degree of inconsistency between the status orders of an organization and its segments -- especially in giant organizations. Then, too, the status order may change from one situation to another, although Caplow thinks the change is usually narrow.

Specialization and a division of labor are together taken to be the essence of organization. It is more elaborate in the larger organizations of the same type (organizational set) and more marked in organizations subject to strict discipline. Organizational activity requires resources of some kind, usually procured from without. The external activity of an organization not only consists of attempts by it to modify the environment but results in modification of the organization by the environment. An important part of the internal activity of an organization is to assure the maintenance of its own structure. Certain activities are essential to survival, but not all organizational functions are essential. An organization, in this sense, is an adaptive system and an economy.

From another perspective, an organization is a social interaction network consisting of complementary roles connected in symbolic terms. For Caplow, a role consists of behavior vis-a-vis other persons. Expectations and behavior are intertwined. Each position consists of an entire pattern of expectations about roles, activities, feelings, perceptions and beliefs, some of which are improvised, vague, ambiguous, and contradictory. Still, cores of expectations exist which command minimal consensus, are shared, and explicitly promulgated. Such a

promulgated expectation is an organizational norm. A norm or rule is a statement, supported by organizational sanctions, describing the behavior of incumbents of a given position in a given set of circumstances. Organizational expectations are shared beliefs about what behavior therein should be; rules are definite statements of what that behavior should be. Norm enforcement, according to Caplow, is easy and painless for the most part because rules are such an important part of organizations. Behaviorally, attitudinally, and doctrinally, norms and their obedience are built into organizations.

Defining a group as three or more people with common identifying characteristics each interacting with some or all of the others, Caplow stresses the fact that it is the repetition of this interaction among members which results in relationships with some degree of permanence and which lends continuity to the group that makes it organized. The components of organizations consist of primary and secondary groups, with peer groups as a special category of the former which are unofficially organized, whereas other primary and secondary groups are either organized or not. The peer group is factional in that it is formed for the protection of its members from certain rules and requirements of the larger organization. It offers its members emotional satisfaction, horizontal communication, performance standards, and allows for engineering the organization from below.

A given organization at a given point in time, then, consists of a set of persons (the group aspect) and a set of positions (the institutional aspect) at base. Some types of organizations may lose their distinctive identity when all or most of their original members are replaced. Such organizations are coterminous with their membership

rosters. Most organizations suffer no or little loss of identity as long as there is no serious break in membership continuity. Recurrent organizations do not depend upon a particular set of members to maintain their identities.

An organization is related to other organizations in several possible ways: as a component of another organization, as a faction of another organization, as congruent with another organization, and as linked with another organization. The second instance covers those cases in which all the members are members of organization A, but their activity is not a part of it. The third instance refers to cases in which all the members of one organization are identical with those of another, but the organizations have separate purposes and identities.

Caplow claims that there are no such things as informal or formal organizations; rather, organizations have formal (explicitly prescribed) elements and informal (not explicity prescribed) elements. There are official organizations which are legitimate and recognized by a "parent organization" and which derive their ultimate authority by state licenses, charters, and registers. Their collectively-owned property cannot be securely held without the sanction of the state which has the legitimate right to means of force and violence. Unofficial organizations are illegitimate, in the sense that they are unrecognized by the state in the above manner, but are sponsored only by its members.

In contrast to the organization, a community is composed of groups residing within a bounded territory. It has a name or a collective identity, but that identity need not imply collective action. A community has an inexact roster of members. Although it characteristically displays regularity and calendarity in its activities, there

is no set program to community activity. The replacement of its members through birth and migration is unlike that of an organization's. Some communities, but not all, are congruent with organizations. Communities generate organizations and may be generated by organizations.

The size of organizations is a very important factor as it affects all phases of their activity. Change in size may be more important at certain points than at other points in time or place. Caplow admits that the classification of organizations by size is arbitrary, but he insists that size as related to interaction possibilities is not. This criterion reflects the restrictions imposed by the sheer number of participants upon interaction possibilities. His classification of organizations according to size is as follows: (1) small -- 3-30 members, (2) medium -- 30-1,000, (3) large -- 1,000-50,000 and (4) giant -- 50,000-?

The small organization can easily provide sustained emotional support and power can be exercised in it without delegation. The medium size organization is too large to permit the development of all possible pair relationships, yet it is small enough for one or more members (or leaders) to interact with all of the others. Such an organization is usually controlled by an inner circle which is large enough to need rationalized procedures and formal specifications but small enough to be easily controlled or modified by an influential individual.

The large organization must have an administrative apparatus, but it need not develop mass inertia. Such an organization is too large for any one member to know each of the others, yet not too large for one or more leaders to be recognized by all the others.

The giant organization has too many members, too widely dispersed, to permit direct interaction of any individual with all of the others. Nevertheless, the key members are recognized by most of the others through internal mass communication. A giant organization is usually pyramidal and very formal, and it is impossible to know its entire structure in detail. The combined forces of population growth, urbanization, and the refinement of communication and record keeping have resulted in the increase in absolute size of giant or mass organizations. There is a tendency across the board for various types of giant organizations to move toward a standard form in personnel systems and budgets, similar rules of accounting, similar provisions for transportation, retirement, sick leave, record keeping, research, and policy-making, Caplow asserts.

Caplow defines an organization as "a social system that has an unequivocal collective identity, an exact roster of members, a program of activity, and procedures for replacing members."[10] These are the minimal elements. A social system consists of a set of persons with at least one identifying characteristic and set of relationships established among these persons by interaction. The unequivocal collective identity resides in the organizational name recognized by all its members and by many outsiders. The name conveys much information about the purposes, location, and affiliations of the organization and it enables collective action to be taken without confusion. The exact roster enables an organization to clearly identify its members. An organization's program of activity may be extensive or very brief; its more crucial aspects are that its activities are arranged in advance according to some calendar to achieve at least some definite, specified goal(s).

Procedures for replacing members of organizations include recruitment of new members and/or the transfer of old members from one position to another. Social "systems" such as races, ethnic groups, social classes, cliques, interest groups, and play groups are not organizations because they basically lack the capacity of the organization for unified, purposive activity or they may lack one or another of the characteristics listed above. Above all, organizations are complex. Caplow, admittedly, has attempted to systematize some of what is known about organizations in general even at the cost of ignoring much of what is known about particular organizations. This contribution is valuable in and of itself, but Etzioni is able to better deal with the general and the particular. Haas and Drabek have lately also sharpened up conceptual tools which are valuable to our purposes.

Definitions of Organizations by Others

Before going on to a discussion of certain problems confronted in studying organizations, let us review the various definitions of organizations offered by some other scholars to indicate what is common to them all and to illustrate the differing conceptual usages. March and Simon[11] have defined the organization as a "system of interrelated social behaviors of a number of persons." In another place, Simon[12] more precisely defined organizations as "systems of interdependent activity, encompassing at least several primary groups and usually characterized, at the level of consciousness of the participants, by a high degree of rational direction of behavior toward ends that are objects of common acknowledgment and expectation."

Selznick[13] views organizations as co-operative systems and as adaptive social structures made up of interacting individuals, sub-groups, and informal plus formal relationships, which is a definite improvement over the non-sociological, basically social-psychological definitions of March and Simon.

Barnard,[14] another non-sociologist with a psychological bias, but very influential in organizational studies, focused on organizations as systems consciously co-ordinating personal activities or forces. By the addition of the phrase "of two or more persons" to the above, he felt he had defined the formal organization.

Weber did not define organizations as such, yet his influence in this area of study has been considerable. He was primarily concerned with bureaucracy as a type of rational organization and with the authority structures of different types of organization such as legal,traditional, and charismatic authority.[15]

Parsons,[16] following Weber quite closely, sees the organization as a broad type of collectivity, a bureaucracy, with its primary orientation being the rational attainment of a specific goal.

Bakke[17] probably offers the most comprehensive of these definitions of the organization as "a continuing system of differentiated and co-ordinated activities utilizing, transforming, and welding together a specific set of human, material, capital, ideational, and natural resources into a unique problem-solving whole engaged in satisfying particular human needs in interaction with other systems of human activities and resources in its environment." While he focuses on the character of the organization in terms of the image of the organization's unique wholeness, he does not ignore the bond(s) of the organization

which integrate(s) it into a wider operating system (its environment). The basic resources which he mentions are derived from outside the organization as well as being generated within, and so the activity processes by which resources are acquired and manipulated loom large in this perspective. This evolutionary approach is most compatible with that of ours.

Organizational Goals

In most definitions and studies of organizations there is sometimes implicit, but more often explicit, an underscoring of the clarity or specificity of goals sought by them. Etzioni[18] has most clearly and cogently addressed the problem of identifying organizational goals.

The goals of organizations serve various functions: (1) they provide orientations by depicting a future state of affairs for the organization to strive toward; (2) they set down guidelines for organizational activity; (3) they are a source of legitimacy, to justify the very existence of an organization's activities; (4) they are standards by which members of organizations and outsiders can assess the effectiveness and efficiency of the organization -- its success; and (5) they are measuring sticks for the student of an organization in trying to determine how well it is doing.

Once formed, organizations may acquire certain needs which sometimes become their masters. Organizations may reduce their service to their initial goals to satisfy their acquired needs rather than adjust their service of acquired needs to their original goals. They may abandon their initial goals and pursue the new goals so that the original goals become side-tracked in the organization.

A goal is generally a desired state of affairs which an organization tries to attain, and this may or may not be realized. If a goal is reached, it ceases to be a guiding image for the organization and it is assimilated to the organization or its environment. A goal is a state sought, not one possessed.

A serious problem in studying organizational goals is phrased in the question, "Whose image of the goal does the organization pursue?" Is it that of the top executives, of the board of trustees, of the majority of its members? Etzioni claims that none of these groups of the organization alone does set the goal; rather each has a part and the collectivity tries to bring it about. A goal is determined both in peaceful consultation and as a result of the power play among various organizational divisions, ranks, and "personalities."

The observer or researcher arrives at a determination of the goal pursued by the organization he studies through using its participants as informants and through depth-interviewing executives and employees of the various departments to determine what they see as the organization's goals. He must distinguish between personal goals and goals of the collectivity, as well as actual organizational goals from the ideal or "ought" goals.

A study of the minutes of board and departmental meetings and the examination of other documents of the organization are invaluable in this regard. By the use of these sources and through participant observation, the division of labor, the flow of work and other activity, the allocation of resources in budget to determine the actual orientation of the organization to a future state of affairs may be revealed and analyzed.

Especially revealing are the situations in which the distribution of manpower and other resources clearly suggests a direction of effort different from that ideal picture expressed by the informants. There are two reasons why the administrator or head of an organization (or others) might say or maintain that his (or their) organization is pursuing certain goals which actually differ from the ones it in fact seeks. He (or they) may be unaware of the discrepancy; the true situation may be hidden from the administrator or head (or others). He may, on the other hand, consciously express goals that differ because expressing them will serve the goals the organization actually pursues.

The "real" goals are determined by the researcher mainly through a careful examination of the allocation of resources and the direction of organizational efforts. It is here that policy-making decisions are crucial; and the way(s) and by whom they are made are most revealing. The future states toward which a majority of the organization's means and the majority of the organizational commitments of its participants are directed, and which, in cases of conflict with goals stated but which command few resources, have clear priority are so indicated. Intimate contact with the key participants sometimes allows the researcher to determine how aware the informants are of any discrepancy between real and stated goals. There should be no confusion, however, on the researcher's part between real and stated goals with the important difference between intended and unintended consequences. Goals are always intended. There may be a difference between stated and real intentions, but unintended consequences are strictly unplanned -- the unexpected results of action oriented toward some goal.

All organizations have a formal, explicitly recognized, sometimes legally specified organ for setting initial goals and their amendment. This is usually the board of trustees, governors, or the like. In practice, however, goals are often set in a complicated power play involving various individuals and groups within and without the organization, and by reference to values which govern behavior in general and the specific behavior of the relevant individuals and groups in a particular community (or society). Many are the factors that enter into the struggle to determine an organization's initial, and shifts in, goal or goals: the departments or divisions of the organization, personalities, environmental forces, and the surrounding community.

Goal Displacement and Multi-Purpose Goals

In some types of organizations substitutions for the legitimate goals by some other goals for which they were not created occur. Resources are allocated for other than the original goals. A reversal in priorities between goals and means is the mildest and most common form of displacement. Interest groups may use the original organizational goals as a means to recruit funds, obtain tax exemptions or status in the surrounding community -- as a means to their own personal goals. It is important to find out to what extent this occurs and by which interest groups this is done in hospitals. Goal succession, multiplication, and expansion, although they are phenomena probably not so important in community hospitals as in other kinds of organizations, are probably more important there than goal displacement.

Many organizations are multi-purpose in that they may serve simultaneously and legitimately two or more goals. Some of these

organizations add additional goals to the original ones. Many organizations are founded with more than one goal. The large community hospital may have treatment, training, and research as its original goals. Many such organizations tend to serve each of the goals separately and all of them more effectively and efficiently than single-purpose organizations of the same category, Etzioni[19] claims. His hunch is that this is mainly due to extrinsic factors. Single-purpose community hospitals are found in the smaller towns, while multi-purpose hospitals are found in the larger urban centers where a larger pool of qualified professionals for recruitment exists.

There are several internal reasons why multi-purpose organizations tend to be more effective than single-purpose ones. Serving one goal -- e.g., research -- often improves the service, within limits, rendered to another goal -- e.g., medical care or treatment. Secondly, multi-purpose organizations generally have greater recruitment appeal, in part because high quality often is associated with multi-services. Some professional individuals find combining two services more attractive in that it allows them to gratify a wider variety of personal needs and it leaves more room for seasonal and life-cycle adjustment.

However, there are limits to the ability of an organization to serve multi-purpose goals. It seems that a loss of effectiveness occurs when all organizations of a specific set or category are made multi-purpose. Effectiveness appears to be maximized when a mix of single-purpose and multi-purpose organizations in a profession allow both types of personalities the opportunity to satisfy their capacities and needs.

Conflict within multi-purpose organization seems to Etzioni unavoidable if not inevitable. A variety of goals often makes incompatible demands on the organization in terms of conflicts over amount of means, time, and energy to be allocated each goal. A set of priorities to clearly define the relative importance of the various goals is helpful but it does not eliminate the problem. The plurality of goals may create personal strains for the personnel of the organization. There is the danger that one goal may subordinate the other and primary one, and that the latter is ineffectively served.

Goal-Model vs. System-Model Methods

Etzioni[20] points out that the common error of the outsider, whether he be a researcher or evaluator, is to measure an organization against its goal(s), asking "How close did it come to achieving its assignment?" There are two potential pitfalls to such an approach: (1) it tends to give organizational studies a tone of social criticism rather than of scientific analysis; and (2) most organizations do not attain their goals in any final sense. (This has become a false detour in organizational research.)

Low effectiveness is a general characteristic of organizations, Etzioni claims. Goals, as symbolic units, are ideals or values. The above approach is labeled as the goal-model by Etzioni. It is valid only from the particular viewpoint chosen by the researcher and its success is limited to the analysis of the complete or at least substantial realization of the organizational goal. Comparative analysis of organizations suggests the better use of the alternative system-model approach which makes a statement about which relationships must exist for an organization to operate.

The goal-model requires that the researcher determine the goal an organization is pursuing and no more. Such an analysis expects organizational effectiveness to increase with the assignment of more means to the organization's goals, but this is a wrong expectation. The system-model leads one to conclude that just as there may be too little allocation of resources to meet organizational goals, so may there be over-allocation of these resources. The use of the systems-model allows explicit recognition of the fact that an organization solves certain problems other than those directly involved in the achievement of its goal(s). The excessive concern with the latter may result in insufficient attention to other necessary organizational activities and to a lack of co-ordination between inflated goal activities and the de-emphasis of non-goal activities.

Drawbacks of the system-model are: (1) that it is a more exacting and expensive approach when used for research; (2) that real goals are harder to establish using it -- unlike the goal-model wherein stated goals are chosen and comparative ease in research is assured; (3) that it is necessary to gain the confidence of the "elite" and analyze much of the organizational structure; and (4) that this demanding approach requires more effort of the analyst in determining what he considers a highly effective allocation of means to be, which task often requires considerable knowledge of the way an organization of the type studied functions -- a time-consuming enterprise. The benefits resulting from the use of the system-model, however, far outweigh the drawbacks in that information collected in the process of developing a system-model of the particular organization will be of much theoretical value for the study of most organizational problems. Theoretical

considerations may often serve as bases for constructing a system-model of the organization. (There is built into this approach the cumulative aspect basic to scientific progress as outlined above.)

A well-developed theory of organizations will include statements on the functional requirements various organizational types must meet. Organizations require different things to operate successfully. The researcher's awareness of these needs will guide him in constructing a system-model for the study of a specific organization. Because of great economic pressures, it may be necessary at the outset for the researcher to use the theoretical system model of a particular organizational type as a standard and guide for the analysis of a specific organization for which such a model is as yet unavailable. Organizational theory at present is generally constructed on a fairly high level of abstraction, even though the middle-range types of studies predominate in the field. Extant theory deals mainly with general propositions which apply equally well, but also equally badly, to all organizations. The differences among various organizational types are considerable. Any general theory of organizations must be highly abstract and as such is an important frame for specification -- for the development of special theoretical models for various organizational types. Such a general theory cannot, however, substitute for such special theories by serving in itself as a system-model, i.e., to be applied directly to the analysis of actual organizations.

As Etzioni, Caplow is aware that the relationship between an organization's program and its goals may not be simple and that conflicting evaluations of success are bound to occur. Goals may be illusory, inconsistent, or impossible and the activites to realize them

may be inappropriate. Most important organizations have long lives and acquire a large assortment of goals in their careers, not all of which are compatible and not all of which are fully accepted by all of its members. Rational action is often diluted by sentiments. The yardsticks to measure an organization's achievement, success or effectiveness are often multiple and can be quite complex. In combination they are even more complex. Quantity of output or quality of output are very difficult to measure in some if not all types of organizations. Caplow sees the various yardsticks as measures of achievement, but not of stability, integration, and voluntarism. The latter are independent variables, the former a dependent one. As such they require independent study.

Conflicting evaluations develop between: (1) insiders and outsiders, (2) higher and lower status levels in an organization, and (3) the organization and its components. In general, insiders evaluate achievement more highly than outsiders; higher status levels evaluate achievement more favorably than lower status levels; and a member of a particular component of the organization evaluates its achievement more highly than non-members of that component. Discrepancies are more likely to arise over the evaluation of achievement; they are less likely over its measurement.

It is the complacent elite of an organization which is most likely to over-estimate its relative success. There is no way in which consistency of evaluation among all organizational components can be assured. Discrepancy is inevitable since one of the goals of a component is to protect its members against the total organization and of the whole organization to protect its components against each

other and outside forces. Competition and co-operation are thus given together. One can distinguish, however, between the success of a component in meeting its separate goals and its effectiveness as a cog in the total organization, yet there is ample room for complete disagreement between the different levels of some organizations.

Drawing in part upon the work of Thompson,[21] Caplow discusses the paradox of authority versus democracy in organizations as related to organizational goals and changes. Thompson strongly criticizes and condemns the practice of the organizational elite of substituting specious integration for the sake of stability whenever friction or stress crops up as a managerial social psychology calculated to divert attention from the real need for institutional change. The adapting of the individual to the existing structure and the legitimation of the status quo deny the existence of conflict by redefining it as personal maladjustment. The techniques used to accomplish this adjustment of the recalcitrant individual are increased communication, primary group social controls, and leadership training -- in all a skillful manipulation of social conflict.

A basic cause for the increasing tension between authority and democracy observed in many organizations is due to the decline of status differences as abundance, mobility, mechanization, technical progress, universal education, the increased scale of population, the growth of the state, secularization and size of the organization (occasioned by population increase and new inventions) have transpired. Since the need for integration and voluntarism remains (each is a function of the other), certain fundamental devices for increasing them under the conditions indicated have developed and organizations

of all types are using them, it seems.

Raising the level of interaction between unequals via conferences, formal and informal consultation, group decision-making, periodic appraisals, and suggestion systems are some devices. Another is the reinforcement of primary groups and their controls by encouraging conversation, free choice of association, and group recreation. Other devices include: the establishment of communication channels between top management and the rank and file via house organs, grievance systems, internal public relations, meetings, etc.; close surveillance to enforce loyalty to organizational symbols and ideology; and the establishment of favorable environmental conditions and fringe benefits. These have been widely accepted as legitimate managerial devices.

The alternation of organizational goals in the long run is the effect of technological advance necessitating change in institutional patterns, as Caplow[22] sees it. Inconsistent goals are attributed to uncertainties in the external environment. Internally, the need for goal changes are seen to be the result of certain limitations of the human mind: rationality leads to simplification and to the isolation of the seemingly significant features of a problem without attempting to understand it fully.

March and Simon[23] characterize this simplification and subsequent need for alternative goals as the result of the tendency for organizations to seek "satisficing" rather than optimal solutions to their problems. Alternation of action and its consequences are discovered largely still through trial and error sequences. Repertories of action programs are developed to serve as alternatives of choice

In re

Each

ques

prop

comp

acti

goal

erro

deve

appl

stre

dema

self

Wher

back

the

iss

To a

Ask

Chos

Star

as

Stop

Ar

in recurrent situations, but not all situations are covered by these. Each specific action program deals with a restricted range of consequences. An organization may be capable of executing each action program in semi-independence of the others -- they often being loosely-coupled.

March and Simon[24] state that the function of a repertory of action programs is to maintain a basic identity of organizational goals even as they are modified day-to-day in response to the external environment or to an internal calendar. It may include procedures for developing programs and procedures for deciding which programs to apply at a given time. Yet a repertory of programs is unstable. They stress the necessity for organizations to focus on procedures for developing and switching programs rather than to the programs themselves to ensure that instability does not get out of hand.

Weber and Etzioni on Bureaucracy and Organizations

Weber viewed organizations, from a central European cultural background, as bureaucracies which set norms and which need to enforce them to accomplish their aims. Rules and regulations and the orders issued must be obeyed if the organization is to function effectively. To a degree, an authoritarian organization can rely on its power to make its members obey. It can use some of its resources to reward those who do and penalize those who don't. Discipline does not require that a recipient of an order agree with it -- only that he accept it as morally justified. Such a person may follow a distasteful order to avoid a loss of money or prestige or to increase his income or status. An organization, to some extent, can maintain discipline by manipulating

various rewards and sanctions to ensure maximal content and minimal disappointment.

The major limitation of exercising power in such a manner as to realize unquestioning obedience is that it keeps the subject, as he conforms, alienated. The subject conforms because of ulterior motives and he conforms to matters explicitly backed by power. Such a person is unlikely to volunteer information, show initiative, or co-operate, except when forced to explicitly. In times of crisis, when the power structure of the organization may be weakened, he will tend to prefer whatever other norms he subscribes to, and not support the organization.

However, when the exercise of power is seen as legitimate by the subjects, compliance will be much deeper and more effective. A subject will "internalize" rules -- be socialized. Discipline in this instance will be less alienating and the subject will follow rules and orders in crises. Legitimation of power does not increase materially the interest of a subordinate in compliance, nor does it make an order or rule necessarily pleasant. Rather, it fulfills a third kind of need: to follow norms which match instead of conflict with one's values. Some legitimate orders are gratifying; many others are legitimate but not gratifying; still others are illegitimate but gratifying.

Weber[25] distinguished between power, or the ability to induce the acceptance of orders, and legitimation, or the acceptance of the exercise of power because it is in line with the values held by the subjects. Authority is a combination of the two, or power seen as legitimate. Weber developed a typology of authority based on the sources and kinds of legitimation used rather than types of power

applied. Compliance to traditional authority exists when a subordinate unquestioningly accepts his superior's orders as the justified way things are always done. Bureaucratic authority is rational-legal and in this circumstance a subordinate agrees with a set of more abstract rules considered legitimate from which the ruling is "derived." Compliance to charismatic authority is due to the influence of the superior's unusual personality with which subordinates identify.

Weber's classification of authority applies to at least three levels: (1) the societal, (2) to different kinds of related social units, and (3) to relations between individual subjects and their superiors within a given organization. Different authority relations tend to arise in different social structures. Traditional authority is characteristic of a diffuse status structure in which a superior in one realm is superior in others. Bureaucratic authority is found in structures with limited scopes of authority. Pure charismatic authority is found in structures where there is no differentiation between the organization and other social units and where there is little internal differentiation between leaders and followers.

To be effective and efficient as an organizational instrument for modern society, the modern organizational structure requires bureaucratic authority since charismatic relations lack any systematic division of labor, specialization, or stability. Traditional relations open organizations to non-relevant political, stratificational, and kinship considerations; and do not allow for the rationalization of production or the administrative process.

Weber was aware, however, of the fragility of the bureaucratic, rational structure of organizations. There are constant pressures

from outside to encourage the bureaucrat to follow norms other than of the organization. The subject's commitment to rules tends itself to decline. The typical organizational dilemma is that for it to be effective it requires a special kind of legitimation, rationality, and narrowness of scope, but that the ability to accept orders and rules as legitimate requires self-denial of its members, which is a hard state to maintain. Bureaucratic organizations tend, therefore, to break in a charismatic or traditional direction.

Briefly, the bureaucratic structural model presented by Weber ideally consists of a continuing organization of offical functions bound by rules. The rules save effort by obviating the need for a new solution for every problem and case; they facilitate the standardization and equality of treatment. A specific sphere of competence is another characteristic. In a systematic way, the sphere of obligations to perform certain functions are built into the division of labor and such a division provides the incumbent of a position with the necessary authority to carry out those functions. The necessary means of compulsion are thus clearly defined and their use subject to defined conditions. The organization of offices follows the principle of hierarchy so that no office is left uncontrolled and compliance is not left to chance but is systematically checked and reinforced as each lower office is under the control and supervision of a higher one. The rules which regulate the conduct of an office may be technical rules or norms. Specialized training is necessary in such cases, if the application of the rules or norms is to be fully rational. It is thus normally true that only a person who has demonstrated an adequate technical training is qualified to be a member of the administrative

staff. The root of authority of a bureaucrat is his knowledge and training -- the basis on which legitimation is granted. It is a matter of principle that members of the administrative staff should be completely separated from the ownership of the means of production or administration. There exists, furthermore, in principle, complete separation of the property belonging to the organization, which is controlled within the spheres of the office, and the personal property of the official. Such segregation keeps the official's bureaucratic status from being infringed by the demands of his non-organizational statuses. To enhance organizational freedom, the resources of an organization have to be free of any outside control and the positions cannot be monopolized by any incumbent. A complete absence of the appropriation of his official positions by an incumbent is required. Administrative acts, decisions, and rules are formulated and recorded in writing so as to keep a systematic interpretation of norms and an enforcement of the rules, which is impossible through oral communication. Officials should be compensated by salaries, not receive payments from clients to ensure the primary orientation to the organization, its norms, and representatives. To reward those loyal to the organization and to reinforce commitment, officials are promoted systematically and their amibitions are channeled through the provision of careers.

Weber saw the head of a bureaucratic organization as the one who sets the rules the bureaucrats follow. He is usually a non-bureaucrat. He decides which goals are to be served and the administrative body actually serves the goals. He is often elected or inherits his position, while bureaucrats are appointed. The head has an important function in helping to keep the emotional or non-rational commitment

of members directed toward serving the rational ends of the organization. It is the identification of the members with the person, leader, or head of the organization or sub-units of it which provides the psychological leverage that reinforces abstract commitment to the rules of the organization, by providing a more concrete and "warm" image with whom it is easier to identify.

Weber saw some bureaucracies emerging historically from charismatic movements in which the founder was also this kind of "spiritual father." The successors have little or no charisma of their own but maintain commitment of the lower ranks by acquiring charisma from the office they occupy. Secondary leaders never match the founder in native charisma because they gradually use up the stock and the structure loses this legitimation, the unit disintegrates, and a new charismatic leader arises through revolution and the cycle repeats. This succession crisis may be staved off for a time by the organization's routinization of charisma. Commitments to a position, not the incumbent, are easier to transfer. In such a way, a rational commitment of the lower ranks to the higher ranks and to the organization makes higher-ranking individual participants dispensable. Only the departure or death of the non-bureaucratic head of the organization involves a major organizational crisis. Sometimes this may happen when a charismatic department or division head is replaced.

Etzioni[26] has some critical observations to make on Weber's bureaucratic model. He claims that genuine charismatic leaders can emerge within already established "head" positions and re-endow the organization with legitimation and that their reign increases rather than depreciates the stock. Rejuvenation of an organization is possible

without disbanding it. The sharp distinctions made by Weber among the three modes of authority and social structure is exaggerated and many mixed types exist. An organization may shift from a more bureaucratic to a more charismatic structure, and back, for example. There is no inflexible order to the changes possible. The appearance of leaders with charismatic qualities is not limited to the top organizational position or the non-bureaucratic head.

As did Weber, Etzioni focuses on the strain existing between an organization's needs and those of its members, which is most evident in the area of organizational control. The strain is caused by the different pulls for effectiveness, efficiency, and satisfaction. To a degree, these two sets of needs may be compatible and little control may be necessary. But such meshing of needs is never complete; in fact, it usually is quite incomplete. The success of an organization is largely dependent on its ability to maintain control of its participants. Because of the artificial quality of organizations and their high concern with performance, the tendency is for them to be far more complex than "natural" units. Organizations can't rely on socialization alone to accomplish the internalization of obligations. The voluntary performance of assignments is unlikely without additional incentives. Organizations thus require a formally-structured distribution of rewards and sanctions to support compliance with its norms, regulations, and orders, and so organizations distribute rewards and sanctions according to performance.

The various means of control available to organizations are classified by Etzioni.[27] Coercive power relies on the application or threat of physical means to produce compliance. Utilitarian power

relies on material rewards of goods and services or money symbolic of same. Normative power (or normative-social power or social power) relies on pure symbols of, respectively, prestige and esteem, love and acceptance, or physical contacts and objects. Normative power is exercised by the higher ranks to control the lower ranks directly; normative-social power is so used indirectly. Social power is exercised by peers over one another. These uses of power have different consequences in terms of the nature of the discipline elicited and are similar in most cultures -- all other things being equal. The use of coercive power is more alienating than the use of utilitarian power (to the subjects), and utilitarian power is more alienating in turn than the use of normative power. Normative power generates more commitment than utilitarian power, and utilitarian power more than coercive power. The application: of symbolic means of control tends to convince people; of material means to build up self-orientation interest in conforming; of physical means to force compliance.

The powers organizations use differ largely according to the ranks of members controlled, with most organizations using less alienating means to control their higher rather than their lower ranks. It is essential to compare the participants of the same rank in different kinds of organizations or different ranks within the same organization. An attempt at such a comparison of controls applied to the lower ranks of different organizations was made by Etzioni.[28] The difference in the nature of controls indicates and predicts many other differences among organizations, even though most organizations most of the time use more than one kind of power.

High in the use of coercive power are such organizations as concentration and P.O.W. camps, prisons, traditional corrective institutions, and custodial mental hospitals. Utilitarian power is in high use in factories and other blue-collar organizations and in white-collar organizations such as banks, insurance companies, civil service, and peace-time military organizations. Normative power is in high use in hospitals, therapeutic mental hospitals, religious, political-ideological organizations, colleges and universities or schools, and in voluntary associations.

Not every organizational type has one predominant pattern of control. The response of the members to a particular use of power is determined by the members' social and cultural exposure and personalities, as well as by that use of power. Comparative analysis of organizations has shown that the kinds of control different organizations use results in different alienation or commitment patterns and that foremost among their differences in organizational structure are the place and role of leadership.

The power of an organization to control its members rests either in specific positions, such as an official or department head; in a person with persuasive qualities -- an informal leader; or in a combination of both -- a persuasive departmental head who is a formal leader. Personal power is always normative and based on a manipulation of symbols which serves to generate commitment to the person commanding it. Positional power may be normative, coercive, or utilitarian or a combination thereof.

A person who is a leader in one field is not necessarily a leader in another. It must be specified in which field he leads or

what the various kinds of activities he performs: be they instrumental activities, in which the input of means into and the distribution of same within the organization are his function, or expressive activities, in which he affects interpersonal relations within the organization and adherence to norms by the organizational members. Each of the two sets of activities tends to develop its own control positions. In most organizations they are segregated so that different individuals tend to occupy them, basically because they require incompatible role orientations and psychological characteristics.

Control in normative organizations depends much more on personal qualities than in other organizations. Through various selection and socialization processes, such organizations try to staff their positions of control with individuals who command personal influence or a combination of positional, normative and personal power. They are formal leaders, and the evolution of informal leaders in these settings is less likely. Formal leaders are successful in exercising both instrumental and expressive control, although some positions are more concerned with the control of expressive activity. It is impossible to completely separate these functions since instrumental matters affect expressive ones and vice versa in normative organizations. Hospital leadership is highly concentrated in the organizational positions. For example, a doctor has to convince the patient to follow his advice or directions (expressive activity). A layman has little basis for assessing the doctor's professional competence. The emphasis on personal qualities of leadership in this sense starts frequently with the selection and socialization of doctors as far back as medical school. (Interestingly, there is no linear correlation between the

quality of medical care [instrumental activity] and a physician's net income.) Normative organizations seem to be the only type requiring considerable formal leadership for their operation and they might do well with the main emphasis on formal control of expressive activities and with less emphasis on some of the instrumental ones.

Some of the implications of the above discussion for studying our hospital are: that we should examine, first, the nature of power typically employed to determine whether it is coercive, normative, or utilitarian and to what degree so. The typical orientation of each group of participants should be established. How alienated or committed are they? What is the place and role of leadership in the hospital? Is its locus in organizational positions (formal) or among lower participants with no organizational power (informal)? Is organizational leadership only institutional, only expressive, or both? In short, how closely does this hospital match up to the picture presented of a normative organization in terms of power and leadership?

Organizational control is correlated with other factors. Selection and socialization of personnel, as briefly mentioned above, are so correlated. Very broad differences in the amount of control needed in various organizations exist because of the differences in their recruitment and socialization of personnel. Small increases in the selectivity of an organization may often result in a disproportionately large decrease in investments for control. One reason for this is that a high percentage of deviant acts is committed by a small percentage of the members. Screening out the deviants results in a sharp drop in the need for control, therefore.

The degree of selection varies among the three types of organizations. Normative organizations vary primarily in the degree of selectivity (it being very high), since in general they have to be more selective as fulfillment of their goals depends heavily on qualified personnel with deep commitments to be at all effective. Differences in effectiveness and commitment, however, are only partial consequences of high selectivity. They are in part due to other factors associated with selectivity, but not results of it.

For example, highly selective organizations of a set are generally richer and have more facilities for achieving their goals, thus attracting more qualified personnel. Often, a set of social and professional norms are used to evaluate the effectiveness of a whole category or set of organizations to which, say, a hospital belongs. Selection is based on the qualities of the members as they enter the organization, but organizational socialization subsequently adapts these qualities for most satisfactory performance of organizational roles as defined therein. The more effective the prior and subsequent socialization, the less the need for control. Socialization in the organization is itself affected by the control means used. Normative organizations are most successful in terms of socialization achievements. Socialization and selection can partially substitute for each other. Medical schools "fulfill" many of the pre-medical educational requirements by selecting students who are relatives of professionals (doctors' relatives, especially). This practice ensures that there already exists a partial socialization to professional norms on the part of the candidate.

Organizations differ markedly in the pervasiveness of the norms they attempt to set and enforce. Hospitals are normative organizations which are relatively highly pervasive in the sense that they attempt to control most of the activities within their bounds but few of those carried on the outside. Prisons are examples of pervaded organizations, or low in pervasiveness, since many of the norms affecting inmate behavior are set and enforced by outside social units. Generally, the more pervasive an organization, the greater are its efforts required to maintain effective control, so that churches are among the most pervasive of organizations.

Organizational scope is substantially related to pervasiveness, but analytically it is distinct. Scope in this sense is determined by the number of activities carried out jointly by members in a particular organization. Where members share only one or a few activities, the scope is narrow; it is broad where members share several kinds of activity. There is no one-to-one relationship between scope and pervasiveness. High scope enhances the normative control of an organization because it separates its participants from social groups other than the organization's and tends to increase their involvement in it. Especially is this characteristic of the hospital.

Among the many factors affecting organizational control, and about which we have little systematic knowledge, the environment of the organization looms large. To legally use coercion, organizations must have a license from the society or community. To perform many of their other functions organizations, as well, need social licenses (the state or other regulative agencies). The state is jealous in the doling out of its coercive power and reluctantly delegates it.

The state needs to protect the public and so it also regulates normative power to a degree. The environmental conditions affecting an organization's use of normative power are less clear than they are in the coercive realm. The presence or absence of competitive organizations of the same set or different types is probably important here. The effect of the environment on an organization is determined in part by the nature of the organization -- i.e., the same community environment, e.g., may have more effect on some ("weak" organizations) than on others. The same environment may have different effects on different types of organizations because the particular differential effects are due in part to some difference in the environment hidden behind the seemingly identical categories of "community," "politicians," etc. We actually know little about the effect of organizational environment on control.

We know much more about the internal control of low-ranking members of organizations than of high ranking ones and yet it is at least as important. We need to know more of the dynamics of control. How do changes in leadership affect changes in the level of alienation? What kinds of leadership emerge as alienation changes? Does a reduction in scope always support normative control? This change in leadership is one part of organizational research to which this dissertation is partially addressed.

Another problem in organizational research has to do with the question of the consequences of conflicting tendencies built into an organizational structure apart from personality-organizational role mismatches. One of the most important structural dilemmas is the inevitable strain imposed on an organization by the use of knowledge.

Organizations, by their nature, use more knowledge more systematically than do other social units. Most knowledge is created in organizations, preserved and passed on by them.

Weber seems to have ignored one necessary distinction in viewing bureaucracy or administrative authority as the prime base for technical knowledge or training. He thought that subordinates accept organizational rules and orders and legitimation because they consider their superiors as being more knowledgeable, rational, and right than they themselves. To a degree this is a valid conception, insofar as the higher the rank of the official, the better he is formally educated and/or qualified in terms of merit and experience as determined by exams and promotion to demonstrate such knowledge possessed. These factors help to establish such an association between rank and knowledge. However, by far the most trained of members in an organization tend to be found in the middle ranks and not in the highest, not in the regular line or command positions, but around them. The experts, staff professionals, or specialists are the most knowledgeable, by-and-large. Thus, the most basic principle of administrative authority and the most basic principle of authority based on knowledge -- or professional authority -- are not identical; rather, they can be quite incompatible.

Administration assumes a power hierarchy. Knowledge is largely an individual property, however, which can't be transferred from one to another person by decree. Creativity is basically individual; only to a limited degree is it ordered and co-ordinated by a superior in rank. In the hospital, the individual professional, e.g., the doctor, is ultimately responsible for the professional decision (or the application of knowledge). The autonomy granted professionals is basically

responsive to their consciences. Of course, there is possible censure by their peers, and in the extreme case by the courts. Only if he is immune to ordinary social pressure, free to innovate, experiment, and to take risks, can a professional carry out his work effectively. This highly individualized principle is diametrically opposed to the very essence of the organizational principle of control and co-ordination by superiors. The case of the hospital is very instructive in this regard, as we shall see.

The ultimate justification for the professional act is that the act is the right one according to the best of the professional's knowledge. He may consult with colleagues before he acts or seeks help from others. A doctor has recourse to the services of the pathologist, lab, X-ray, and other ancillary services, but the final decision is his. If he errs, his colleagues (or peers) will usually defend him. The ultimate justification of an administrative act is that it is in line with the organizational rules and regulations and that it has been approved -- directly or indirectly -- by a superior rank. The conflict is obvious here and needs no further elaboration.

The question of how to create and use knowledge without undermining the organization is a rough one. Knowledge in medicine, and in other fields as law, is formulated and applied strictly in private situations. It has basically a non-organizational context with face-to-face interaction of professional and patient or client. Yet the need for costly research and auxiliary staff has grown in medical practice and the traditional professions, such as the physician's, face mounting pressure to transfer their work to organizational structures such as the hospital. Professions or semi-professions -- in

which the amount of knowledge (measured in years of training), the degree of personal responsibility (measured in the degree of privileged communication), and questions of life or death are lower than in medicine -- are more easily integrated into organizational structures. In the case of the hospital, nurses and various medical technicians are good examples of semi-professionals. The older and more highly creative profession of medicine clearly differs from these. The "professional" work of nurses is more readily carried out within the organization and is more given to supervision by persons higher in rank. More administrative authority applies, although there may be no more or less "professional" competence required.

There are three basic ways in which knowledge is handled within different organizations. In professional organizations which are established for the purpose of producing, applying or communicating knowledge and with a high proportion of professionals on the staff (at least 50%), the professionals have the superior authority over the major goal activities of the organization and more authority than do non-professionals. The university is an apt example and the larger general hospital with research and teaching functions combined with treatment is another. Full-fledged professional organizations are largely staffed in these capacities with persons with professional training of five years plus; semi-professional organizations are those whose personnel have less than five years training. Generally associated with such differences in training are differences in goals, privileges, and concern with matters of life and death. "Pure" professional organizations are primarily devoted to the creation and application of knowledge and its key personnel are protected by

guarantees of privileged communication and are concerned with matters affecting life or death. Semi-professional organizations are more concerned with the communication, and less so with the application, of knowledge. They have less guarantee of privileged communication and less protection in matters of life and death. In some service organizations (such as in a child guidance clinic) professionals are provided instruments, facilities, and auxiliary staff for their work, but the professionals are not employed by the organization nor subordinate to its administrators. Professionals may be employed by organizations whose goals are non-professional and therein they are assigned to special positions or to a division. A plant physician in industry or doctors in the military medical corps are such examples. There are problems in applying this analysis to the small or run-of-the-mill community hospital.

Professional authority in non-professional organizations usually bends to the superiority of administrative authority. Privately-owned and managed industrial production or business organizations are the largest and most common examples. Their basic goal is to make profits and their major means are production and exchange. The line managers or administrators handle expressive tasks; the professional staff deals with the various aspects of the production and exchange process. The line personnel head such organizations and they co-ordinate the various activities so as to maximize the major organizational goals and to direct them. The staff professionals apply their specialized knowledge as means of engineering, quality control, marketing, etc., and are seldom heads of private business.

The administrative orientation is consistent with private business. Both are concerned with economics and bureaucracy, with the rational combination of means and procedures developed to maximize the goals given. Social and cultural conditions in the U.S. strongly support the modern economic activities and administration. The orientation of the staff is largely incompatible with these orientations. They are largely outside of the regular chain of command but are subordinates with certain autonomy accorded them due to their expertise. They are not regular subordinates.

There are two interpretations of the relationship between staff and line authority principles. In one, the staff has no administrative authority at all: it advises the administrators on the technical action to take. It does not issue orders to the lower ranks and any corrective action is accomplished through the line. In the other interpretation, the staff advises on various issues and takes responsibility for limited areas of activity and on some matters issues order to the lower ranks.

Both interpretations generate considerable strain. If the line alone issues orders, it becomes overloaded by demands for decisions and it tends to repel at least some of the professional advice and the staff's requests for action. Line personnel have other functional requirements to look after. Rarely are comprehensive bases of actions required by the staff so the line tend to neglect or under-represent staff demands. Lower line subordinates find themselves subordinate to two authorities at the same time as a result of the functional division of control by which professional matters are referred to staff, other matters to line. In practice, however, issues may be ambiguous since

they may be matters both of means and expressive. The lower line can play one authority against the other when conflicting orders are issued. High and low line members often unite against the staff along lines of age and experience: line members tend to be older and have greater organizational experience, while the staff is younger and college-educated. Different patterns of speech, dress, and recreational preferences are additional factors for separation between the two. In many plants it is considered desirable for the administrators to have major line authority since it is they who direct the major goal activity.

Insofar as the distinctions of staff-professionals versus line-administration show correlations or apply at all in full-fledged professional organizations, the reverse of what occurs in the above organizations happens in this setting. The administrators are in charge of secondary activities. Administrations supply the means to the major activity carried out by the professionals. In such organizations the professionals should hold major authority and the administrators secondary or staff authority. The administrators in this setting advise about the economic and organizational implications of the various activities planned by the professionals. But the final decisions, functionally speaking, are in the hands of the various professionals and their decision-making bodies such as committees or boards. The administrator may raise objections, but it is the function of the professional one to decide on his discretion to what degree administrative considerations should be taken into account. Let it be said that this is an ideal picture!

Administration in a professional organization is usually fraught with institutional role conflict over who is superior. According to the principle outlined by Etzioni, this role should be in the hands of a professional in order to ensure that the commitments of the head will match the organizational goals. Yet such organizations have needs unrelated to specific goal activities. It must obtain funds to finance its activities, recruit personnel, and allocate funds and personnel. The system has to be kept integrated and a balance struck between the primary and secondary needs of the organization. In the case of the hospital, patients' fees and insurance plans, endowments, contributions, and drives for building, equipment, etc., are vital to keeping it a going concern, yet this is not the central goal of such an organization. The professional administrator may overemphasize the major goal activity and neglect the secondary functions. He may lack skill in human relations to the extent that he must integrate and balance people with different interests and backgrounds. The most successful professionals seem not to be motivated to become administrators because of their commitment to professional values and ties to professional groups. Also, they feel incapable of performing the administrative role successfully. They seem to avoid the training grounds for, and channels of mobility to, the top positions.

The professionally-oriented administrator is one of the various solutions to the above dilemma. This person combines a professional education with a managerial personality and practice. Hospital administrators are increasingly of this type. Although it may vary as to where and how their educations were received, there is a sameness about such administrators: (1) the professionals themselves and (2) those

with special administrative training in the particular field. Of the professionals it is said that it is those who feel they have little chance of becoming outstanding professionals in their field and who are more skilled in administrative activities who make this career choice.

The advantages of professional administrators over lay administrators with no training in serving the major goal activities of the organization are that they are trained for the particular role. They tend less to goal displacement and suffer less strain as a result of conflicting demands. They usually have a considerable understanding of the organization before entering it. Having shared some of the professional values, they are sensitized to the special tensions involved in working with professionals. Still, the physician as a hospital administrator presumably has a deeper commitment to professional values, commands more professional respect, and has a greater number of social ties with the professionals, thus tending to render his efforts more effective than the professionally-oriented administrator with special training as such. The sources of strains created by lay administrators in professional organizations, which may lead to goal displacement, are compounded by the fact that some goals seem more precarious than others, the professionals themselves are troublesome in many respects, and the community presence in the form of the board of trustees may present problems due to their limited interests and value systems. Although the head of an organization is in a strategic position in institutional conflicts, the lay administrator with a strong bureaucratic orientation seems to be more likely to endanger professional goals than a professional or professionally-oriented administrator.

In the hospital there are really two lines of authority: the one professional, the other administrative. The hospital is only in part bureaucratic. A clear line and central authority exists precariously only in the latter. Low level individuals in the hospital are directly subject to both authorities, especially in smaller hospitals, and they are responsible for the secondary activities. There do exist sanctions exerted by the informal pressure of peers, but there is less such control in the peer groups of these organizations than in other organizations. As far as the major goal activity is concerned, such control does not take the form of a hierarchy with superiors issuing the orders and requiring performance reports. The three areas of activity in professional organizations are broken down into: (1) the major goals which the professionals carry out, almost completely under their own authority; they either perform the tasks or direct semi-professionals and non-professionals who perform the tasks; (2) the secondary activities performed by the administrators and non-professional personnel under their control; and (3) secondary activities performed by the professionals such as preparing statistics, engaging in public relations, or allocating facilities. There is no established hierarchy in the first area; in the second the hierarchy does not involve the professionals directly; and in the third there is often a clear hierarchy in which the administrator predominates. The hierarchical principle in professional organizations is limited to the secondary activities. The main goal activities provide much autonomy for professional authority.

In semi-professional organizations, professional authority is based on shorter training and involves values other than life and death

or privacy; it covers communication of knowledge basically. Professional work in this setting involves less autonomy; it is more controlled by those higher in the ranks, and is less subject to the discretion of the professional. Still, there is greater autonomy for the professional than for the blue-or white-collar worker.

Semi-professionals have skills and personality traits which are more compatible with administration, it appears. The qualities needed for the communication of knowledge are more like those needed for the administrator than those needed for the creation and, to a degree, the application of knowledge. The primary school is the most typical of such organizations, with the social work agency less typical. The semi-professional nursing sector of the hospital is also less typical, especially if a breakdown into R.N., P.N. and aides is made. Registered nurses do apply knowledge. Their training is much shorter than that of physicians. The question of what therapy to administer is in the hands of the doctors. Although their work is related to the professional decisions of life and death, the work of R.N.s is not directly so related.

The work day of semi-professionals is tightly regulated and their duties comparatively highly specified. Where the performance is not visible, detailed reports on performance are required and supervisors are allowed to make surprise visits to check on the work done: in hospitals by supervisory R.N.s and physicians. Much of the supervision is done by semi-professionals or professionals. Some deprofessionalization has been occurring in nursing, as in other full professional occupations, as increasing and various pressures are pushing nurses into supervision. The typical professional is male;

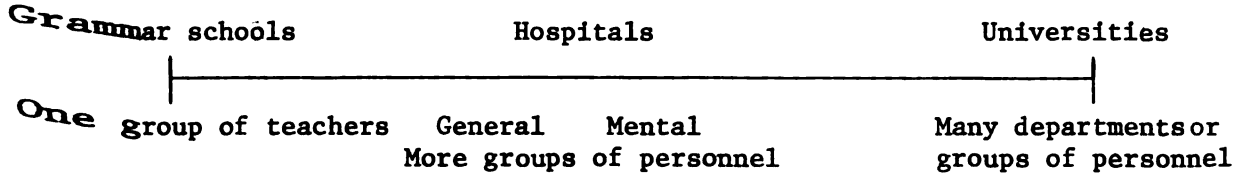
the semi-professional female. Etzioni surmises that females are more amenable to administrative control than men. The female on average appears to be less conscious of organizational status and more subordinate than men. Females tend to have far fewer years of education than men. Their acceptance into medical school, for instance, is sharply limited. (These impressions apply to the situation in the U.S.A.)

A strain may be created in the professional organization, such as the hospital, when semi-professionals, as the nurses, take physicians, full-fledged professionals, as their reference group and view themselves as full-fledged professionals and feel that they should have more discretion and be less controlled. Nurses often feel themselves to be more experienced than the young intern or more knowledgeable than an older supervisor and resent the command of either.

Proprietary hospitals and clinics owned by groups of physicians provide their doctors with facilities. As proprietors the doctors also often make up the board of directors and control the administration of this type of hospital. Even under these conditions a strain may develop in that many doctors feel they are wasting their time on administrative work. The conflict may be prolonged as there is no neutral agent to arbitrate the differences of opinion and interests among the professionals. Since the doctors own these organizations, there is no separation of the profit motive and professional motive. Displacement effects on professional goals may result in low quality medical care. The conflict between administrative and professional authority in such circumstances exists within each doctor and among them and cannot easily be eliminated.

Such and other contextual factors influencing the above organizational dimensions and problems in professional organizations must be examined empirically, because other things are hardly ever equal. Invariably there are variations. Hospitals are organizations with broad scopes in that they take care of most of the non-professional needs of patients in addition to the professional ones. There is a heavy externalization of functions in addition to the internalization of functions. The more professional functions are internalized and administrative functions externalized, the closer to the ideal type do professional or semi-professional organizations come. A hospital requires a greater percentage of non-professional staff and has many more administrative problems as a result of its scope than does the school, for example, with its much narrower scope. The effect of nationalization on the organizational structure of hospitals in England was to allow administrative, externalized functions to be taken over by a higher-level administrative unit freeing the heads of subordinate hospitals of these functions and allowing them to devote themselves much more to professional concerns.

The number of professionals co-operating in one organization and their mutual attitudes are other important contextual factors. The greater the number of professionals, the higher the tensions among the various professionals, and the greater the need for a neutral administration as the final authority. Hospitals fit in the middle of the continuum as far as this factor of single versus multiple professions and resultant tensions are concerned.



The general hospital is nearer the school as it is dominated by one professional group of physicians. The size of such a hospital, the services rendered, etc., may affect this position, however.

One of the most important dimensions for the study of professional organizations has to do with their ownership and how they are financed, as these factors impinge on the relations between administrators and professionals. Many such organizations are partly financed through contributions (gifts) or from tax money and clients' or patients' fees. The way in which the professionals are compensated, whether through salaries or fees from the organization or clients, is important. From the viewpoint of the professional goals, the distorting potential of a lay administrator seems to be the highest in those "private" professional organizations where its professionals are salaried. In those public organizations where professions are not salaried and administrators represent public interests, the distorting potential seems to be minimal. There are almost no studies of these various arrangements and their effects on the relation between professional and administrative authority.

Etzioni's major contribution from our point of view is in pointing out the need to link the organization with its social environment and it is at this point that his contribution most explicitly relates to the concerns of Warren. "Under what social conditions do modern organizations rise and develop? What is society's or the community's role in the regulation of relations among organizations? How will the relations between society or the community and the organization change in the coming decades?" These are highly complex questions and there are few hard facts available to guide us in answering them.

Summary and Evaluation of Organizational Theory and Research*

Before moving on to the literature dealing specifically with our type of hospital organizations, it is necessary to briefly summarize and evaluate in general the contributions of the above approaches and the contributions made from other perspectives, to winnow the organizational framework essential to our purposes from the non-essential. Presumably, each of the eight perspectives below represents the rudiments of a theoretical model in that each, to a degree, designates significant elements thought by its adherents to approximate the patterning of order inherent in organizations. These eight perspectives, however, do not appear to be models.

Models are useful to the extent to which they clearly specify key variables and a "mechanism" by which the variables are related. Models are crude maps for research as they provide structure for analysis. When models are tested repeatedly and found to be predictive of phenomena for which they are designed, they become miniature theories. Such models, by the way, are not meant to describe all facets of organizational life.

Following Haas and Drabek,[29] the eight perspectives below are not models, but rather they are different images of organizations with different emphases on what are considered to be "key" variables. Collectively, analysis has been deflected in different directions, even with the many similarities and points of overlap apparent.

*In Part Two of this dissertation use will be made of selected aspects of these various perspectives in an eclectic fashion to describe and analyze the Mills Springs Community Hospital.

Synthesis -- individually and collectively -- has not yet been attained. Nevertheless, some important insights have been achieved. Many organizational theorists have spanned more than one of these perspectives. There is nothing "ultimate" about these eight. To reduce them to their essentials involves the danger of over-simplification.

1. The Rational perspective of Max Weber focused on social conduct, not only objectively but from the subjective viewpoint of the actors involved also. To properly understand social conduct the researcher needs to observe and understand how each actor takes account of the behavior and expectations of others. Some actors have the power, to an extent, to get desired behavior from others. One must examine why the less powerful comply. Basically, Weber saw the reason to lie in legitimate authority -- ultimately physical force or its threat and duty, a feeling of obligation.

His three general types of authority exhibit differing sources of legitimation: traditional authority by time; charismatic by the over-powering personality (special grace) of the leader; bureaucratic or rational-legal by appeal to a larger set of rules designed to achieve valued ends, by belief in the "legality" of patterns of normative rules and the rights of those elevated to authority under such rules to issue commands.

Weber's general image is one of organizations as instruments. An organization is a system of continuous activity pursuing a goal of a specific kind. The focus is on legally-prescribed structures and mechanisms by which organizations are maintained. Members value these, thus there is compliance. The purest type of legal authority entails the most bureaucratic administration and functions according to the

criteria spelled out above.[30]

The view of organizations as instruments implies several central ideas. The whole organization and its parts are means to goal achievement because organizations have explicit and reasonably well-defined goals. Policies, decision-making, etc., are consciously and rationally administered with these goals in mind. By following policies and rules, organizations save time and are more efficient. An organization is a collection of structures to be manipulated for overall effectiveness.

Several criticisms can be made of this perspective. Many important questions remain hidden when organizational goal is used as the central concept. The difference between official and operative goals is ignored. The difficulty in operationalizing "goal" is slighted. Informal behavior and unofficial group norms are excluded. The possibility for exaggeration exists in the distinctions made among types of authority. Environmental changes and their resultant repercussions for organizations are largely ignored. Finally, internal conflict seems implied to be undesirable.

2. The Classical perspective, exemplifed in Taylor and Scientific Management (Gulick and Urwick) and in "neo-classicism" (Simon et al.), hinges on the following general image. Paraphrasing Taylor's still germane posing of the basic issue: "What workers want is high wages; what management wants is low labor costs." The need of industrial organizations is efficiency-effectiveness. Through time-motion studies and re-organization of structure this is attained. The emphasis is on formal structure, with the parts consisting of men and machines. The organization appears to be one large machine.

Several criticisms can be expressed. This is largely a normative, not an analytical perspective, in which the analytical part is deficient. Do workers only want money? It omits interactions among many critical structural variables (but especially in organizations--among them industrial -- with professionals working in them). Rule violation is seen as undesirable and is unexplained other than on the basis of moralistic terms. It is weak on the recognition of the relationship of rules and rigidities in rule violation. It is overly simplistic. It ignores informal interactions, norms, etc. Finally, organizations are viewed as existing in a vacuum. Nothing is said on the external environment and constraints on the organization coming therefrom.

3. The Human Relations perspective contains several central ideas in its general image. Workers are seen as complex social creatures with their job behavior influenced by many factors besides economics. Motivations of other sorts are important as well -- ego, security, new experience, etc. Actors get primary satisfactions through the groups in which they interact. Group formations and processes are manipulable, and the most important factor in this regard is the style of supervision, thus the emphasis on human relations training for supervisors. Group norms of an informal nature, more so than formal, are seen as the major regulatory devices of members' behavior. Effective organizations consist of sets of interlocked functioning groups -- importantly, informal and, less so, formal. The linking in of members to the organization via informal means is emphasized, as is concomitant self and organizational realization. The participative group system is seen as the most effective.

Critically, this perspective is overly prescriptive. Analytically, the variables used are often vaguely defined, frequently highly value-laden, and lack comprehensiveness. The concept of power is absent entirely. A pervasive "social humanitarian spirit" presents conflict as an evil (except in terms of avoidable "personal clashes"). It fails to recognize individual needs which need not nor always can be adjusted to the extant system. Finally, little mention is made of the organization's environment. The emphasis is on internal functioning of organizations.

4. The Natural System perspective at base likens organizations to biological organisms in continually changing in their efforts to deal with environmental modifications (mostly unplanned). Planned changes are much subject to unanticipated consequences. Functionalists, such as Parsons and Selznick, and Michels emphasize equilibrium -- the constant adjustment of the system -- whether homeostatic or dynamic.

The general image consists of several central ideas. The focus is on the organization as a "natural whole," a structure with a history, a "character," and a "personality." Organizations have goals and a set of basic needs and they develop systematic means of self-defense for maintaining an equilibrium or balance. Organizations exist in environments and their equilibria are most directly influenced by their environments. Many types of adaptive processes are discussed collectively, although varied emphasis is applied -- e.g., Selznick sees "cooptation" as a prime adaptive process. All see adaptive processes as dynamic. Organizations seeking to adapt to environments modify their basic structures and "personalities" in the process. Policies, goals, and day-to-day activity are closely related. Members of

organizations are seen as more or less committed to the general values of the institutional functions served. Changes in the qualities of members may bring about institutional change of the organization. Goals and the behavior of members may often be unplanned, unconsciously emerging out of patterns of constraint. The concept of equilibrium is used to stress interdependence of parts of organizations. The total organization is seen as a collection of sub-systems, each of which is in potential competition with the others. The total system is in competition likewise with outside forces.

Critically, there is a sharp de-emphasis on the formal organizational structure; little attention is devoted to rational planning and to decision-making. Desite an emphasis on the informal structure and actors' responses to values, little attention is paid paradoxically to interpersonal relationships. The central variables are highly abstract and vaguely defined. As a consequence, much operationalization of concepts awaits doing.

5. The Conflict perspective contains a number of major ideas, making up its general image. Conflict is viewed as a natural process, not a pathological one; and is inevitable because there are limits to resources and freedom in all organizations. Groups are seen to vary in power, although all seek it. Coercion is regarded as very important and unavoidable, and it underlies economic and other kinds of conflict. Systemic change is claimed to be best understood through an analysis of conflict over power. Change is ubiquitous. Conflict has many positive functions -- such as Coser's safety valve function. The presence of conflict may indicate a highly stable system, contributing positively to maintenance and vitality. Several mechanisms by which

conflict, in this sense, is tolerated and controlled are seen as alternatives to group consensus. (E.g., Litwak's role separation, physical distance, transferral occupations, and evaluation procedures.) Even violence need not be seen as irrational, aimless outbursts.

One can criticize this perspective by indicating that there is more to social life than just conflict; it ignores social integration and co-operation. Co-ordination, likewise, is ignored. Group cohesion is seen mainly as a response to external threats and hostilities. Planned and consensual change are slighted in favor of a view in which social change as an outgrowth of conflict looms large. Adherents to this view criticize a multitude of concepts -- e.g., equilibrium, homeostasis, etc. -- for being narrow, vague, politically biased, but they are hoist by their own petard. Many of their concepts -- intensity of conflict is but one -- are highly abstract, unspecific, narrow, vague; in short, not operationalized. Finally, analysis of group or organizational environment is minimal.

6. The Exchange perspective's general image contains the following central ideas. Analysis must focus on actors and their interactions to arrive at the structure or pattern of observed interactions in rigorously measurable and objective terms. Interactions of members are analyzable at several levels: individual, group, and organizational. Not all interaction is rational nor based on exchange. Several forms of transactions are identified: positive and negative exchange, trading, joint payoff, competition, open conflict, and bargaining. Many patterns of interaction are explained through exchange transactions. Small group exchange processes are seen to have counterparts in more complex systems, with some important qualifications. As

interaction patterns persist over time, interpersonal relationships emerge with persons forming both abstract patterns and informal reactions, or a mix. Groups and organizations maintain their stability through a system of emergent norms and sanctions dependent on the degree to which interaction is repetitive or patterned; likewise do expectations emerge within, but they may also be brought into organizations, as may norms, when new members come in. Importantly, the comparability of data collected on the organizations of the U.S. to those of other countries is questioned.

Critically, there are problems with this perspective revolving about the unclear conceptual distinctions made, as between normative and interpersonal expectations -- analytically these are too often blurred. There is a tendency to drift into personality analysis, losing sight of social positions, e.g.; reductionism too often prevails. Except for Blau, conflict too often is seen as necessarily undesirable behavior resolvable through better human relations. There are masses of data, but too little generalization. Valuable as the case descriptions are, one often seeks the point(s). There are too few insights offered into how the networks of analytical propositions given can aid in explanation or prediction beyond the cases dealt with. Formal structure too often is ignored or is seen merely as a set of constraints for inter-individual behavior. Finally, little effort to analyze or conceptualize environmental influences or organization-environment interaction or "exchange" has been expended. Even in Homans, where the subject of the environment is broached, the emphasis is more on description, less on analysis. The organizational contribution or impact of technology is ignored.

7. The Technological perspective presents the following general image. Organizations are seen in terms of work performed on basic material to be altered; in other words, they are systems using energy (animate or inanimate) in patterned, directed efforts to alter the conditions of basic materials (animate or inanimate) in a predetermined way. Technologies are defined by abstracting the properties of the transformation process through which "raw materials" are manipulated. The state of the art of analyzing characteristics of raw materials is likely to determine what kind of technology will be used in any particular case. Raw materials are differentiated via interrelated perceptions: the degree to which raw material is perceived to be understood, and the degree to which it is perceived to be stable, treatable in a standard way. A plug for easier comparative analysis of organizations by using technology rather than other social variables is made. Many organizational variations are seen to be directly related to and explained by variations in technology so defined. It is claimed that different theoretical models may define different organizational "types" where technology is used as the criterion for defining types.

Critically, this is an extremely narrow perspective (self-acknowledged by some of its adherents). Technology does not explain everything about organizational behavior. It is but one and an insufficient type of constraint. Technology needs integration with other organizational factors in a neater way than has been done to date. The insights gained are analytically isolated, and thus there is a tendency to exaggeration, an overemphasis of technology. Operational specification of its variables needs doing. Whose perceptions, e.g., should be used in assessing technology or raw material -- the

respondents' or analyst's? Subjective and objective criteria are both needed. Organizational environment, except as providing input for new technology, is ignored. Finally, the informal structure and ideological conflict, as related to technology but to other organizational aspects as well, are virtually ignored.

8. The Open System perspective displays a general image somewhat similar to the natural system perspective. Organizations are viewed as systems within systems, much as an onion's layers. Systems are complexes of elements standing in interaction. The focus is on relations among interacting elements and the whole consists of more than the sum of its parts.

Organizations are open systems which cannot survive in isolation. An open system maintains itself in a steady state, internally and externally at the same time -- there is a continuous in- and out-flow, a building up and breaking down of components. While alive, the system is never in a state of chemical and thermodynamic equilibrium. Open systems work to avoid an increase in entropy and develop increased order and organization (negative entropy). They restore their own energy and repair breakdowns in organization through environmental interaction.

Open systems follow the principle of equifinality -- the same final state can be reached from different initial conditions and in different ways. No single final state or structure is assumed to be best for all organizations, as the qualities of environments differ. This is similar to the notion of multilinear evolution and Huxley's views.[31] Open systems are posited to have complex feedback and regulatory mechanisms permitting adaptation to many kinds of environmental

change. These provide the system with the basis for judging whether environmental manipulation may accomplish desired "purposes." Systems are seen as varying in their degree of self-direction as a result, with "purpose" defined as a property of organizationally-specified values of internal variables, in regard to which systems take corrective actions to maintain them in steady states.

Uncertainty is ever-present and coping with it ever-important. Uncertainty confronts organizations from within and without (the environment). An "optimal" solution to problems is not possible; only a satisfying one is possible. Organizations are viewed as self-directed in the sense that constant monitoring via feedback processes indicating degrees of self-regulation occurs in a dynamic reaction to continuous and expandable threats.

Organizations are viewed as patterned sets of events, with the focus on patterns of activity, not upon individual actors per se. One begins by identifying and mapping the repeated cycles of input, transformation, output, and renewed input which constitute the organizational pattern. Feedback implies that organizations exhibit cycles of events, patterns, the events being observed behaviors. The focus is on "concrete systems" based on behavioral observations rather than abstracted systems. A major problem of analysis is to indicate the degree of convergence between role behavior and role expectation.

Organizations are seen to have boundaries that differentiate them from various environments, which may be hard to conceptualize. All boundaries are ultimately dynamic. It is the problem at hand that helps the researcher to spell out what is to be included within the boundaries. Organizations are permeable by degrees. Boundaries are

lines or areas (regions) for defining an appropriate systemic activity, for admission of members into a system, and for imports into the system; in the reverse, barriers for many types of interactions between people inside and outside the organization. Boundaries are also seen as facilitating devices for particular types of transactions necessary for organizational functioning.

Systemic interaction, within and without, reflects different layers of control and autonomy: there is a co-ordinative hierarchy. Power and control are exerted through intra- and inter-system messages that evoke compliance. Messages must contain the following critical characteristics: an address, a signature (sender's identity), a legitimacy indicator (evidence the sender has authority to give orders), expected compliance to orders or commands, and specification of action to be taken indicated.

Some systems have varying degrees of power over others. Power may be measured by: looking at the percentage of acts systemically controlled and/or changed from one option to another; by examining how critical the acts controlled or changed are to the system; by ascertaining the number of sub-systems controlled; and by ascertaining the level of systems controlled -- high, intermediate, low. It is assumed that the determining of degrees of power will be difficult due to its dynamic nature, since power is seen as continually subject to renegotiation in a complex "bargaining" system with a mix of strategies and negotiating processes used by a network of groups involved. Open system analysis need not be reductionistic: the organization at all levels always consists of systems and sub-systems.

Critically, the open systems perspective is a useful, broad overview, but it presents complex problems of operationalization. Few of its propositions tie the various components of complex vocabularies together; they contain terms impractical to operationlize, such as boundaries, adaptation, feedback; and they make it hard to make predictive statements. Ideology and belief systems are too frequently conspicuously absent. Some notion of stress or strain is not seen as central to analysis of organizations. The concept of interpersonal expectations used by some (Katz and Kahn, e.g.) is not clearly defined -- is it social, social-psychological, or psychological? Technology has not been successfully integrated into any of the frameworks of this "model." Discussion of inputs, through-puts, and outputs doesn't go too far in addressing the problem. Little effort has been made to categorize analytical types of event systems wherein different processes might operate -- except in the crudest terms and with a hazy focus on patterned event systems (e.g., people-changing versus thing-changing organizations). Empirical studies are too few.

Buckley[32] has lately spelled out some of the needs in this area to sharpen concepts and to test some of the hypothesized relationships. Accurate mapping of the internal organization by researchers and organizational members is needed, as it is for the environment. Depiction and analysis of the essential features of the component sub-systems is called for. More extensive specification of the transactions of these units at a given time, of the degree and stability of a given structure seen as varying with the degree and depth of a common meaning generated in the transactional process, is required. An assessment of the ongoing process of transactions from stage to stage via deviation-

reduction and deviation-generation feedback loops, and relating these to organizational tension, goal-seeking, and decision-making, indicating the appropriate sub-units involved in the communication nets: this still needs doing with the aid of techniques now being developed.

Community Hospital Research Bearing on Policy- and Decision-Making

Zugich

One of the first attempts to study voluntary general hospitals on an empirical and comparative basis was that of Zugich in 1951, Influences on Interpersonal Relations in the Hospital Organization.[33] Not a sociologist, he was mainly concerned with discovering the factors which cause poor internal relations and poor co-ordination of activities in non-profit, general hospitals. Relying on a human relations approach to the study of organizations, he analyzed five hospitals in the U.S.: three in the East, one in the South, and one in the Midwest.

As a result of his study, Zugich found the obstacles to a "logical" or fully rational organization of the hospital to be due primarily to its social makeup and the attitudes (and values) of the groups of individuals making it up and their reactions to one another, in addition to influences coming from outside the organization, such as the attitudes of the community and pressures from professional and other types of organizations. His main emphasis was on the internal aspects, however. These combined factors, he felt, distort the day-to-day, necessary co-ordination of functions of the hospital in providing better care.

He saw as the one major built-in obstacle to co-ordination the fact that the hospital's total organization contains two broad lines

of authority. (This point was better presented and elaborated later by Harvey Smith,[34] whose contribution will be discussed below.) This split in authority between the upper level management and the lower levels of the hospital organization was linked by Zugich to the complicating influence of memberships of personnel in outside professional or common interest groups and to the interpersonal relations within the individual hospitals which results in the development of status groups and diminished co-ordination.

Communication was seen by him as a co-ordinative principle in hospitals meant to overcome the status problems indicated and other blockages, some closely related to status or common interest groups. Due to the presence of many different segments at the different levels making up the hospital's total organization, certain built-in situations and attitudes which discourage co-operation and teamwork result.

Zugich saw the probability of interaction between individuals at work increased in the hospital due to the nature and frequency of its "contact" services. Yet, these services, being applied by heterogeneous groups and individuals with widely varying backgrounds of training and motivations, combined under many departments, present a major obstacle to effectiveness and efficiency. Other factors contributing to lessened co-ordination and understanding and regarded as built-in obstacles, according to Zugich, are: overlapping objectives; 24-hour service, year round; conflicting balance of power; life and death emergencies; and the inflexibility of fund resources which makes it difficult, if not impossible, to adjust hospital operation to meet the demands created by outside influences, both community and farther afield.

Zugich saw another significant problem in such hospitals to revolve about defining the goal of the hospital, in that what is the best quality of patient treatment is not equally or clearly perceived and grasped by all segments. Evidence of these problems was found by him to take the form of growing conflicts between the professional groups and management, the consistent shortage of workers, high employee turnover rates, and lay opinions of hospitals as inefficiently operated organizations directly leading to high hospital care costs.

Another serious problem had to do with implementing the recommendations of such organizations as the American Hospital Association, American Nurses Association and American College of Hospital Administrators which collectively have increased the emphasis on interdependent relations in hospitals, yet which face the reluctance or outright refusal of many M.D.s to move in that direction.

Zugich asserted that the community and hospital cannot be easily separated, emphasizing in the main that the hospital "sells" its "product" in the same community in which it's made. An influence on the hospital's character, mentioned by him but not extensively analyzed, is that the major share of its workers are recruited from the area it serves. He declared that what happens in the hospital affects the community's reactions to it. Community opinion of the hospital is important and reflected in the public support given, and the hospital must reorganize to service public needs. He made more of the proposition that patterns of informal associations in the work situation are translated from the hospital environment to the family or social relationships than was actually demonstrated. Changes in the socio-economic character of the community results in changes in

existing human and financial resources and these, in turn, are reflected in changes on worker relationships and satisfaction; but again, little analysis, more assertion, was given.

At the crux of the problems of human relations in general hospitals, Zugich declared is the basic split in their authority structure. On the one hand, there is the broad hospital organization proper, incorporating the administrator-top executive at the apex of the pyramid, with the departmental heads, supervisors, group leaders, and lower personnel in a descending order of wider layers at its base. Theoretically, Zugich asserted, this organizational pyramid should be controlled by one individual in a chain of command framework. On the other hand, and this is distinctive of these hospitals, there is a second, but by no means secondary, structure of authority composed of the physicians (the key or core professionals). They are not, Zugich declared, controlled or directed by the administrator.

Physicians are independent workers, only in a special way a part of the hospital organization. They are linked together by nominal departmental heads or committees which seldom exercise effective direction or control on a continuing basis.

The specific functional groups of nursing service, dietetics, laboratory, X-ray, and other departments are caught between the demands of two structures.

The vertical and horizontal structures (Zugich's terms) must be co-ordinated to serve the total hospital function or goal of better patient care; however, it falls to the administrator, as the top executive, to stimulate what diverse motivations and desires he can to adjust these needs. He must provide incentives and a semblance of

security. But the different values held in each structure and at the various levels often spell difficulty. Thus, co-ordination, direction and consultative control are not clearly linked in such hospitals through the "normal" superior-subordinate relationships. Authority (or power) and responsibility areas are difficult to outline.

The two main structures are, therefore, loosely linked by intermediate committees and co-ordinative groups which develop broad "policies." Often, definite decisions hinging on these "policies" are far from conclusive, rather they appear to be made by default. Of course, there are the serious decisions revolving about the core medical care goals which must be addressed, but such decisions (as evidenced in the area of malpractice or unprofessional conduct) are shrouded in secrecy and not always clearly and consistently dispatched.

Some of the principal reasons for the major strains or conflicts, then, that occur in such hospitals are due to this unstable balance of power at the top level and feeding into the lower level. Additionally feeding "trouble" into this situation may be less than full understanding of the management of their duties, obligations, and the limits of their authority. A particular sub-unit in the management team may not accept this vague organizational plan.

The governing board is the supreme authority, legally the trustee for the community over its hospital. Although, ideally, it is intended that the composition of the board be widely representative of the community segments, often in reality only selected strata of it are represented. Zugich contended that the composition of the board is important as is the slow evolutionary process in arriving at practical principles of hospital organization. They go hand-in-hand.

Since board members are citizens with their own full-time responsibilities, with backgrounds in non-medical professions, business or trades, they have strong tendencies to judge hospital performance and successful goal attainment by a favorable financial report. Yet, the social philosophy and unique relationships in a hospital can't be readily translated into terms or principles of competitive business. A slow introduction and assimilation of the board to these normative values of the hospital via periodic meetings, services, committee work, and skillfully offered advice from the administrator and medical staff are necessary. Too often, no planned or concerted effort is made to indoctrinate a new individual on the board in the responsibilities, duties, or lines of authority and power which exist in the hospital by its nature. Rather, there is the too frequent use of standing committees producing narrow participation and directing members of boards to certain aspects or phases of hospital operation highlighting their business world experience. As a result, such members often cannot fully appreciate the problems in other aspects or phases.

A sounder approach, recommended by Jackson[35] and others, is to rotate members through task committees appointed to develop and investigate facts in the varied problem areas as current needs arise. This procedure might lessen friction at the top management-professional level.

The board -- due to its members' lack of time and their limited backgrounds, and its basic organization -- usually directs its main outlook toward the public, narrower but important, aspect of supporting internal hospital operation. It considers public reactions prime; only at a sub rosa level do the behavior and reactions of the medical

staff receive high priority. But it is here that community needs bend to medical staff pressures, conflicts over controls occur, and the board's understanding of its duties and obligations is tested. The medical staff's advisory function vis-a-vis the board gives it additional power, especially in the sphere of recommendations as to policy-making, since these have wider ramifications than most board members, who are little-informed in the above sense, realize. It is the medical staff which most often controls the hospital's "customer volume," and which determines hospital prestige. And this is the prime area in which discord could seriously impair the provision or maintenance of facilities.

As far as the administrator's position in the hospital organization is concerned, Zugich identified it as the most visible means of authority to the various workers. He does not set overall policy for the hospital, but does influence it; basically, he is responsible for its managerial direction. For the most part, he serves as a catalyst and buffer between those groups not under his control. It is he who, on an operational basis, thinks and must act in terms of the whole hospital and all of its activities. He also tends to be more idealistic regarding the hospital's functions and its groups than are the other top management personnel.

The main attention of an administrator for clues in running a hospital is directed upward to the board and the medical staff. He is subject to dismissal by the former and to various sanctions of the latter. As far as most boards are concerned, the administrator is responsible for "efficient" operation and for overseeing the finances of the hospital. In many ways, the only tangible measurement of

"efficient" operation is a balanced budget. This often entails, however, a conflict between better medical service and finances, which can become unbearable. The administrator's position is even more precarious because he does not control, and is not in authority over, the medical staff. His is, in a sense, a peripheral role and he supplements the main function performed by the physicians. Control and authority over the main function rests in the province of the medical staff who apply the principles and carry out the discipline of patient treatment. For all intents and purposes, the major problems of administrative co-ordination are with the medical staff; the administrator always has to consider this group. His tenure of office, then, rests primarily on his ability to "get along" with the medical staff and the board and their interpretation of his technical competence.

The rest of the hospital, by comparison, is a stable unit over which the administrator has direct supervision and control. His task is to manipulate relationships and responsibilities of these other segments to provide a better "workshop" for the doctors. From Zugich's viewpoint, he must fill positions to persons rather than vice versa. Patient treatment standards are obtained from secondary sources by the administrator. He seldom visits patients and sees them as groups, not individuals. A major problem has to do with his limited time. In this regard, assessing treatment standards, Zugich suggested that comment cards are far from accurate bases for an administrator in assessing patients' reactions to their hospital treatment and care.

Zugich's study showed that the background and prestige of administrators varied, as did their salaries. There was, however, no clear-cut pattern. One pattern he did find to exist in all cases studied: the size of the hospital definitely lent prestige to the administrator. Those in institutions of the 100-500 bed range were more respected and better paid than administrators in smaller hospitals. Most of them had made rapid progress in their careers by first serving in subsidiary administrative positions in large hospitals and then advanced to the top positions in other hospitals.

The medical staff is a quasi-authoritative segment of the hospital, which is self-disciplining and self-appraising. It may exercise or share principal control in matters reflecting on the major objective of the hospital, but it does not see itself in the overall hospital structure nor does it accept the organizational plan. In Zugich's study, vocal minorities of the medical staff influence the total hospital operation. Although they may or may not always participate in the initial planning toward future developments or in overall policy-making, yet their approval or acknowledgement is usually obtained. The loyalties of the medical staff are divided. Although in a sense outside the chain of command, the medical staff does exert pressures on the organizational lines of authority. In addition to approving the appointment of departmental heads and/or the hospital's executive officer, it frequently is in effect a part of management and both shapes policy and translates it into action. Power resides in their exercise of control over major appointments. Then, too, they direct nurses and other personnel, directly or indirectly.

A distinctive and important medical staff point of view was seen to emerge in controversies, issues, or conflicts in the hospitals Zugich studied. The board and administration think in terms of authority lines and controls throughout the organization, but the physicians (not usually employed by the hospital) see little need for such organization since they have the sole responsibility over the treatment of patients. Rather, they stress independent action. They work in two environments: their practice is one and the hospital is seen as an extension of it. Their background and training emphasize individual initiative and resolution of problems. Their scientific training does not predispose them to viewing the collective aspects of a hospital's operation favorably. Their independence from such organizational constraints is enhanced by the great prestige they derive from the community and society in pursuing their life and death related jobs.

Most conflicts between the medical staff and the other hospital segments, according to Zugich, center around finances or service, over new equipment or instruments and their long- or short-range usage. The board and administrator often wish to place restrictions on equipment acquisitions with full utility in mind, whereas the medical staff more often is concerned with improving services and experimentation to this end. The result is often severe criticism by the medical staff of the lay, and even professional, administrator. Physicians are at times too reluctant to request formal consultations as this might reflect (they feel) on their personal abilities and because some of them fear the reactions of their patients. Then, too, there exists among the general practitioners a personal insecurity when they match themselves against the specialists who are the consultants.

Zugich found the situation in which the medical staff is responsible for its own affairs via self-government and self-discipline an anomalous one in that patient treatment is seldom thoroughly appraised in such circumstances. It is very hard to approach this area at formal medical staff meetings -- it being too inflammatory a topic. At the core of the difficulty lies the reluctance of the typical M.D. to sacrifice his position as an independent professional worker by a review of his competence and efficiency from his colleagues or peers. "Self-protection" is a powerful norm; they do venture evaluations of each other "off the record," however.

Zugich stated that each of the major groups -- board, administration, and medical staff -- should be educated toward an understanding of their mutual problems and obligations. To this end a resumé of the current financial statements should go to the medical staff; written reports on professional performance should go to the board and administrator; and the latter two should attend medical staff meetings. Communication and co-ordination are critically important and must be constantly attended to, he thought. Zugich contemplated as alternatives to honest, firm self-discipline by physicians a divided balance of power with review of professional performance coming from some single governmental controlling agency, intra- or extra-organizational.

Zugich viewed hospital departmental heads, supervisors, and group leaders as members of a management team who have close and daily contact with rank-and-file employees and patients. Their faulty selection or recruitment results in poor supervision. Given the technical nature of their hospital work, nevertheless, Zugich claimed supervisors are chosen too frequently on the basis of technical skill alone. He

bemoaned the fact that too little indoctrination on how to handle a variety of people exists in the educational backgrounds of many supervisors and others. Head nurses, although they receive brief courses in "ward management," need more such indoctrination. Loyalty and seniority should not be used exclusively in choosing supervisory personnel.

A complication in hospitals revolves about the fact that departmental heads or supervisors and group leaders are involved in production, and supervision is a task tacked on to this. Group leaders are often "working foremen." The result may be a lack of participation in the problem-solving related to the total organization. Operational decisions may be centralized above the supervisory level and be reflected in poor co-ordination and communication downward. Leadership in such circumstances, then, is less democratic, more autocratic. Zugich saw the need for management to critically analyze its own effects on the supervisors -- to revamp its selection criteria to allow for freedom of action, increasing participation in overall hospital problems, and the greater elimination of the "working supervisor" principle wherever practical.

Zugich saw the source of current and potential disturbances in the hospital as due to changing attitudes and values of certain professional service and ancillary or auxiliary worker groups toward the present economic insecurity and low salary systems identified with hospitals. He foresaw a nationwide conflict over these issues between hospitals and professional organizations which show aspects of the trade union movement in the use of tactics, pressures, and activity. Nurses and, increasingly, aides and others have put pressure on the hospital

organizations to improve their economic conditions; the resultant tension has affected the objective co-ordination of workers and has placed pressure on the provision of more adequate patient care at a reasonable cost. Costs in hospitals have skyrocketed.

Another problem, Zugich found, has to do with the fears professional medical societies expressed about hospital prepayment insurance; the biggest fear of the doctors being over what they see as the jeopardy of their future relationship with patients. Additionally, the fear of the hospitals gaining increased control over the terms of their compensation and that their independent contractor status will deteriorate were cited. Physicians and their associations want more money for the specialties, but hospitals can't absorb this without raising their rates to patients. At the nub of the problem is whether the hospital is a workshop for the physicians or does it practice medicine. It is becoming increasingly evident that the hospital practices medicine.

The other professional associations or societies (nurses, medical social workers, pharmacists, et al.) all want more economic security and raises and are well aware of the doctors' demands and realized benefits as well as their privileged positions. For many of these semi-professionals, their jobs are dead-ends; there are real blocks to their further mobility in hospitals. They are in non-transferable professions. Given the diversity of the semi-professionals working in hospitals with their respective bonds to parent organizations and their different stands and demands, it is no wonder that hospital managements dread the increasing demands made of them. Collective bargaining, personnel and employment practices in hospitals are difficult

of establishment on a uniform basis due to this heterogeneity. In some states governmental mediation is taking place but much more is needed to iron out these complex problems. To date, that professional or semi-professional organization with the most drive and whose services are in greatest demand is able to extract the greatest compensation and benefits. There appears to be little order or justice, however, in the matter. Problems of a similar nature are now occurring at the lowest level of hospital personnel, such as aides et al.

Zugich was not fond of the formal view of hospital organization. He saw the real problems of such an organization to exist at the informal level. Special interests and attitudes do tend to correspond roughly to the formal, departmental divisions, to the extent that departmental heads tend to defend their own groups' position and interests first; however, co-ordination tends to quickly break down. In the larger organization, where social distance between the group leaders and their supervisors is broader, one finds a greater or closer identification of the rank-and-file with the group rather than with the supervisor. In the nursing sections studied, for example, Zugich saw this to be clearly evident; the gap is great between the nursing office (director of nurses) and head and staff nurses. He was convinced that the informal groups more often show how such organizations function than does the formal paper structure thought to exist by top management. The major determining factors for co-ordination, worker productivity, and morale operate at the informal level. When the workers find congenial social satisfaction -- the informal, interpersonal realtionships -- there are found the higher values which have the most direct and real influence on hospital structure and co-ordination. These informal groupings may

influence the pattern of co-ordination in another way, by extending outside the hospital setting. Reciprocally, community, racial, political and religious identifications may similarly be transferred into the special groups within the hospital. Other groups of non-employees -- the patients, visitors, auxiliaries, labor organizations, hospital supply representatives, insurance agencies, etc. -- may break up co-ordination.

Policies or decisions, according to Zugich, cannot be applied to the formal groups in the hospital. To this end, a free-flowing transmission or expression of ideas and information, up, down, and across the formal organization is needed. The major problem in communication is that ineffective methods are used and impressions of insincerity on the part of management or supervisors are too often conveyed. Seldom is the subject matter of the communication a problem. Conflicts between the various hospital groups are due frequently to ineffective communications or the lack of them toward understanding the hospital goal(s), relationships, and responsibilities.

Channels of communication are formally represented by an organizational chart, a blueprint of relationships between supervisors and subordinates. In a sense, this is a routing map for information between top management and the worker level. However, the type of organization in hospitals and the human factors mentioned break down such a system of communication. The line of authority depicted by an organizational chart is seldom stabilized or up-to-date.

Periodic changes at key levels readjust the supervisor-subordinate relationships. Adjustments inevitably have to be made to fit the background, abilities, and "interests" of the key individuals to

the ongoing informal system. If there is a withholding of the free flow of information up or down the line, subordinates can't learn the new supervisor's opinions, wishes, and concerns regarding their work or their responsibilities. The chain of command can distort a suggestion or complaint and it can even get lost on the way. Policies, decisions, or orders from top management similarly can be filtered down at the various levels and be finally construed as "propaganda." Filtering -- whether up or down -- is due to the desires of various people in the chain of command to maintain their prestige relationships and favor both with top management and subordinates or to inadequate understanding of their responsibilities to their supervisors and subordinates. In such cases one finds suspicion of management's motives at the lower employees' level, an inadequate knowledge of relationships, and a focusing on job security. The chief areas of blockage here exist between upper management and the lower supervisory levels.

Generally, Zugich found that the departmental head fails to add to the necessary communication in his own department. Workers are given little opportunity to identify with the hospital's major goal or to share meaningfully in resolving the institutional broad problems. Too often they are "told" what changes are desirable and too rarely are they informed how the changes are related to the total organization's progress. Participation in planning by all segments of the organization is ignored so that unanticipated problems almost inevitably occur. Then, too, negative communications are too often used; rather than positive statements, remarks such as "You're doing O.K. unless you hear to the contrary" are used, which do not conduce to security and morale.

Zugich indicated that more communication across the line is needed, especially between departmental heads. Too often this is discouraged among subordinate supervisors as well, so that conflicts which might be resolved at the lower levels on a personal contact basis occur and the speed of transmission of pertinent information going up to the higher levels is slowed down and the channels of communication are clogged by non-essential squabbling. The existence of the "grapevine" (centered around the informal organization) as a rapid system of communication indicates the ineffectiveness of the formal channels of communication. Conflict may be heightened by the rumors generated in such a system. Management must be aware of this problem and actively overcome it by clearing the lines, as Zugich saw it.

To a certain extent, Zugich felt, status systems have to be recognized in hospitals, so that symbols and status identifications are inevitable, yet these can be overdone. He found inordinate stress or importance placed on these aspects in the hospitals he studied resulted in conflicts -- over uniforms (length of coats), over location of work area and physical plant changes (e.g., rugs and furniture), over separate dining rooms, over favoritism, over salary and seniority.

Harkness, Holloway, Georgopoulos and Mann (and Smith)

Of the three pertinent empirical studies[36] of general hospitals to be now discussed, the two case studies by Harkness and Holloway focused on selected aspects of decision-making. These sociologists studied two hospitals: Harkness, the only one (middle-sized) located in a western Pennsylvania town of 14,000+ people; Holloway, the largest of three large hospitals located in a Michigan city of 100,000. Both case studies are of particular interest here because they were concerned

to a considerable degree with the impact of community influentials upon the policy-making and decision-making activites of the hospital. Of the two, Harkness's study tended to be wider in scope, being structural-functional and cultural in approach -- focusing mainly on the value-orientations and attitudes of members of the board of trustees, medical staff, and administrator with regard to policy- and decision-making, but including some examples of these activities. The focus of Holloway's study tended to be basically social-psychological and was concerned primarily with the decision-making activities of the board.

A comparative study of ten medium-sized general hospitals in Michigan communities of over 10,000 population was done by Georgopoulos and Mann. Concerned with the basic question of organizational effectiveness, this study was a structural-functional and social-psychological effort to better understand the community general hospital as an organization. It was the most comprehensive of the three studies. The behavior of the total hospital as complex social system was studied, with special emphasis devoted to the areas of patient care, organizational co-ordination and intergroup relations, supervision and administrative behavior, and communication. Their theoretical emphasis was on social-psychological concepts.

Explicit or implicit in the studies of hospitals cited, and in Smith's below, is the evidence that authority and power, essentially, is unequally shared by the board of trustees, doctors, and the administrator, to some extent by the director of nursing. Authority does not emanate from a single source nor does it flow along a single line of command as in most formal organizations.

Smith[37] identified the two lines of authority as this type of hospital's dilemma. He saw the hospital as an organization at cross-purposes with itself and this basic duality makes for the difference between what is said is done and what actually is done. The system of controls and the hierarchy of authority pictured in formal organizational charts are too simple and the observed situation is inevitably more complex.

Every study cited confirms Smith's observation that almost no administrative routine is established in such hospitals which cannot be (and frequently is) abrogated or countermanded by a doctor claiming a medical emergency. Not only is the actual authority of the M.D. very great, he exerts power throughout the hospital structure at all levels. Smith saw lay authority (basically bureaucratic and rationalized) in conflict with professional authority (charismatic). The hybrid areas of authority (and competence understood as included in this) are those of the laboratory, X-ray, pharmacy, medical records, admissions et al. The attempt to handle two different principles of authority within one institution, Smith claimed, is fraught with potential conflict. The special problem of such a hospital's administrative structure is that it must contain and regulate charismatic professional persons who are very often defiant of lay regulation. In every case, there is a built-in conflict situation for hospital administration. Barnard's[38] distinction between scalar status and functional status delineates the essence of this conflict. Scalar status refers to the administrative system and it inheres in a position within a hierarchical system; functional status inheres in certain kinds of work (such as the doctor's) regardless of the worker's position in a ranked system.

A dual system of values corresponds to this system of disparate statuses. Many purposes or goals in the hospital are rarely subsumed under a "single master symbol" or value, rather one finds, e.g., such as "Money" versus "Service." Thus one is not quite sure what kind of organization a general hospital is or should be -- a service organization? Or business? Or both? Administrative personnel (and the board) tend to think primarily in terms of "money" values, professionals in terms of "service" values. As a result, the hospital possesses a peculiar form of power structure. Flowing from this state of affairs are the problems of balancing collection of money versus service and a host of personnel problems. The hospital is a seedbed of professionalization and this results in special kinds of motivations of its personnel and peculiar personnel problems due to blocked mobility. Labor market competition increasingly adds to this problem.

The studies cited have shown that although the ultimate authority and overall responsibility for the organization resides in the board of trustees, it actually has limited de facto authority over the doctors. It delegates the day-to-day management of the organization to the hospital administrator who in turn delegates authority to the heads of various non-medical departments and to the director of nursing with her kind of authority further delegated. The heads of departments possess varying degrees of authority and, depending on the size and complexity of the organization and their particular sub-unit, they may delegate some of it. Because the medical staff is outside of the lay administration line of authority, doctors have a peculiar free-riding power. They do exercise a lot of authority at all levels and enjoy a very high degree of autonomy over nursing staff, patients, and "guests" of the

hospital. Their professional authority and charisma carries with it an inordinately high status and great prestige in the U.S.

Administrative and operational problems (in part also psychological) result because of the relative power and influence exerted on the organization's functions by the doctors, trustees, and administrative personnel. Co-ordination is made difficult not only in the formal aspect but in the informal aspect of hospital organization because it is not always clear where authority, accountability, and responsibility lie.

The differences in demands make for difficulty in communication, as do technical demands. Quite often the conflict between doctors and administrators is over the particular versus overall hospital goals, over quasi-bureaucratic demands which means a reduction in the doctors' influence which is resented and fought by them. Multiple lines of authority require a very delicate balance of power be maintained and it is the job of the administrator to seek and pursue this end of co-ordination. Positively, he must devise a system of "checks and balances" to prevent organizational inflexibility. He must use his authority to lighten the burden of responsibility and it is he who most often sees the organization on a group rather than individual basis.

To this end, he is in a sense hamstrung by the main distinguishing characteristics of the community general hospital. Its main objective is to render personalized service -- care and treatment -- to individual patients. To that extent, the economic value of the organization's products and objectives are secondary to their social and humanitarian value. Such an organization is directly dependent upon

and responsive to the surrounding community (the needs and demands of its "consumers" and potential "customers"). Thus the patients' needs must always be paramount. To serve these, a high agreement about the principal objective of the hospital among the members of the organization must obtain, and the personal needs and goals of the different members should conflict little with the objectives of the organization. The demands of much of the hospital work are of an emergency nature and non-deferrable. A heavy moral and secular functional responsibility falls on the organization's members. Great concern for the clarity of responsibility and accountability must be taken, with very little tolerance allowed for ambiguity or error. The nature and volume of work is so variable and diverse that it is subject to little standardization. The hospital is a human rather than a machine system. It cannot lend itself readily to mass production techniques, assembly-line operations, or automated functioning. The "raw materials" and "end products" are human and participate actively and have considerable control over the "product process." The principal workers are doctors and nurses -- professionals and semi-professionals -- posing certain administrative and operational problems for the organization. Hospitals have relatively little control over their workloads and over many of its key members -- especially doctors and patients. Administration, as a result of these factors, has much less authority, power, and discretion than its managerial counterparts in industry. There are lay, professional, and lay-professional mixed lines of authority which result in problems business organizations are largely spared. The hospital is in part a formal, quasi-bureaucratic, quasi-authoritative organization which relies greatly on conventional hierarchical work

arrangements and rather rigid impersonal rules, regulations, and procedures; it is highly departmentalized, professionalized, and specialized. But, just because of these characteristics, it needs more than other types of organizations greater effort in co-ordinating activities and maintaining highly interlocking interdependence. Overriding all these considerations is the great concern for efficiency and predictability of performance, since the hospital performs such a vital function for all people in the community.

Work interaction patterns among hospital personnel in all four studies reveal that medical staff and nursing staff have the most intensive interaction in treating and caring for patients. Most interactions of the nursing staff have to do with co-ordinative functions, therapeutic functions, and contacts with patients and medical and paramedical staff, as related to the care of patients. They have fewer dealings with non-medical personnel. Medical staff members have most contacts with nursing staff, followed by X-ray, laboratory, records and admissions personnel. Supervisory nurses, R.N.s, and P.N.s deal with laboratory, pharmacy, and dietary personnel often. The medical staff appears to have most difficulty in dealing with personnel in dietetics, laboratory, nursing and the business office. Departmental heads cite personnel in nursing, maintenance, laboratory and X-ray as difficult to get along with. Supervisory R.N.s cite housekeeping, dietetics, laboratory, X-ray, and maintenance personnel as difficult; while non-supervisory personnel R.N.s cite dietetics, laboratory, housekeeping and pharmacy personnel. Practical nurses see dietetics, housekeeping, X-ray, and pharmacy personnel as difficult; aides -- pharmacy, laboratory and maintenance personnel. Tension

among hospital groups stems from the nature of the work structure and is highest among doctors themselves. The least tension exists between doctors and trustees. A good deal of tension exists between doctors and nurses. There appears to be less tension between R.N.s and P.N.s than between shifts of nurses. Yet much interaction over and above the purely technical aspects required occurred not only among nurses of the core (supervisory staff) but was carried out by the administrative staff (departmental heads) to establish and maintain co-ordination.

Harkness' study attributed the problems and issues occurring in the community general hospital to differences in the value orientations of the top level groups within it. He saw a wide divergence and associated incompatibility in the philosophy, values, and interests of the top groups -- the trustees, administrator (one could add his staff), and the medical staff (one may add the nursing staff). At base this is a difference in values between professionals (doctors and nurses) and top lay authority (trustees and administration). The issues boiled down to "service versus finances" and were fed by the professional-non-business versus business backgrounds of the antagonists. Cleavages in value orientations led to tensions and conflicts, difficulties over power and authority, inadequate co-ordination, lack of consensus on issues of common concern, and differential emphasis on problems and their means of resolution. These cleavages in value orientations tended to undermine a unified point of view and unified action by the total organizational system.

Georgopolous and Mann questioned this type of approach on the basis that quantitative evidence is lacking to substantiate it, or what there is is meager and statistically non-generalizable. They also saw

the methodology involved as highly questionable. On the basis of their research, they saw differences but not sharp cleavages between the top-level groups. Rather, they preferred to refer to the higher tension they claimed exists among professionals than between professionals and lay people. On the contrary, they saw very little difference in the degree of interest doctors and trustees show in the hospital as an institution. From their study, doctors, trustees, and administrators all agreed as to which of various facilities were most inadequate, etc. They saw doctors' and trustees' ideologies to be very much alike -- predominantly conservative.

Harkness and Holloway found significant differences among board/community influentials and medical staff and administrators on issues and problems and real differences in value orientations, among these groups. Surely, there were also some similarities in values, but stereotyping is a trap one can easily fall into in attempting assessments. A conservative, functionalist bias is perhaps at work here; stress on balance and co-operation is most evident.

Dealing with the influence of key groups in the hospital, Georgopolous and Mann failed to link value orientations to power and authority as one of the key components for such action or influences on policy-making and decision-making. They saw imbalances or discrepancies between prevailing and desired patterns of influence in the system, however, when large enough and unmitigated, resulting in power conflicts, intra-organizational strains and dissatisfaction among organizational members, ultimately affecting organizational performance adversely. The most influential groups were seen to be the trustees, administration, medical staff, and nurses -- directly -- patients and

the "community" indirectly. Trustees deal with long-range institutional policies and financial matters; administrative departmental heads deal with day-to-day operations and the non-medical areas; doctors deal with purely medical matters; and nurses deal with nursing matters, with organization-wide matters less or through the medical staff indirectly. Each group was seen to exercise more influence than the others in its own sphere of jurisdiction. Doctors derive their great influence from professional expertise and high prestige, status, and (charismatic) power they enjoy among their patients and the larger community. Trustees enjoy an institutional-constitutional authority and are usually the most prominent men in the community. The administrator has conferred upon him his influence or authority and is responsible to the board. Nursing influence derives from professional expertise.

In theory, trustees have ultimate overall authority, but in practice their authority over the medical staff is quite limited. There is little direct de facto control by the hospital over two of its central components -- doctors and patients. Doctors are responsible to their own staff organization which establishes its own rules and regulations according to professional-medical considerations and requirements of the Joint Committee on Accreditation of Hospitals. There are few restrictions on medical rules and regulations exerted by the hospital constitution and/or the board (although there are broad boundaries set). On the whole they implement and enforce their own behavior in this regard. Neither the trustees, doctors, or administrator can run the hospital unilaterally or determine the fate of the organization as a whole. Factors that keep the power of the medical staff in check, according to Georgopoulos and Mann, are that the doctors,

board, and administration accept the basic objectives of the organization -- patient care and service to the community -- more than superficially and that this acceptance leads to consensus and co-operation. The organizational division of labor is sufficiently clear and unambiguous to make easily apparent attempts to usurp authority or inappropriate action. With the administrator as co-ordinator, a system of checks and balances is maintained. All segments, in other words, are very influential and can facilitate or obstruct the interests of the others. With a high functional interdependence and an elaborate system of committees (conferences, consultations) and joint committees, co-operation is practically inevitable. They saw no evidence of large-scale power conflicts or attempts to usurp authority from one another. Rather, all segments appeared to them to be power conscious and aware that a balance of power is a very delicate thing potentially subject to change, hence the necessity to exercise their "veto" powers. They found the prevailing influence pattern to be one in which administrators, boards, and doctors agree in attributing more overall influence to the administrator than to the trustees, doctors, or nurses.

Lay authority was seen as more influential than the two professional groups. Administrators studied attribute much less influence to the medical staff and nurses than to the boards. The boards attribute more influence to the nurses than either to the medical staffs or administrators. The doctors see smaller gaps between their and the boards' or administrators' influence. As far as desired influence patterns are concerned, administrators prefer no changes in the relative influence position of the four top groups. The boards prefer every one of the groups to exercise more influence but not to change their rank-

order; they would increase the nurses' influence most, thereby balancing the power of medical staffs. Doctors prefer a change in the balance of influence with more to go to themselves and the R.N.s, decreasing somewhat the administrators' and boards' influence. Their rank-order would be medical staff, administrator and board, then nurses.

Organizations are dynamic, developing, open systems which may be expected to change over time. External pressures for change come as a result of medical and technological advances, the development and increasing utilization of hospital plants, community growth, and other external factors. These all make certain demands upon the organization and require corresponding adaptation. Internal pressures for change may arise from changes in professional and administrative practices, changes in personnel and equipment, and from modification of routines, which also require organizational adjustments. There are gradual long-term changes in the environment and more or less frequent internal changes whose effects must be balanced. Sudden changes necessitated by crises or emergencies (such as disasters, accidents, etc.) are ever possible. Yet success does not always or automatically accompany change; the new problems encountered in the trial-and-error career of organizations may rival or surpass those to be replaced. Flexibility is needed and organizations must become accustomed to change. Hospitals are very likely to be adaptable because they experience many technically-instituted changes.

Georgopoulos and Mann found the vast majority of their respondents have a very favorable attitude toward internal change in their respective hospitals. Ninety percent of the members of each group felt that practically all or the majority affected by various changes in hospital

policies, procedures, and equipment accept them and adjust to them. Less than five percent of respondents say that adjustments are slow. Successful overall adjustment is maximized or facilitated: where communication among top levels is seen as adequate; where organizational members in different, but related, positions have a good understanding of others' problems; where little tension exists among interacting groups and organizational pressure for better performance is not seen as unreasonable or excessive; where the administrator has a high awareness of problems of others in the organization and effectively solves conflicts; where non-supervisory and non-medical personnel feel that their respective immediate supervisors understand their points of view and evaluate them highly on technical skill; where hospital policies, rules and regulations are clearly defined in the opinion of organizational members; and where co-ordination of the preventive type is relatively good.

A separate problem, not addressed extensively by Georgopoulos and Mann, has to do with organizational adaptation to externally-induced change. Problems of this kind are potentially more difficult, more dangerous, and more disruptive than internally-induced change because of the magnitude, significance, and impact upon the organization are difficult to predict and evaluate. The organization has little or no control over externally-imposed changes. It may be insufficiently flexible to respond to such changes and may be unable to respond to the new situation as promptly as needed. Some strain for the organization and its members is likely; the more sudden or unpredictable the external change pressure, the more the strain.

Hospitals are particularly vulnerable in this respect because of the continuous dealing with their environments. After all, their main objective is continuous service to the community. They are expected to meet the relatively normal health needs of the community, to be responsible to its general and specific demands, to handle any emergency or crisis, and to keep up with any and all advances in health and medicine.

More questions are posed than are answered. How successfully do particular hospitals meet certain temporarily unpredictable changes necessitated by extra-organizational conditions? How much strain do these changes create for the organization and its members? Georgopoulos' and Mann's impressions were that hospitals are very successful in adapting to sudden, abnormal rises in patient loads. Of course, the price is considerable strain for the organizational members. The more successful, the higher the intra-organizational strain; a disequilibrium ensues which may lead to neglect of normal problems and routines. Co-operation among R.N.s and co-ordination within the nursing department are important as facilitating factors in this regard, as R.N.s have to absorb a good part of the initial impact.

As for what relationship, if any, exists between adjustment to internal changes and adaptation to externally-induced change in the hospitals studied by them is concerned, the authors found a low correlation. Those hospitals most successful in adjusting to internal changes are not the same as those most successful in adapting to external changes. They admitted a vague understanding of how hospitals manage to adapt to changes in medicine, nursing, pharmacology, pathology, and other relevant fields, as well as to changes in communities which

they serve, or the factors which facilitate or hinder adaptation of this kind. A similar lack of understanding existed as to how hospital organizations can maintain sufficient flexibility to meet emergencies successfully and without strain.

The studies of community hospitals referred to above were of aid in this dissertation in the following ways. They all suggested avenues of approach to an uncharted area of research. They all suggested, directly or indirectly, areas of hospital activities needing investigation -- that required description and analysis. Those of Zugich, Harkness, and Holloway dealing with facets of policy- and decision-making were also of aid in suggesting the kinds of questions to be asked of respondents in interviews and questionnaires, as well as offering leads as to observations that ought to be made.

CHAPTER IV

ANALYSIS OF THE MILLS SPRINGS COMMUNITY HOSPITAL

Historical Background of General Hospital Developments

Let us briefly look at the changing national environment in terms of advances made in public health and its effects on hospitals from 1900 to 1950. One is struck by several significant trends in the United States. Between 1900 and 1950, the death rate dropped almost 45 percent, from 17.2 to 9.6 for each thousand persons in the population. According to Bachman,[1] these figures reflect three major factors: the control of communicable diseases, the advances in medical science, and the increased use of medical facilities.

The impact of these changes upon the medical profession was dramatic and many accounts relate to controversies which the new ideas ushered in. It was the Flexner report, Medical Education in the United States and Canada,[2] which spurred on the medical profession -- initially in opposition to reforms and changes -- to adjust to scientific medicine and to inaugurate in 1910 a series of sweeping reforms in medical education to make it respectable. Specialization became widespread by the first quarter of the century as advances in medical knowledge snowballed. Virtually all American doctors could have been classified as general practitioners in 1900. By 1949, only 38 percent were so classified by the American Medical Association.

The increased use of medical facilities is seen by Bachman and others as equal in importance to the advances in medical science in reducing the

death rate, since having knowledge is useless unless it is put to work. With the rise of the general level of education and standard of living, the knowledge and acceptance of medical advances were for the most part transmitted with remarkable speed throughout most of the country, although benefitting people differentially according to their region, community, race, and socio-economic level. One indication of the increased use and prestige of hospitals and professionally-trained personnel can be found in the use of hospitals for childbirth. The number of babies born in hospitals in the U.S. had reached 86.8 percent by 1948 and from 1900 to 1949 the infant (those under one year) mortality rate had dropped from 162.4 per thousand live births to 31.3 as a result.

During the period of 1900-1950, American society was on its way toward an economy of abundance for most of its people. The rising standard of living was reflected in better educational facilities and longer terms of schooling for the average person. Mushrooming communication media transmitting news about medical discoveries and advances reached many of these people. They were enabled to make donations to hospitals and to support the whole sequence of developments in medical science as never before because of the benefits accruing to them of an expanding economy. An improved highway system made possible carrying the sick to hospitals and for relatives to commute to visit them. People became more selective in their choice of physicians and hospitals, traveling greater distances to find the most eminent physician-specialist. A division of labor among hospitals according to geographical location began to occur, with big city hospitals attracting the most advanced professional personnel. Increasingly, minor surgery, obstetrics, and geriatric cases were relegated to the small, outlying hospitals.

The national trends discussed thus far can be traced back at least to 1900 and they increased in tempo until approximately 1930. In the decade of the 1930's with its severe economic depression, developments of all sorts were brought to an abrupt halt, but with the beginning of World War II, the upsurge of activity along all fronts, including advancement of medical and biological sciences, the growth of medical specialties, increasing utilization of hospitals, etc., was terrific. Although the economic depression of the 1930's brought catastrophe to many voluntary hospitals all over the nation, some weathered the storm relatively intact. There was an appreciable drop in occupancy but operation continued.

The New Deal encouraged trade unions and this in turn acted upon employer-employee relationships in many communities. Hospital employees did not typically join unions, but they began in the larger communities to request increases in wages and improvement in working conditions as the general standard of living began to rise again.

Related to the depresssion and the rise of unions was a significant change in the economic life of the voluntary hospital. The creation of the Blue Cross, a plan for voluntary hospitalization insurance, and other similar plans occurred then. Backed by labor unions and hospitals as a means of deliverance from impossible economic conditions, this plan succeeded at first in the big cities. By 1954, 57 percent of the American people, the largest portion being industrial workers in the big cities, were covered by some form of voluntary hospitalization insurance. They could afford hospitalization without asking for charity.

The first, and probably most severe, effect of the war upon hospitals was the drafting and enlisting of doctors and nurses for military service at a time when, due to the increased demands prompted by the Blue Cross

and other plans, more people crowded into hospitals. Government subsidies speeded developments of many kinds in the field of medicine and medical technology to fulfill the great demands made by dramatic human needs born of warfare. They hastened the spread of information about these developments. The discovery and use of antibiotics was the first development, beginning with sulfa drugs and penicillin. The second development was the rapid spread of the technique of early ambulation, cutting down the time spent in hospital. Professionally-trained persons were increasingly required, however, to administer the new drugs, which meant another reason for hospitalization and helping to send the price of wartime and post-war hospital care soaring. Changed procedures in hospitals were the result and personnel had to be trained and retained to keep abreast of the times.

In the country, generally, the booming war industries also had an impact on hospitals as greater numbers of workers were brought into the cities to increase war production. There they fast became acquainted with personnel policies, Blue Cross insurance, and city hospitals where medical techniques were most advanced. Post-war inflation had raised wages and the cost of living for organizations as well as individuals. Many hospitals were now bulging with patients at a time when almost no physical renovation had been made during the depression or war years and they struggled desperately on a seller's market for building materials and modern facilities. As costs rose, hospitals everywhere raised their prices.

Public criticism of the rising cost of hospital care resulted in political pressure and, partly in reaction to it, the federal government passed the Hill-Burton Act. It was a measure providing some subsidy to hospital building programs. This act encouraged state-wide surveys of existing facilities and needs and it distinguished among hospital types: (1) health

centers, (2) outlying hospitals, (3) district hospital centers, and (4) major medical centers. It recognized current trends and attempted to build upon them by defining the possible relationships which might be encouraged among hospitals of various types. The national hospital associations were at the same time arguing for and succeeding in getting an arrangement whereby final power to make appropriations was left in the hands of state and local levels.

Each voluntary hospital existed as an entity unto itself and was molded by its immediately surrounding community at the beginning of the twentieth century. Much the same, if not more so, probably was true for proprietary hospitals. Recognition and support for both types of hospitals came from the locality. The trends noted briefly above converged to force a new and broader perspective upon people in the health field. In many communities the problems of running effective and efficient hospitals and training adequately prepared professionals became too big to be handled on a local basis.

The American Medical Association (founded in 1847), American College of Surgeons (1913), American College of Physicians (1915), American Nurses Association (1897), American Hospital Association (1907), and the American College of Hospital Administrators (1933) all saw as their function the improvement of their own professional groups and the dissemination of specialized knowledge among them. Power within these groups shifted to the national level and became the source of strong influences or forces which helped to break down the insularity of local hospitals as time passed. In one way or another, all of these and other medical or related organizations acted upon hospitals and/or the occupational groups within hospitals to modify and improve their standards of operation.

The Hospital Picture in Mills Springs*

The first hospital in Mills Springs was founded in 1918 by two medical doctors who had been classmates and had graduated together from a prominent mid-western university. Dr. Charles A. Morton, a native, and Dr. Francis M. Davis, born in a nearby township, were joined in starting what was a proprietary hospital by Miss Harriet Chapple, a registered nurse. The three purchased a mansion located on the main street in town and they remodeled it into a hospital with a top bed capacity of 15. (The large house had been built by a prominent pioneer-merchant family in the early 1870's.) This was the Harriet Chapple Hospital.

Dr. Davis fell down the hospital's elevator shaft one night in 1919 and died, leaving Dr. Morton and Harriet Chapple-Dunk to run the profit-making medical practice and hospital together until 1930, when Mrs. Dunk died. In 1919, Dr. Harry J. Crawley, another graduate of the University of Michigan, joined the staff and was with the hospital for some 10 years. Dr. Morton and Miss Estelle Evans, a P.N. who had trained at the Harriet Chapple Hospital, ran the organization until 1943, when Dr. Morton died. The beneficiaries were Miss Evans and Mrs. Morton, now the wife of Mr. Smith, President of Smith Dairy Farms. No medical doctors were affiliated with the hospital again until 1948, when Herbert Roos and his nephew Herman Roos and the son-in-law of the former, Albert Rhine, purchased the hospital and re-named it the Morton Community Hospital. These doctors ran it as a non-profit corporation.

In large measure the Chapple/Morton hospital fulfilled the needs of the one-industry community for a local medical facility in which minor surgery, obstetrical confinements, geriatric cases, and various emergencies

*For ethical reasons, names and other identifying characteristics have been fictionalized within reason.

such as flu epidemics could be handled. From time to time and for various purposes -- mainly for the support of charity cases and for aid in the purchase of major equipment or for minor renovations -- the Chapple/Morton hospital enjoyed the sometimes substantial, private, financial aid of two very close friends and patients of Dr. Morton: the second-generation head of the Sampson Mill and the head of the Smith dairy farms enterprise.

Prior to the establishment of the Harriet Chapple Hospital, most medical and patient care requiring prolonged treatment and confinement had been administered by the few available general practitioners in the homes of the patients who could affort it. Less serious and confining illnesses continued for some time to be treated on an individual house-calls basis. In this community a small number of the residents (who were financially well-off, who had earlier than most others realized the benefits to their well-being of more specialized and advanced medical care available elsewhere, and who had lost the traditional fear or abhorrence of hospitals as places where the less fortunate or indigent ended their days) had previously traveled to hospitals located in the capital or in other large cities in the area -- sometimes out of state -- to satisfy their personal needs in this regard. With the establishment of the Chapple/Morton hospital there was lessened need for such traveling to have minor ailments taken care of.

Unlike the traditional situations portrayed in a number of case studies of hospitals, the Chapple/Morton hospital from its outset served the socially prominent, the middle class, the workers, and the indigent. This hospital, though quite small by modern standards, was evidently of sufficient size and quality to adequately treat and house the patients of Dr. Morton who required hospitalization. (People went to hospitals or doctors less

often in those times than they do today.) Over the years, Dr. Morton's local and area practice grew and the hospital enterpirse modestly expanded its operation. Apparently, the hospital's level of care improved with the adoption of the modest advances being realized in medical science. More of the community's citizens utilized the hospital somewhat more frequently.

The basic organization of the Chapple/Morton hospital was very informal and simple by comparison to the Mills Springs Community Hospital of today. The first set of physicians, and then the latter set, were in firm control of their domain which was (in both instances) in effect a medical monopoly screening out competition from other practitioners. The doctors made the basic policy decisions. In both stages the hospital was subject to certain local ordinances and to extra-community regulations enforced by state inspectors of sanitation and safety but largely free of such political authority otherwise. The restrictions on their medical practice coming from the county and state medical associations were slight since all were members in good standing. Each hospital, in short, was able to meet fairly easily the various sets of standards then prevailing, although the second was having a more difficult time because standards were rising quite rapidly in the post-war period.

Although there was no board of trustees as such, nevertheless the original hospital group informally sought and was offered the friendly advice and counsel of the Sampson and Smith interests on the various aspects of operating the organization as a "community" facility. Bearing considerable financial and political power and prestige, they saw their private financial and moral support of the hospital as one of the symbols expressing their status in the community. Seeing themselves as "stewards" (more accurately custodians) of the community, their support of the hospital was an act of

charity or noblesse oblige. The hospital served "their workers" after all, did it not? It was a duty of friendship as well. This state of affairs continued well into the 1940's.

A far-reaching dependency relationship -- long typical of the community as a whole -- existed between the patients and the hospital staff and between the hospital's upper level and its few employees. Except for the more affluent and socially prominent patients, most were in no position to make personal demands on the hospital. The daily regime of the hospital was set by the medical staff. The typical patient acquiesced to the rules and regulations set from the top down. Similarly, the small number of hospital employees -- almost all women -- were dependent. They consisted of two groups: (1) educated local or area girls who were graduate nurses (R.N.s) and (2) relatively uneducated, older women from the community or area who were working as dietary, housekeeping, or aide personnel. The salaries of both groups were not high and held fairly close to the subsistence level in the latter's case. Most of these women in both groups were married and were working mainly to supplement their husbands' earnings or to help support their families in the case of the single women.

Dr. Morton (and later Dr. Bert Roos) was for all intents and purposes the Doctor-Administrator, carrying an extensive practice along with his key administrative duties. First with his partner Harriet Chapple, and then with Estelle Evans, he conferred daily with his Head Nurse-Supervisor and he channeled through her any recommendations regarding employee behavior or policy which she discharged in an informal manner. All of the "lower" employees were under her immediate control. She supervised the full-time and part-time R.N.s (varying over time from 2 - 3), trained the

nursing aides and supervised them (2 - 3), and directly supervised patient care. Supervision of the housekeeping and dietary workers (3 - 4 persons), tending to the distribution of drugs and linens and replacement of these supplies, rounded out the activities of the Head Nurse-Supervisor. With the help of a part-time female bookkeeper, Miss Evans also went over the hospital's financial accounts. She was the manager, as had been Miss Chapple before her. Medical policies, treatment, and facilities were the exclusive province of Dr. Morton in the first instance and later was shared by the physicians in the group practice. The Supervisor was periodically in informal consultation with the doctors, upon their invitation, on some of these medical matters in both the Chapple and Morton hospitals.

As respected friends of the elite (Dr. Bert Roos was a classmate of Mr. Smith at college) and as professionals, the upper level of the hospitals were fully entrenched in the social system of the community. The lower level of female employees -- skilled nurses and unskilled personnel combined -- had a corresponding low position both in the hospital and in the community. There were no in-between personnel to worry about. The fact that the first hospital was proprietary made it only minimally responsible to the community, and then only through its patrons or financial supporters during the Second Stage. Later, the hospital was still a monopoly of sorts, although presumably non-profit, and enjoyed the support of the Smiths. In both periods, hospital affairs were essentially considered apart from the usual kind of business or community concerns; the operation to be conducted with unique goals in mind, and to be held accountable to its professional owners.

The traditional pattern of power and authority obtained in the Chapple/Morton hospitals, as it did in the community -- both comparable to Weber's

model of the traditional type of organization. The role of the physician was in a sense sanctified by customs passed on from past generations. The younger men within the profession gave obedience to the older ones, not only because of the latter's status as teachers (which relationship is retained in part in medical practice today) but also because of the perceived moral virtues of the older doctors. In the old-fashioned sense, they were "betters" as well as superiors. The relationships among the doctors were distinctly those of either comrades or subjects, depending upon the age of the man and his place in the apprenticeship system. In the Morton Hospital, family ties and changes in the medical profession altered this traditional pattern somewhat, but it could be detected operating.

Paper work in both hospitals was minimized at all levels (although the latter had more such demands due to the nature of payment) and management followed rules of thumb and tradition, rather than a body of technical knowledge. Nobody -- even in quite a few of the larger hospitals of the time of the Chapple Hospital -- seemed to consider specialized training in office management necessary or administrative work as requiring the full-time services of an able-bodied man or woman. Competence was respected and required for many tasks, however, but it was assumed that in most positions (other than in the top or professional) a person of normal intelligence and good character, loyal to the organization, could easily acquire the necessary skills under supervision.

Those improvements made in the medical arts and sciences were introduced mainly by the physicians as a part of their practice and professional responsibility. The at first limited demands or needs for extensive laboratory tests and other ancillary services were satisfied on a crude basis locally in the Chapple Hospital and later contracted, for the most part, in the

Morton Hospital. Both were deficient in this respect. The first hospital did purchase a used X-ray machine which was used by the group practice doctors later. However, a virtual revolution in both medical education and ancillary specialization was in the making in the country, which in due time was to shake the entire hospital system in North America, some of whose effects were to be profound on the hospital scene in Mills Springs.

Before passing on to the description and analysis of the modern hospital situation in Mills Springs, some of the loose ends need tying up. The Chapple Hospital had weathered the storm of the depression intact, being tided over that rough time by the aid of its financial "angels". It had experienced an appreciable, temporary drop in occupancy, but its operation continued. As for the impact of unionization upon either hospital, it was nil in Mills Springs for the reasons already discussed.** The hospitals' female labor was quiescent. Blue Cross was late in coming to Mills Springs with the re-opening of the Morton Hospital. Well into the 1940's, and to an extent today, charity was the main means used to supply medical and hospital care to the needy. From 1943 to 1945, Mills Springs suffered a loss not only in terms of a hospital staff, but also in terms of the hospital's closing. Patients had to go out of town. Soon, however, the doctors Roos were recruited by prominent citizens. The community actually benefitted after the war by the addition of several younger and better-trained professionals to the local medical practice and hospital. Newcomers from larger cities and the commuting workers did bring in new medical values and increased needs in this area during the war and after.

In any particular community, the impetus for the building and organization of the hospital may arise from many different sources. Those

**See above, Chapter 2, pgs. 74-75.

community considerations bearing on the decision to build the new hospital in Mills Springs were presented above in the basic terms of the hospital issue.*** In this section, the various internal considerations and activities which went into the actual building and organization of the hospital and consequent developments therein will be examined in some detail.

Of the many considerations which rationally enter into any decision to build a hospital, some are: (1) the size of the community and its tributary population; (2) the availability of existing hospital facilities in nearby communities; (3) the character of transportation and transportation routes available; (4) the sickness rate of the community; (5) the habits of the community as to utilization of hospital facilities; and (6) the physicians available for staffing the hospital. Explicit attention was devoted to few of these considerations, and only in passing, by the people responsible directly for building and organizing the Mills Springs community hospital.

Already commented upon, and clearly recognized by these decision makers as non-problematic, have been the considerations encompassed in (3) and (5): to wit, that good highways and adequate private and public transport were available linking Mills Springs with the capital and other communities, but that by preference the Chapple/Morton Hospitals over the years had been patronized increasingly by local citizens of all levels and by rural residents in the environs. The nearest hospital -- located in the neighboring community and county seat -- is a voluntary, non-profit, general, county-owned one serviced mostly by osteopathic physicians and some M.D.s. On the basis of some unfortunate incidents, it has enjoyed only a fair-to-poor rating on quality of medical practice and care among all of these people,

***Ibid., pgs. 85-90.

and it was and is not patronized by the bulk of them. Besides, a rivalry of long-standing has existed between Mills Springs and the other community. For those critical cases requiring very specialized treatment and care, the majority of local community people still travel primarily to the large general hospital located in the capital. Since the new hospital has been built and put into operation, certain concomitant changes which have occurred in the local medical practice have lessened the need for most people to do this any longer.

Local pride and the desires and ambitions of the activist and others in the community largely determined the construction and initial organization of the hospital. Involved as a part of local pride was the avowed aim of maintaining traditional neighborliness with the rural people who were seen to be constituents of the community as far as utilization and contribution to the hospital were concerned.

Although there have been many studies into the relation between the size of a community and its hospital need, done under the auspices of the United States Public Health Service and of various professional organizations, such as the American Hospital Association (these studies relating specifically to beds provided for the care of acute general diseases), those people deciding to build the Mills Springs community hospital did not consult any of them extensively nor did they heed those they did consult to the letter. Such prescriptions as were contained therein, or in other available sources, or which could be gained from consultation with experts in the field, were largely ignored or regarded as irrelevant or unimplementable.

The hospital "consciousness" of the community, spurred on by the activist and his cohorts, was a factor of far greater importance in building

and organizing the hospital than were rational or objective considerations. It was felt at the outset by those doing the planning -- in fairly vague terms -- that the emergency, obstetric, minor surgical, and geriatric needs of Mills Springs would remain constant and that they could be adequately cared for by the four M.D. physicians in the Morton Group Practice and one independent osteopathic physician in a new hospital with a proposed capacity of 25 - 35 beds. This estimate was later found to be a gross miscalculation of both needs and bed space required. Of paramount concern to the power holders on the Board, ostensibly, was that the new hospital organization should be more responsive to the wider community's needs than had been the Chapple or Morton Hospital.

STRUCTURAL-FUNCTIONAL ANALYSIS OF MILLS SPRINGS COMMUNITY HOSPITAL, INC.

In what follows, the major components and sub-parts of the new hospital organization**** will be described and analyzed along with their particular functions. Next, the interconnectedness of these activities, but especially in regards to policy-formation and decision-making on the various levels, will be treated to reveal the organization's power patterns. This analysis will incorporate such events in a chronological sequence.

As in all voluntary, non-profit, general hospitals, the three basic components of the Mills Springs Community Hospital, Inc., consist of: (1) the Board of Directors, (2) the Medical Staff, and (3) the Administration. Since the Board is wholly and legally responsible for hospital

****Material presented herein pertains to the time of the actual research, 1959-61. Biographical sketches are in Appendices A-D, also.

policies, property, and services, and directly represents certain community values in its organization, its structure and functions will be depicted and analyzed first.

The "By-Laws of the Mills Springs Community Hospital, Inc."[3] -- largely the handiwork of the lawyer-activist -- is an informative document in many ways. It chiefly spells out in formal terms the purposes, membership requirements, election procedures, governance, responsibilities and duties of the corporation, its board and officers, etc. But it is necessary to examine the informal aspects or the actual workings of this body to fully understand how and why certain events came about.

Board Structure and Activity

There was very little change in the composition of the hospital's Board of Directors in its first six years plus of operation. Only three of the original nine members elected have been replaced: two resigned voluntarily and one failed to be re-elected by the members of the Corporation. The offices of President, Vice-president, and Secretary have each been occupied by two different people, whereas that of Treasurer has been filled by the same person since the hospital's inception. Four of the members of the present Board are key influentials in the community; three are top influentials (the one person not re-elected makes four); the remaining members lack appreciable influence or power. These three (women) have been elected, evidently, for services they had rendered in the original hospital drive or for duties they could perform on the Board -- two of them have been Secretary of the Board. One former board member, a local florist, who had been active in the initial solicitation of contributions resigned from the Board for personal reasons after having served

less than one year. The following thumbnail, biographical sketches are of the current and/or important members of the Board of Directors.

Certainly, the most important of the members of the Board and the real driving force behind the building and organization of the new hospital is the activist, Herbert P. Warrington. This key influential was born in Mills Springs in 1877, the son of an itinerant cooper who later became a local cement contractor. Educated in Mills Springs schools, Warrington worked for a time with his father, served in the Spanish-American War, later graduated from a prestigious university with a LL.B. degree, married a local girl, and settled down to practice general law in the community for over fifty years. Childless, the bulk of Warrington's avocational energies has been directed to community service. Besides having initiated the hospital project, Warrington was Chairman of the Construction Committee and largely responsible for planning, and supervising construction of, the physical plant. He has served two terms as President of the hospital Board, and is serving a third term. (He was Vice-President before incorporation took place.) Previously he had been a member of the County Hospital Board. For seventeen years he had been Chairman of the County Selective Service Board. He has held numerous offices in civic, fraternal, political, social, and religious (Methodist) organizations in and out of the community. Very well-off financially -- possessing considerable property and investments -- Warrington has in 70 years consolidated his pre-eminent position in the community. Now retired, he devotes by far the most time to the hospital of any board member and is always on call for advice and aid. In a real sense, it is his "baby".

Martin O'Toole, a local and prominent automobile dealer, was the first Board President, serving two consecutive terms. As a widely-known, key

influential in the community, he spearheaded the membership drive for the newly-formed Hospital Corporation. Born on a farm in 1903 in the northern part of the state, the son of a lumberman, O'Toole received his B.A. in Industrial Arts Education from a "normal" school. He taught the subject in the local high school for some seven years before he married a local girl, the daughter of a prosperous farmer. His involvement in civic, fraternal, religious (Methodist), and social activities in the community is considerable.

Thomas F. Kingston, another key influential, was born in 1906 in the eastern U.S. A resident of Mills Springs from the age of four, he graduated from the local high school and went immediately to work in his father's woolen mill which he had founded after having worked for the Sampsons for a time. Since their father's death, Mr. Kingston and his brothers have operated the plant. For 30 years or so, Mr. Kingston has been Vice-President of the company. On the hospital Board, he has served as Vice-President for three terms. He has held offices and actively participated in the activities of two service clubs, the Community Chest, and Boy Scouts. Congregational Church and Republican Party activities round out his interests.

The fourth key influential on the Board is Mr. Guy Smith, the President of Smith Dairy Farms, Inc. He was born in Mills Springs in 1895, the son of a dairy farmer who became an ice cream manufacturer. He has been Vice-President of the local bank and is presently one of its board members. The most recently elected member of the hospital Board, he is also on the Board of the Rotary Club. He is a member of various fraternal, social, and patriotic clubs such as the Elks, V.F.W., American Legion, Masons, and

Country Club. He is also very active in Methodist Church affairs. Mr. Smith has a degree in agriculture.

The top influentials on the Board include the following: C. Carlyle, the President of Mills Stamping Company and a very recent addition to the hospital Board, was born 43 years ago and raised in Mills Springs. Graduated from the local high school, he began his work career in the stamping plant his father had founded, which he now heads. Mr. Carlyle has confined his community activities to participation and contributions to the Lions Club, Boy Scouts, Golf Club, Masons, the School Board, and Congregational Church.

Mr. William P. Kennedy, 58, was born and has lived most of his life in Mills Springs. He is the Vice-President and Cashier of the local bank. He entered the financial world upon graduation from the local high school. His father, a farmer, was the brother-in-law of Mr. Warrington. Mr. Kennedy has been the sole Treasurer of the hospital Board. His other activities have been restricted to participation in the Kiwanis Club, Methodist Church, Masons, Boy Scouts, and Y.M.C.A. Although considered an influential by many, Mr. Kennedy is not one of the more aggressive or ambitious of this group.

Mr. Dean Smathers who is no longer on the Board -- some say because he was on the "wrong side" of the school issue and thus "eased out" by Warrington -- is a top influential with a following; in fact he could be considered to be a "coming" key influential. A farmer, 64, he was born in Kansas but has lived in the Mills Springs area for 57 of his years. Possessing a degree in agriculture, he operates a poultry and dairy farm with his sons. He served one term as Vice-President of the Board. His many activities include important offices held in conservation and farm-

related circles or organizations, on the local, county, and state levels. The Republican Party, Kiwanis, Boy Scouts, School Board, Y.M.C.A., Masons and the Methodist Church are other associations in whose activities he participatesor in which he has held offices.

Another farmer on the Board, who is respected if not as influential, is Mr. Ross Rowlands, 58. He was born in, and has been a life-long resident of Mills Springs. A high school graduate, running a modest family farm, Mr. Rowlands' interests lie in Farm Bureau, Rotary, Blue Cross, Boy Scouts, Masons, and Methodist Church activities. He has held offices in each.

The remaining two Board members are women and are not top influentials: Miss Estelle Evans, 54, at present a doctors' assistant, was born on a farm in a nearby county and has lived in Mills Springs since the age of 19. She out of economic necessity entered the work world early and eventually became a practical nurse and for a long time was the Superintendent of the old Morton Hospital. Presently, she is associated with the group practice in town as an office supervisor and doctors' aid. Her main outside activity in addition to the hospital Board, is in the Baptist Church. She is also a founding member of the hospital Auxilary Board.

Mrs. Stanley Evers, 57, was born in a small town in Pennsylvania. For the last 16 years, she and her family have resided in Mills Springs, after having lived in a half dozen different communities, mainly in the Midwest. A high school graduate, she is the Secretary and Bookkeeper for the Mills Stamping Company. Her husband runs a small appliances store. Previously, she had been the secretary of the local school superintendent and the school system's accountant. She has been President of

the Business and Professional Women's Club and is secretary of every other women's group of which she is a member. Participation in the activities of the Methodist Church, Girl Scouts, Community Chest, and on the Board of Education round out her interests.

A detailed study of the informal activities and the recorded minutes of the hospital Board from its inception in November of 1955 through October of 1961 has been made with the intention of documenting the kinds of policies and decisons which had been initiated and implemented by the Board in general, and, in terms of key issues and projects, how and by whom specifically. The actual observation of a number of more recent meetings of the Board was accomplished to supplement the in-depth interviews with all the board members (interviews which tapped the existing patterns of values and attitudes) to discover how the Board is presently operating in these respects and what the prospects for the future are. What follows is necessarily a distillation of all the pertinent information so gathered.

In the period 11/55 - 10/56 thirteen Board meetings were held. The really busy year, as far as crucial organizational business transacted is concerned, was that of 11/56 - 10/57, during which time 20 meetings were held; also in this year the annual October meeting of the Corporation -- open to all -- was instituted at the suggestion of Mr. Warrington. Fourteen meetings were held from 11/57 - 10/58; 13 from 11/58 - 10/59; 11 from 11/59 - 10/60; and 10 from 11/60 - 10/61. Of course, there were many more informal gatherings attended by committee members, whose proceedings had not been recorded, but valuable second-hand information about these was gathered in the personal interviews.

Attendance figures were kept for the first three critical years of the Board's existence and they are very revealing. They show the key influentials -- Misters Warrington, O'Toole, and Smith -- and Kennedy, the top influential, in virtually constant attendance. The best attendance record was compiled by the first Secretary, a Mrs. Jones, who resigned after three years' service. The worst record was that of Mr. Kingston who was very busy with his vocational pursuits. Nevertheless, his was an important influence and he consulted regularly and informally with Misters Warrington and O'Toole on various matters, but especially on strategy and tactics. Miss Evans was a fairly regular attendant, whereas Mr. Rowlands and Mr. Smathers both missed a little over 25% of the meetings due to their farming activities.

In general, during this early period, the majority of the proposals for the various projects to be undertaken and for the resolution of various issues which cropped up were suggested to the whole Board and were implemented by the influentials in constant attendance. In the first year, a local doctor, and, later, the Administrator appointed served as consultants, advisors, and initiators.

In the first term, the officers were: President, Mr. O'Toole; Vice-President, Mr. Kingston; Treasurer, Mr. Kennedy; and Secretary, Mrs. Jones. At first there was little need for setting up many committees to handle business. The first two important committees were: (1) the Construction Committee, under Mr. Warrington's chairmanship, consisting of Misters Smith, Kingston, and Rowlands, with an outside party -- the new community co-ordinator -- as consultant; and (2) the Finance Committee, with Mr. Smathers as chairman, consisting of Mr. Kennedy, Miss Evans, and Mrs. Jones. The committee heads, usually, or various committee members,

would present their reports to the whole board for approval and/or action. The President, in charge of public relations, would later pass on to the local newspaper publisher progress reports in the various areas, which were printed as news.

The first order of business, in the first and subsequent years, consisted almost invariably of financial statements issued or reported by the Treasurer. A regular accounting of income and outgo was kept scrupulously. Membership progress reports -- in terms of pledges made, paid, and delinquencies therein -- were made by the President and they took up time in 5 meetings the first year. This problem of collecting delinquent pledges was one of considerable magnitude and was to continue in the years to follow. (Gift-giving evidently is easier said than done.) While construction was going on, various contracts for supplies, labor, equipment, and utilities services were let (mainly on a pay-as-you-go basis) and these bills were periodically due and needed payment. Yet, with certain pledges outstanding on a chronic basis hampering these payments, credit had to be secured from the various suppliers and contractors by the reluctant key influentials to allow essential work to continue. Fortunately, the credit ratings of these people were high among the local and regional firms with which they primarily dealt. The city was more than willing to grant credit on the utilities services, due to political considerations and personal ties (already mentioned above) as well as for reasons of community pride. The various members of the Construction Committee concerned made their reports and the Board as a whole acted upon their requests and/or recommendations with dispatch.

The important policy formulations contained in the "Bylaws" of the Corporation and an amendment to them took up considerable time in two

meetings, with Misters Warrington and Smathers, respectively, making important contributions and recommendations. It was Mr. Smathers who had put into the "Bylaws" the amendment to restrict practice in the new hospital to M.D.s only. It was said by many informants that he was prompted to this action by the eldest of the group practice physicians (his personal physician) and, although reluctant to do so, Mr. Warrington voted to unanimously pass this amendment. (The physician was also his personal doctor and friend.) This action was to result in the refusal of a number of patients of the local osteopathic physician to honor their pledges.

The proposed organization of a women's hospital auxiliary was presented by Miss Evans at one meeting and subsequently approved by the Board at another. It was seen by them as a good device to involve community women in the hospital's operation and a public relations ploy. The auxiliary formed, however, is predominantly composed of wives of prominent men in the community and is basically a social activity with little direct bearing on the hospital's policy- and decision-making activities.

Although not a member of the Board (the "Bylaws" prohibit it), the leading younger physician in the group practice and the first person among them to opt for the new hospital, Dr. Rhine, was very early brought in as a consultant to the Board on medical matters -- organizational and otherwise -- at the instigation of Mr. Warrington and Mr. Kingston. He was supported strongly in this regard by Miss Evans. It was Dr. Rhine who proposed looking into the possibility of transferring the Ford Foundation Grant already made for up-dating the laboratory facilities of the old hospital to the new one and he brought to the Board's attention the necessity to seek in this way, and in all other ways possible, to build and to organize a hospital worthy of accreditation by the Joint Commission on Accreditation

of the American Hospital Association. This matter of accreditation, and the steps necessary to attain same, became problematical as time transpired, but the former item of business was disposed of in three more meetings with a successful transfer of funds from the Ford Foundation for new laboratory equipment being accomplished. Possible federal grants to the hospital, and the Hill-Burton Plan specifically, were brought to the attention of the Board by President O'Toole, but Mr. Warrington and Mr. Kingston both voiced strong opposition and suspicion of federal governmental aid and of the "strings attached to it" -- namely "stringent controls over every aspect of operations". The notion was dropped.

Other board business in this first year of operation had to do with: public relations releases to solicit additional needed contributions; the need to secure affidavits for various purposes, such as meeting the legal requirements for the transferral of the Ford Foundation Grant; naming the hospital (the name suggested by Dr. Rhine was approved by the Corporation's membership); nominating and electing new officers; securing windstorm, fire, and extended coverage insurance; and the suggestions of Dr. Rhine as related to new medical equipment needed in the new hospital and the old but serviceable equipment in the Morton Hospital which could still be used.

In the second year of operation, 11/56 - 10/57, more organizational considerations than before were added to the business transacted by the Board. With the exception of a new Vice-President, Mr. Smathers, the newly-elected officers were the same as before. Part of the business of 13 of the 20 meetings in this year had to do with the usual financial reports and bills due or contracts let.

At the first meeting Dr. Rhine advised the Board that the physicians had been offered an operating table at a great reduction in price by a

national medical equipment firm which had used it in the region for display purposes only. Misters Warrington and Smith moved, and it was carried by the Board, that "Dr. Rhine be authorized to buy it if in his judgment it is what is wanted for the new hospital", and he later did purchase it. At this same meeting Mr. Warrington spoke at length of the necessity of the Board to be seriously thinking of appointing an administrator for the new hospital. A general discussion followed, but no definite plans in this direction ensued.

At the next meeting, Dr. Rhine and his younger colleague, Dr. Sheridan, presented a detailed list of furniture and medical equipment needs for the patients' rooms. There followed a discussion relative to the cost of furnishing such rooms and whether this should be done on the basis of contributions by individual families or organizations so desirous. A policy was adopted by the Board for the furnishing of rooms, suggested by Miss Evans and Mr. Rowlands, to the effect that "organizations which had supported the new hospital be allowed to furnish a room and have a plaque placed on the door in recognition of same, subject in all cases to the Board's approval." Policy relative to individuals being granted similar permission was tabled indefinitely.

At the next meeting, Dr. Rhine presented a guest who was willing to discuss and assist the Board with plans for equipping and administering the proposed laboratory in the new hospital. His experience and training in hospital administration was duly noted by the Board, but only that. An order for additional X-ray equipment was also discussed by Dr. Rhine, and he then presented the application form for membership in the Michigan Hospital Association to the Board. The proper filling out of it was delegated to Miss Evans.

The continuing problem of delinquent pledges was presented by President O'Toole and a plan to personally contact these people and to apply personal pressure was proposed by Misters Warrington and Kingston. It was unanimously but reluctantly approved. The key influentials were to do the job. At another meeting, this same problem of delinquent payments on pledges was again discussed; and a motion recommending the publication in the local newspaper of the names of donors who had or had not paid their pledges -- offered by Miss Evans but failing a second -- was effectively defeated.

The matter of the hospital's administration was brought up at this same meeting by Misters Warrington and Kingston who moved that a committee be immediately set up to study the matter of recruiting such personnel and with the appointment of an administrator to be its prime concern. The Recruitment Committee elected at this meeting consisted of Misters Smith, Kingston, and Dr. Rhine. In 2 to 3 weeks time it was to make its recommendations at a special meeting, after having solicited and received and reviewed applications for that top position.

The special meeting saw the consideration of a number of applications which had been solicited through the professional hospital administration associations -- formally -- and through several consultants in the area -- informally. The committee had concurred that in their small hospital the Administrator should be "trained in and capable in some other job to combine those duties with administration." Several applications were thus eliminated "off the bat." The committee recommended for the post a young and promising laboratory technician-administrator, Mr. B. Edwards, who was about to complete his military service in that capacity. He would be available for the job in March upon his discharge from active duty with

the U.S. Army. After having his application read to the Board, Misters Warrington and Kennedy moved to empower the committee to offer Edwards the job and such was subsequently done.

Dr. Rhine reported to the Board on his continuing investigation for securing vital laboratory and pathologist services for the new hospital, and he underscored the point and explained that in order to be an accredited hospital the laboratory had to be registered under the name of a registered pathologist. He recommended such a pathologist, a Dr. White, whom he knew personally and whom he had contacted, from the capital. This person would agree to register their laboratory under his name and would be willing to supervise it. Also, in order to become an accredited institution (unlike the old hospital), there would have to be a radiology service, the "duties of the radiologist-M.D. being to head the X-ray Department, see that all necessary equipment is there and kept up-to-date." Such persons, it was pointed out, are usually paid either on a percentage of actual (e.g., X-ray) service collections or on a percentage of (again, e.g., X-ray) billings. Dr. Rhine recommended a Dr. Short from the capital who was acting in that capacity for a community hospital in the area and who could also take care of some additional work. It was moved by Misters Kingston and Warrington, and carried by the Board, that Dr. Rhine be empowered to speak for them officially to both the pathologist and radiologist to arrange their meeting with the Board with the aim of securing their services. This was done.

At the next meeting, it was announced that the Recruitment Committee had interviewed Mr. Edwards for the position of Administrator and that he would be present for the Board to "size him up." The Board was favorably impressed with Mr. Edwards and decided to make him an offer as soon as possible. Other important business had to do with the establishment of

a separate bank account for furniture and equipment donations and for setting up an operating fund. The former was suggested by Warrington and Evans, the latter by Smathers and Rowlands. Both passed. Medical liability insurance was discussed and Kingston and Evans moved that the Board purchase $100,000 worth. It was carried. An annual audit of the books by a local C.P.A. also was suggested and passed. The President reported that an area hospital supplies firm had offered to supply the hospital's furniture and equipment needs at their cost plus 10% and to set it up and place it in working order at no additional expense, and, also, it would go along with the hospital's policy of pay-as-you-go and/or would extend credit. The offer was accepted gratefully.

The next two meetings' business consisted mainly of by now routine matters: relating to purchases of equipment, furniture, and the sinking of a well for water; it was reported by Dr. Rhine that the majority of the laboratory equipment ordered was in hand; the audit report was submitted and approved; and additional donations were reported.

The new Administrator, now hard at work, first displayed his command of the situation, his initiative, and his organizational abilities, at the second of these meetings when he presented an integrated, comprehensive, and impressive discussion of the building program, status of equipmemt items, and need for a well-thought-out plan for handling operating funds, and the need for phasing these activities in connection with the opening of the new hospital. He stressed the importance of establishing a definite opening date for the hospital and advised the Board regarding his work in the past week relative to completing applications for various licenses needed in the operation to the hospital. On his own, Edwards had applied for state sales tax exemption, for

membership in the Blue Cross Association in Michigan, and had sent the forms needed to establish a narcotics license for the hospital. He also had sought the approval of the Michigan State Health Department for operating the hospital as well as seeking regular payment for the care to be offered county patients who were indigent. At this meeting, Dr. Rhine stressed the importance of the Board granting authority to the Administrator "for the purchase of certain specific small items of equipment in order to have them available when needed." It was concluded by Edwards and Rhine that to open the hospital there should be an available operating fund of approximately $15,000 and, at Kingston's and Warrington's suggestion, the Board authorized the Administrator to make the necessary arrangements and to procure smaller expendable items.

At a special meeting called for the purpose of discussing the matters of finances and the granting of authority -- attended by O'Toole, Warrington, Smith, Kingston, Evans, Jones, Rhine, and Edwards -- the matter of the hospital payroll was broached. A plan proposed by Kingston and Warrington was approved. The Administrator's salary was temporarily to be paid from the Building Fund account, pending the establishment of an operating fund. Edwards advised that he had sent for all the necessary forms in connection with application for Workmen's Compensation, Social Security, Withholding Tax, etc. Smith and Warrington moved that authorization be given the Administrator to sign for the Corporation all documents in connection with a permit to use alcohol free of tax and that Rhine be authorized to sign for narcotics use for the Corporation. These passed.

At the next regular meeting, additional insurance needs on the building and its contents were discussed and passed on. Rhine brought to the Board's attention the pressing need for definite plans to be made toward the hospital's

opening and that very definite plans should be made with regard to granting the Administrator authority to act on specific problems having to do with hiring key hospital personnel, such as a Superintendent of Nurses, and other personnel. As a result of this prodding, an opening date of July 1, 1957 was offered by Smathers and Evans, "with whatever facilities are then available", and approved. Evans and Smith moved "that authority be given the hospital administrator to select, employ, control, and discharge all employees necessary to the proper operation of the hospital". Carried.

A special meeting followed in which the President suggested setting up a community-board committee on administration, its purpose being "to suggest and advise in such matters, and thus assist the hospital Board and Administrator of the hospital." He further suggested soliciting the services of the defunct Sampson firm's head, but this person refused and the whole idea eventually came to naught. A limited equipment purchasing authorization for the Administrator and an operating fund were finally approved, however, as well as a petty cash fund. Additional and important items of business transacted included: the appointment of Rhine as the hospital's Medical Director, recommended by Warrington, seconded by Smathers; and the establishment of per diem room rates for semi-private and private rooms suggested by Warrington and Evans.

At the next meeting, the principal topic of discussion was the dedication ceremonies forthcoming. From an organizational point of view, of more significant import was the review and approval by the Board of the applications presented for active staff privileges in the new hospital by the following physicians: the four M.D.s in the local group practice -- the 2 older doctors (uncle and nephew) B. and H. Roos, and two younger doctors (related by marriage to the daughters of the former) Rhine and

Sheridan; C. Haft, a M.D. practicing general medicine in a nearby township; the pathologist, C. White, and his assistant, Eleanor Load; and the radiologist, Short. Kingston and Smith moved that staff privileges for these persons be granted and it was carried.

Rhine advised the Board at the next meeting that the Medical Staff was to meet to enact its "Bylaws" and to formally organize itself. Approval by the Board of these actions would be sought. The President of the Board revealed that the Kresge Foundation, which he had contacted upon the advice of the school superintendent, would contribute a conditional grant of $10,000 to the hospital to liquidate equipment debts provided other matching contributions would be made locally in the next year.

The hospital was to be dedicated on June 23rd.

The problem of insurance was to take up two consecutive meetings. The President announced that in checking on the insurance for the building and its contents that it was not possible to secure such coverage on the same policy; that contents are insured at a higher rate. Hence, he had secured a policy from a local agency to cover contents alone and all policies on the building were to remain as originally written. The question as to requirements in the way of insurance to cover injury to patients was brought up by Warrington, and the President asked Edwards and Rhine to confer with the Comptroller-Office Manager on this matter, including the problem of Workmen's Compensation payments, and to report their findings at the next meeting.

Edwards presented the requested information in a report in which he suggested that adequate malpractice insurance coverage of $300,000 could be reasonably purchased from a local insurance agent but that "there first

must be an inspection of the hospital plant by insurance engineers." Warrington and Smathers moved that "the President be empowered to act as per his judgment in the matter of malpractice insurance." Carried. Edwards had already secured Workmen's Compensation for hospital employees through a local insurance agency. The hospital's insurance business had been, as equitably as possible, distributed among the four local insurance agencies.

The hospital had been in actual operation only one week by the July 8, 1957 meeting at which Edwards reported that in that time occupancy of medical and surgery beds had been roughly 75%, a creditable figure. He predicted that if the rate of occupancy achieved in the first week were to continue, there would be a little over twice as many patients cared for in the new hospital as over the highest rate cared for in the Morton Hospital. (The new hospital had a variable bed capacity of 25 - 33 beds, finally.) The income for the week and the salary figures needed for the first payroll were introduced by Edwards. Rhine advised that the Medical Staff had received applications from two area M.D.-physicians for consulting memberships on the staff, whose appointments were moved by Evans/Warrington and approved by the Board. Evans' suggestion to charge an extra dollar per day per patient to apply on the cost of medical equipment was tabled upon the motion of Smith and Kennedy.

Warrington and Rowlands moved that an endowment fund be established from which only the interest earned could be used. Such a fund was to be made up "of memorial cash gifts and any other contributions that might be so designated for this fund." It was "to be invested as designated by the Board." It carried. Edwards cautiously indicated that the hospital was doing very well financially, and that as returns from the various medical

insurance payment plans and other sources became routine, the hospital should have no trouble in carrying its own load in the community. He was, however, concerned about the payment of current bills, stating that his present operating account plus what might be received in patient payments by his next payroll period would not be sufficient to meet the payroll and also pay the bills. Smith and Rowlands moved a "transfer of sufficient funds from the Building Fund to the Operating Fund to pay the bills". Carried.

At this meeting the President brought to the Board's attention an unfortunate incident involving the patient of the local osteopathic physician. While he was out of town on a case, a heart patient of his became severely ill one night and was refused admission to the hospital because there was no authorization from a local physician to do so. Fortunately, the patient was rushed in time to an osteopathic hospital in the capital. The osteopathic physician sent an angry letter of complaint to the Board President. Clarification from the President and Rhine via letter was promised and sent. Following this incident, a special meeting was called to amend the "Bylaws" concerned with the procedure to be followed in operating the hospital. After considerable discussion, Section 6 A was amended to read as follows: "In any case where the "Bylaws" pertain to the operation of the hospital any such provision may be delegated to an administrator by resolution of the Board." Moved by Kingston/Rowlands, it carried. In effect, discretionary, though narrow, power to cover such unusual cases was granted the administration.

Six specialists from the capital and another nearby community soon after requested staff privileges in the hospital and all were approved. They included three specialists in Obstetrics and Gynecology, one in

Internal Medicine, and two in Urology. Edwards reported at this meeting that the hospital showed less "profit" than in July and that the X-ray Department seemingly was not making money. He suggested that this matter might be discussed fruitfully with the Medical Staff. Unpaid bills of patients on hand were studied, and Edwards again indicated a need for additional funds to meet current operating expenses. A sum from the Building Fund was again diverted to the Operating Fund. Moved by Kennedy/ Warrington, it carried.

At a special meeting held in September, Edwards and Rhine gave an analysis of the Blue Cross situation related to the type of service then being given at the new hospital. A proposed request to the Blue Cross "for withholding 10% instead of 20% they have advised the hospital they are withholding" was recommended. Rhine explained very fully where the Blue Cross funds fitted into the medical operation of the hospital and that part of this operation would in effect, he felt, take care of itself if the proper reports were submitted. He did not recommend "any cutting down that would lower the type of service currently offered and thus jeopardize the workings of the hospital or its desired accreditation". At the next regular meeting O'Toole and Edwards reported the possibility, as discussed with a Blue Cross auditor, "of the 20% withholding being reduced to 10% or perhaps even 5% if interim reports are submitted showing that the hospital's operation is definitely less profitable." It was Edwards' opinion, however, that the withholding figure of 20% in all probability would not be far off. If occupancy could be maintained close to capacity (and all indications appeared favorable for so doing), it looked as though the hospital could then be self-supporting. For the first time in a long time, Edwards was able to pay all the month's current operating

bills and some $2,000 on outstanding items. The matter of billing the V.F.W. National Home for orphaned children (located in Mills Springs) for hospital services was brought up by Edwards in this connection. Upon receipt of their first three months' billing, the management of that organization indicated to Edwards that they felt "some consideration for a reduced rate for hospital services was in order due to their being a charitable, non-profit organization operating a child care program." Rhine suggested two possible courses of action: (1) the preferred plan was "to withhold a percentage until an audit is made and the actual cost of services determined, thus assuring the home service at cost (in other words, treating the home on the same level as the Blue Cross)"; the other plan (2) might be "to treat the children-patients on the same basis as Michigan Crippled Children Commission patients. The latter probably is the less advisable plan since there seems to be considerable dissatisfaction on the part of hospitals and doctors elsewhere in the state with the low fee schedule which necessitates taking a loss on such cases." Evans and Warrington moved that "the V.F.W. billing be at the regular hospital rate and it be allowed to withhold 20% of billings, then at the end of the fiscal year the payment be adjusted to the hospital cost on the same basis as the Blue Cross adjustment is made, and that at any time the maximum discount on service to the V.F.W. National Home will be no more than 20 percent." It carried.

The first "Quarterly Operational Report" of the hospital showed that the percentage of occupancy had steadily risen from 45.1 to 48.6 to 56.9 in the months of July, August, and September (usually a slack period for general hospitals.) Higher occupancy rates were expected in the next two quarters by the Administrator and the Medical Director. In-patients treated

rose from 123 to 141 to 167; newborn infants fluctuated from 22 to 13 to 22; out-patients declined somewhat from 191 to 189 to 183; so that total patients treated had risen from 236 to 343 to 372. A financial accounting showed the hospital to be seemingly holding its own. A report by the Secretary showed that approximately 81.5% of the original 1,268 pledges made to the new hospital were paid, but that 253 people made no payments whatsoever on their pledges. Of a total of approximately 300 Corporation members, half were from a township very close by. A very small percentage of the 1,268 pledges were Corporation members.

At the first meeting of the third year of operation, Warrington was elected President of the Board and Kingston was elected Vice-President. The other officers remained as before. Warrington's first action was to suggest the formation of 3 permanent Board Committees: (1) Public Relations, (2) Building and Grounds, and (3) Membership and Finance; and the following meeting saw the appointment of their memberships -- (1) O'Toole (head), Smathers and Jones; (2) Smith (head) and Rowlands; and (3) Kingston (head), Evans and Kennedy. Administrator Edwards brought up a problem in the form of shortages of space in the Laboratory and Business Office, along with a request for permission to move the Laboratory to the basement and to house part of the Business Office in the space to be vacated. He was sure this move could be effected at a minimum of expense and he expressed confidence that it would increase the working power of the Laboratory and increase the intake of funds through this medium. No action was taken.

At the next meeting, it was announced by Kingston that the Kresge Foundation Grant would come through to clear the hospital's indebtedness. Upon Edwards' report, the Board fully discussed the increasingly pressing

problem of outstanding hospital care accounts. Kennedy and Smith moved that Edwards, with the President's and Vice-President's approval, be authorized to proceed with the collection of such accounts "in any manner deemed necessary". Carried.

In the remaining space to be allotted here and in Appendix A to board business only crucial problems and issues which arose will be dealt with and further detailing of routine business will be dispensed with, since a pattern of policy-making and decision-making (following established policies) had clearly developed by the third year of operation. A summary of such routine business matters and their handling will be presented below.

The lack of space for the Laboratory and Business Offices, handicapping the hospital's operations, was again brought to the Board's attention by Edwards. Smathers and O'Toole moved that the Building and Grounds Committee be authorized to make immediate arrangements for moving the Laboratory and enlarging business office space, such alterations to be paid from funds advanced for operating expenses. It carried. At this meeting the possibility of enlarging the north wing of the hospital building was offered as food for thought by the Administrator as more in-patients were being admitted, as was foreseen by him earlier. Subsequently, O'Toole introduced the idea that "the directors should formulate a definite plan for hospital expansion, and new facilities, in order that the public could be informed of the hospital needs, and funds necessary for these needs". Warrington asked the Administrator to work on the specific needs in terms of physical facilities and discussed the necessity of an all-out effort of the directors as a group to formulate this plan. Collection of receipts outstanding was improving, Edwards reported. Rhine reported that the hospital had been receiving good advertising in the surrounding areas, particularly from

mothers who had had their babies in the hospital and that more patients were coming in from a wider area. Plans were in the making by the group practitioners toward getting another physician in Mills Springs.

The Administrator and Rhine gave a brief report pertaining to the hospital's progress in the direction of accreditation by the Joint Commission on Hospital Accreditation, noting that the hospital still had some minor deficiencies preventing application to the Commission for a survey. Progress was continually being made, however, they assured the Board in that ultimate direction.

In August of 1959, Edwards reported a grave financial situation. After much discussion relative to the cost per day of patient care in the hospital, it was recommended by O'Toole and Evans that an increase in the daily room rates be made and a flat rate for four days be charged all O.B. patients. It was subsequently approved.

In Edwards' absence, Rhine reported later that a great deal of progress had been made in setting up certain records-keeping procedures and working out more rational methods of bookkeeping and business records, etc., as a result of much time and effort put forth by the Administrator.

At the annual meeting of the Corporation, Warrington's report on the hospital's operation revealed that 55 employees had been paid 52% of the entire cost of operating the hospital. Total assets of the hospital had grown to over $450,000. It was a considerable business in the community. The average stay in the Mills Springs hospital averaged 4.7 days as against the Michigan average of 7.6 (a creditable figure, indeed, he felt.) Current occupancy was 81%, and expansion was definitely on the horizon.

In a March 1959 meeting, Edwards discussed and suggested changes in regard to out-patient services, to the effect that such services be placed

on a strictly cash basis, and upon Smathers' and Evans' motion, this plan carried. Later, he announced that "when the hospital can obtain a medical library, a request could probably be made for a Commission survey to become an accredited hospital".

In July, the number of Consulting Staff recommended and approved had expanded to 20, and the Active Staff Medical Staff to 6.

In October, the establishment of the new Doctors' Clinic and "its expected tie-in with the hospital operation with a view to offering even greater service to the area's sick" was presented by Rhine. President Warrington reported that several estates and cash bequests had been willed to the hospital Corporation.

In June of 1960, Smith reported that he had been approached by two prominent community citizens as to when there was to be an addition to the hospital. A general discussion followed: as to the number of patients who were or could be turned away because of the lack of beds; as to whether or not to have an architect draft expansion plans (seeing as certain problems had cropped up over space allocation); concerning the need for more surgical beds (which was a pressing one); as to the possibility of turning the present kitchen into a Pediatric Ward (it had been placed in an awkward place in the main part of the hospital); in terms of moving the X-ray Department to the first floor from the basement where its operation was being hampered.

Edwards called attention to the importance of a state bill increasing appropriations for crippled children cases. Present agreements with the County were only on a yearly basis and, sooner or later, the County should be asked to bring their figures more in line with actual costs. Reviewing a malpractice suit then pending in the County Hospital,

Warrington stressed "the importance of utmost care being taken in every way possible to avoid damage suits of any kind". The building expansion was again discussed, with Rhine presenting and explaining a preliminary drawing offered for criticisms, changes, etc., Edwards noted "that a few more beds right now would make a difference between struggling and building up an operating fund. Six or 8 more beds could be handled with the present nursing staff." The need for ward beds or private rooms was discussed. The occupancy rate was the highest ever -- 84%. Corridors had had to be used in several emergencies. Warrington asked for a discussion as to how much a ward would save. It was suggested by Edwards and Rhine that a ward of a minimum of 8 beds would be required to insure a decrease in per capita cost and that it would save time and require less housekeeping care. The real savings would be more in terms of using nurses' aides rather than R.N.s. (At that time the hospital employed one aide per seven patients.) An income increase of $125.00 per diem could be realized. Still, no action was taken.

At the Annual Meeting in 1960, the President pointed out that within a year's time projected "long-term plans" for taking care of community needs were seen to be short-sighted. Citing the fact that "practically all of the country's hospitals have had diffuculty meeting their expenses", he noted the M.S.C.H. had had to borrow money only one month, which loan was paid back within a month. It had been able to keep operations in line with its income. This was seen as very important in this case, not being backed by City or County funds. "With no one to pick up a deficit we must operate within our income or close."

Edwards later questioned the Board whether there should not be a set rule (or policy) as to the granting of Life Memberships in the Corporation in view of the increased number of large donations received. Ten Life Memberships for services rendered had been granted by the Board. The suggestion was tabled until a later meeting, at which time such action was to be taken.

The crowded conditions continued to plague the hospital's operation. A drive for more rooms was again discussed and a plan for an extensive care unit for 14 or 16 beds was presented by Edwards and Rhine. It was reluctantly agreed that Edwards was to contact a representative of both the Civil Defense and County Hospital Board regarding federal funds towards financing a building addition.

In February of 1961, Warrington started a discussion as to how long the hospital could keep going as well as it had with Blue Cross Insurance or similar insurance plans, given the financial difficulties Blue Cross in Michigan was facing. It was the general opinion that some type of insurance, probably (and, unfortunately, it was felt) federal insurance would replace Blue Cross coverage. Edwards reported that it was "almost hopeless to get any funds for expansion through Civil Defense, as there are beds available in the County".

At a special meeting following this, Edwards tendered his resignation and informed the Board he had accepted a position as Superintendent of a 230-bed general hospital. He felt he could not turn down the opportunity nor the salary -- more than double his present one. He recommended as his successor C. Coachman, the Head Laboratory Technician, who, Edwards felt, "had proven his ability to get along with personnel and the Medical Staff and had also shown good business sense".

Rhine was of the opinion that if Coachman could be interested in this promotion, serious thought should be given Edwards' recommendation. Following a general discussion of the recommendation and other possible choices from within the hospital, it was decided that Edwards talk to Coachman to see whether or not he would be interested and, if so, to ask him to submit an application. Other applications were also solicited following this contact. At the next meeting, Edwards turned over two letters of application for the job of administrator to Warrington, who read the letters. Besides that of Coachman, the application of the Chief X-ray Technician was submitted. The President was empowered to interview both applicants and to hire one at a specified salary, at the motion of Kingston and Smith. Coachman was hired as a result.

The last two meetings covered by our research in 1961 saw the matter of expansion of the hospital re-introduced, but, again, no action was taken. The reasons for this inaction will be dealt with below. Administrator Coachman suggested making provision for treating geriatric patients in any new addition(s) to be built. Warrington suggested the whole problem of expansion be studied. Evans informed the Board that the employees of the hospital would pledge $1,000 toward this project. Coachman had been approached by a community group with the promise of a $3,000 pledge. He estimated that the figure of $85,000 was minimally necessary for a 20-bed addition.

Summary of Board Policies and Decisions and Individual Contributions

Before proceeding to an analysis of the hospital expansion issue from the informal, behind-the-scenes considerations and aspects it presents, here is a summary of the basic policy and decision-making

concerns of the Board, according to areas and contributors. A review of the total number of topics considered formally, combined with the items of business transacted, reveals that there were 346 such separate entries made in the minutes of 6 years' meetings covered. Many of these items cut across several areas of concern, so that their classification into clear-cut areas is arbitrary to a degree. Under the rubric of "financial concerns", for example, one could reasonably place certain "legal concerns" relating to endowments, contracts, audits, the treasurer's bond, grants, and insurance purchases. Similarly, Blue Cross and Blue Shield considerations are financial, legal, and administrative ones -- depending on from what vantage point one is viewing them. This is the case not only with respect to the business of the Board, but as well applies to some of the "business" of the administrative component and that of the Medical Staff.

Clearly financial, however, are the reports and/or presentations of the contracts let and bills for various purchases submitted by the Treasurer. Fully 74 such items were routinely handled by him. Kennedy's participation in other areas was very slight, being limited in almost every one of 9 other items to seconding motions made by the key influentials, especially Warrington's. It is obvious from this that the role he was playing was in a technical capacity and supportive, rather than showing initiative as a policy-maker or key decision-maker. His experience in finance was valuable nevertheless. The participation of both Secretaries of the Board was on the same basis and even less significant: only 2 seconds were made by Evers to motions pertaining to Corporation membership policy; Jones made no such contributions whatsoever. Carlyle's

limited participation consisted of contributions of several pieces of office and communication equipment and restricted public relations activities.

Increased and more significant contributions were made by the other Board members in the various areas to be listed. We find that Rowlands played basically a supporting role in the areas of equipment purchases, building and finance, medical staff appointments, legal contracts concerning Blue Cross and Blue Shield insurance, and administration for a total contribution of 12. Evans, again more supportive than initiating in her overall activities, made 27 contributions. In the areas of administration, medical and other equipment purchases, space allocation, legal and building contracts, and insurance, she was supportive. In the matters of the auxiliary, membership, public relations, medical staff appointments, and accounts receivables she attempted to initiate but with only relative success.

The division of labor effected by the power-wielders on the Board into areas of concern was as follows. Warrington contributed the lion's share of policy formulations and his suggestions and desires carried much weight in the critical areas of finance, building and contracts, membership, grants, medical staff appointments, insurance, legal matters, medical and other equipment and space allocation, public relations, accounts receivable, and administration for a total of 59 contributions -- the most of any key influential. The records of O'Toole and Smith, of 42 and 41 contributions respectively, were noteworthy too. O'Toole tended to concentrate his efforts on matters of membership, public relations, grants, medical staff appointments, and administration. However, his contributions and initiative in the areas of building, contracts, insurance,

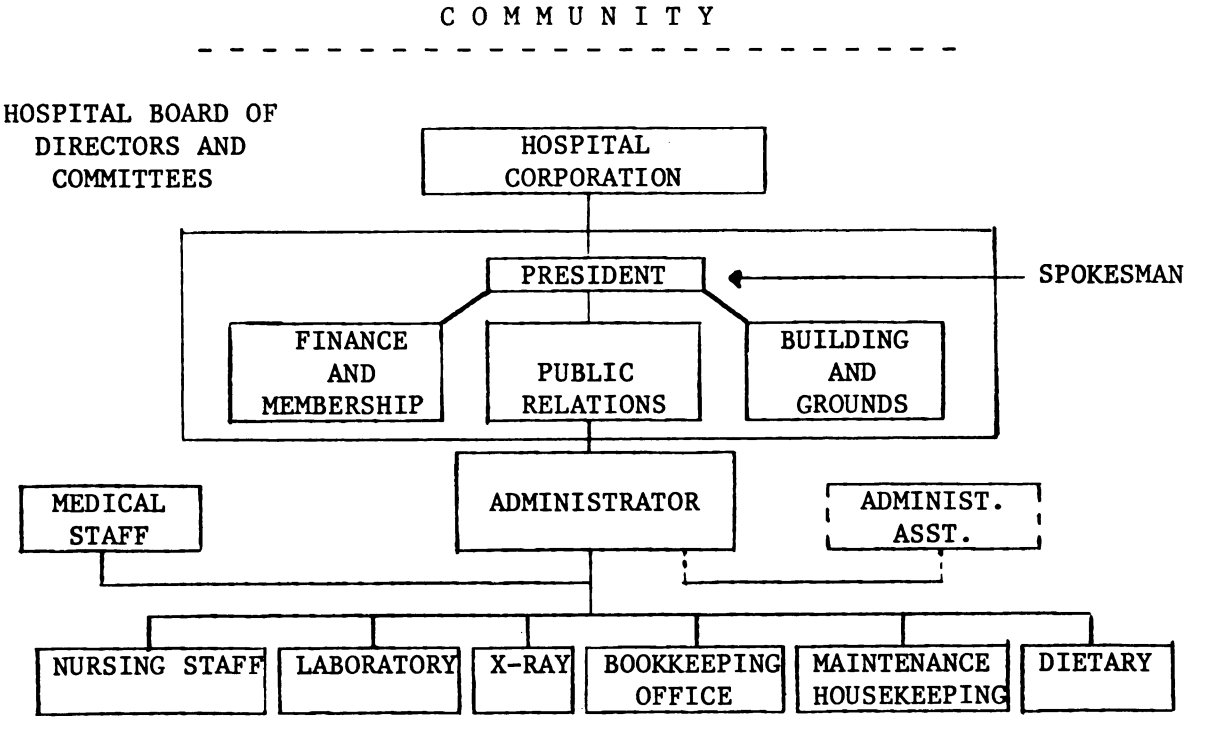
medical and other equipment, and space allocation were significant in giving direction, especially in the very early stages. Kingston, with 29 contributions, made up for his relatively sparse number of contributions by the quality of his contributions. Along with Warrington, he shone in the areas of finance, building, membership, medical staff appointments, insurance, legal matters, space allocation and equipment purchase, and administration. Smith concentrated his talents in the matters pertaining to general and medical equipment, but space allocation, accounts receivable, administration, medical staff appointments, building, legal, membership, and public relations matters also concerned him. Smathers demonstrated initiative in matters of building, insurance, medical staff appointments, and administration, with contributions of a lesser nature in terms of public relations, finance, grants, membership, and equipment needs.

On the basis of the information gathered in the in-depth interviews, the hospital Board members who displayed the most detailed and accurate overall knowledge of the organizational components and functions, problems and issues, of the hospital were the key influentials, by-and-large, and of these especially Warrington and O'Toole. The knowledge of the other Board members (with one exception) was less detailed and accurate in these respects, although they all were quite knowledgeable about the structure and functioning of the Board itself and of the issues and problems confronted therein. The whole organization had grown considerably from a small (approximately 28 people) to a medium size organization (approximately 80 people) in its 7 years plus of operation. Most of the Board members admitted that they were unable to keep up with the many and fast changes; nor did they feel that it was as necessary

for them to do so now that an administrative pattern and routine had been established.

The members of the Board interviewed each drew a requested basic organizational chart of the hospital. These charts were remarkably similar in their major aspects. The composite rendition of these charts below shows the President of the Board at the top of the whole organization, sitting on all the Board Committees, and -- as all the members' charts did -- labels him as the chief spokesman for the Board and the hospital. Warrington described this position as "primarily one of trust for the Corporation and the community." Interestingly, on his chart and that of all the Board members but Evans', the Medical Staff component was depicted as a separate yet subordinate division of the organization under the authority of the administration. This view was not shared by that component or other components of the organization.

Figure 1



With the exception of Evans, none of the Board members were quite sure who the actual heads of the various departments of the hospital were not how many people were employed by each division. Exact knowledge of the particular functions and problems of the various divisions varied widely among the Board members. Evans, in her present capacity as doctors' assistant and because of her past and present hospital experience, had more occasion than many of the others to interact with the medical staff, the nurses, administrator and other personnel -- thus her more detailed knowledge. But this did not seem to appreciably enhance her influence or power.

The pertinent comments of various hospital Board members revealing their basic attitudes and values regarding the operation of the organization will be presented in Appendix A. The emergent pattern of values and attitudes held by the Board members generally will be seen to be fairly consistent and complementary to those of other components in essential respects below.

Medical Staff Structure and Activity

It was the Active Medical Staff of the Morton Hospital, under the informal leadership of Rhine, which had prepared the formal document entitled "Bylaws, Rules, and Regulations of the Medical Staff of the Mills Springs Community Hospital, Inc." This set of medical policies was approved virtually intact by the Board of Directors. It was patterned mainly on the model of medical staff organization and hospital relationships set out in MacEachern's Hospital Organization and Management.[4] Its fairly detailed and, on the whole, accurate spelling out of medical staff organization, policies, rules and regulations actually observed in use in the hospital made its inclusion in the appendix[5] mandatory.

Although there were six active medical staff members in all on the new hospital's staff, it was possible to thoroughly interview but two of them. Fortunately, these were the younger physicians, Rhine and Sheridan, who, as was discovered, were most active in helping set up the hospital. As well, they were much more active than the other doctors in hospital-community relations and in their practices. The two older doctors were very reluctant to give up any of their valuable time from practice to be interviewed: Bert Roos refused outright; Herman Roos was reluctant or unable to fully discuss many of the items. It was necessary to gather much second-hand information about their personal backgrounds, hospital and community activities, attitudes and values from the above two doctors, the Administrator, and others. The fifth active medical staff member -- a new M.D. -- had just been added to the group practice and hospital medical staff at the time of the interviews. He was, thus, unacquainted with many aspects of the new situation he found himself in. Pleading ignorance in this regard, he excused himself, and only personal background data about him was collected. The sixth active medical staff member was a contemporary of Bert Roos and had been an active staff member in the Morton Hospital. As the only G.P. residing in a nearby township, he was too busy to be interviewed at length. It turned out that his position on the Medical Staff and his policy-making and decision-making activities were not as critically important as those of the local, active staff members, however, so that this missing, direct information is not too serious a drawback.

The organization of the Active Medical Staff -- all G.P.s -- is as follows: the Chief of the Medical Staff and its President is Bert

Roos; the Vice-chief of the Medical Staff or its Vice-president is Charles Haft; the Secretary of the Medical Staff (actually Secretary-Treasurer) is Rhine who is also the hospital's Medical Director. The other three members -- Sheridan, Herman Roos, and Hardt -- are not, nor have been, officers. With the exception of Rhine, all the officers are, and have been, the senior physicians. Herman Roos -- Rhine's senior -- has not been elected officer at his own request, preferring not to take an active administrative role.

Besides the Active Medical Staff, the Medical Staff consists of the Visiting Staff of the hospital, which numbers approximately 35 members, if 2 D.D.S.s are included, and it is divided into three categories: Consulting Medical Staff, Courtesy Medical Staff, and Honorary Medical Staff. Consulting and Courtesy staff members are specialists. The number of specialists consulting in the various medical areas are: 2 in Internal Medicine, 5 in General Surgery, 6 in Urology, 4 in Obstetrics-Gynecology, 2 in Pathology, 1 in Radiology, 2 in Pediatrics, 3 in Orthopedics, and 2 in Dentistry. Courtesy privileges have been accorded 2 in Pediatrics, 2 in Orthopedics, and 1 in Urology. There are no physicians in the "Honorary" category as yet, although Bert Roos will probably be the first to be placed in that category upon his imminent retirement.

There are 5 full-fledged medical committees established by the Medical Staff consisting of the following members: (1) Executive -- Medical Director, Chief of Staff, and one member to be appointed by the Chief of Staff (formerly to be elected by the staff); (2) Credentials -- one consulting staff member and one active staff member appointed by the Chief of Staff; (3) Joint Conference -- Medical Director

and an active staff member appointed by the Chief of the Medical Staff; (4) Medical Records and (5) Tissue - with the whole active staff as members and Sheridan and Bert Roos formerly and respectively chairmen, now Hardt and Load; and several (6) Special Committees, with the whole active staff as members -- (a) Sterilization, chairman H. Roos, (b) Administration, Rhine and Sheridan, co-chairmen, and (c) Surgery, Rhine chairman, and (d) Medical Records Library, with a medical records librarian from Detroit in attendance as a consultant. The functions of each committee are formally spelled out in the "Bylaws". The significance of those persons and committees bearing policy-making and decision-making power over medical or other aspects of hospital operations will be discussed below.

A detailed review of the pertinent information -- factual, attitudinal and valuational -- gathered in the extensive interviews with the key medical informants will follow thumbnail biographical sketches of the Active Staff Members of long-standing.

Dr. Bert Roos, 65, was born of conservative parents in a middle-sized city in the Midwest, where he was raised and educated. He received his B.A. from a prestigious university in the state and his M.D. from a medical college in Chicago. Born, raised, and educated in western Europe, Dr. Bert's father before him had been a medical doctor practicing general medicine. Dr. Bert was associated with his father in this practice for some years in his hometown. Shortly before and after his father's death, Dr. Bert shared this medical practice with his own nephew, Herman. The two of them phased out the practice and moved it to Mills Springs during the early years of World War II.

The Roos doctors had been recruited and brought there by the heads of the Smith and Sampson families who, respectively, were close friends and people whom they knew socially. The community needed doctors at that time to replace the deceased Morton and two other physicians who had moved out. Besides, Chapple/Morton Hospital, which had been reduced to the status of a nursing home at a time when more people were moving into the community, needed reviving and improving. Conditions and prospects looked good for setting up an exclusive general practice or clinic and for re-opening the hospital on favorable terms (with the "secret" aid of the Smiths and Sampsons), so the Rooses moved to Mills Springs.

The younger phycisians were added to the practice after World War II and the Korean War. Dr. Bert's older daughter had met and married Captain Rhine during World War II. The younger daughter had met and married Captain Sheridan during the Korean War. Rhine joined the practice in 1946, while Sheridan joined in 1954.

Over the years in Mills Springs, Dr. Bert has gained considerable influence. He has gained the respect and admiration of many: of his colleagues and of both the influential and common citizens. This has been accomplished without recourse to his participating extensively in community affairs, but rather his status has been a result of his obvious devotion to his patients and practice. Along with Mr. Smith -- his closest friend -- he has participated mostly in his church's activities. Although he was uniformly described as "strong-willed and arbitrary", it was reported that family activities are cherished by him. In over 35 years of practice as a G.P., he has only lately begun to restrict his practice by specializing on geriatric cases and in the treatment of diabetics.

Dr. Herman Roos, 56, was born and raised in the same city as his uncle. He received his B.A. from the same university as his uncle, whereas his M.D. was earned at a different university than his uncle's in Chicago. He is married, but he and his wife have no children. Dr. Herman -- variously described as "weak-willed" and "fun-loving" -- preferred not to carve out any special area of practice. He seemed to be the one physician of the group most content with just pursuing a modest general practice. He also was the one with the fullest, private, social life preferring "as little community or extra-professional activity as possible." He preferred "to stay in the background" and "to enjoy life." With the exception of nominal medical, social, and religious affiliations, Dr. Herman "steered clear" of memberships in organizations.

Albert Rhine, 42, was born and raised in the largest city in the state. His father was a salesman for most of his life. Receiving his B.A. from a liberal arts college and his M.D. from the university where his inlaws received their B.A.s, Rhine served 2 years in the U.S. Army as a battalion surgeon with the ski troops stationed in Colorado. He was discharged with the rank of Major.

In addition to family ties, one of the personal reasons for establishing himself professionally in Mills Springs was Rhine's "desire for space". He voiced dissatisfaction with life in cramped cities. The "better knowledge of neighbors and patients possible in a small town" also attracted him "in a way". But the "economic advantage of practice in such a prosperous, small town really" attracted him. "There are more cars, fur coats, etc. owned by the local merchants and retirees. The chance to make money is good here."

The disadvantages of living in Mills Springs, Rhine felt, had to do with the "poor quality of education" being offered in the community.

Rhine is a member of the Kiwanis Club which he attends regularly, but he has avoided being elected an officer.

> "I joined the Kiwanis for a chance to sit down for an hour or two. I think I could be just as successful a doctor without belonging. Yes, it does perform a service in raising money for worthwhile charities. It gives some people the opportunity to participate and lead in the community.... People who belong to many clubs need something for themselves."

His participation in civic or welfare organizations is limited to financial donations. He is not associated with, nor particularly interested in, any governmental or political activity. "Lack of time" prevents his (and the other doctors') participation in more community activities. He does occasionally "talk to community organizations on medical subjects. It gives the organizations prestige. My scientific or medical opinion is asked: such as by the City Commissioner and City Attorney on sewage disposal; and the Lions Club on the fluoridation of our water supply."

Rhine is an irregular attendant of the Congregational Church. "There is a real need for church activities in all communities. It is something for them to hang onto. Until politics, religion, and law catch up with science, we're going to stay in a chaotic state. Certain doctors I know have to ignore certain scientific evidence to maintain their faith."

Of his memberships in, and irregular attendance of, two professional associations -- the American Medical Association and the Michigan State Medical Society -- Rhine said, "They're just political associations. The county association is more important to one's practice. I've been President

of the Mills County Medical Society out of necessity. Our local group has spearheaded medical standards. Your professional liability insurance goes out of effect if you're not a member of the county association." Rhine donates five dollars annually and receives a magazine published by his medical fraternity alumni group. He is a member of the American Academy of General Practice. Continuing his remarks on the A.M.A. in particular, and medical professional associations generally, Rhine stated,

> "The people involved actively in them are not very good doctors. They're good politicians. I don't agree with all the A.M.A. policies. For example, Medicare or Social Security. I am for Social Security as long as the rest of the public are willing. I'm for Medicare, but I draw the line at government interference with the doctor-patient relationship, with the right of the doctor to prescribe. A patient should be able to freely choose his doctor and the doctor to make prescriptions and to practice freely. If Medicare were an insurance with indemnity features and actuarially sound, I would be for it."

Elmer Sheridan, 33, was born and raised in a small town in the Midwest, the son of an insurance salesman who later moved his family to the largest city in the state. He earned his B.A. at the same liberal arts college as his brother-in-law and his M.D. at the university in the above city. Presently a Major in the Air Force Reserve, Sheridan was a Captain in the Air Force Medical Corps stationed in France for two years following his internship.

The father of six children, Sheridan likes "a small town for family life. There are purely medical advantages here for me in terms of our group practice and opportunities for specialization in the hospital." He dislikes the "political aspects" of the community. "I don't like one-man rule and that's what we've got with Warrington. He's a pinch-

penny. This is not a progressive community." Sheridan felt that he had been "very well-integrated" in the community before he became a school board member.

Sheridan is the most active in community affairs of any of the local doctors; he is also most outspoken on political and related affairs. He is a member of the National Chamber of Commerce, headquartered in Washington, D.C. He maintains a "special doctors' affiliation."

Sheridan is a regular attending member of the local Rotary Club, about which he comments ...

> "Our Rotary Club has the largest number of unprogressive individuals in the community as members. It is a platform for myself and speakers from many walks of life, however. It gives you a wider picture of the world you live in. Its program gives aid to, and promotes, student activities in Boys' State and the U.N. at [a small liberal arts] College. I like the leader training camp we've run and I've diligently supported the international program."

Having been a Boy Scout for a long time, Sheridan is the County Director of Health and Safety and on the district Committee of Health and Safety of this group. "The Scouts give a boy the desire to be a woodsman, hunter -- to lead a healthy outdoors way of life."

He is a member of the P.T.A. which he attends irregularly. The Board of Education membership was "an eye-opener for me". This position convinced him, more than any other, of the difficulty in accomplishing desirable community ends. "We brought about annexation, despite a considerable segment of the community's reluctance to do so. We helped construct one new elementary school. I found, however, that people don't believe facts and figures; I found people are swayed more by emotional appeals and impacts."

Sheridan viewed his Methodist Church activities to be "very important, in fact most important. I'm on the Board of Stewards. I feel I am able to contribute specifically there in the church group with regard to certain problems as alcoholism, juvenile delinquency, and the like, by linking science and religion."

Sheridan felt that,

> "My contribution, as far as official policy-making in the various community organizations to which I belong is concerned, has probably not made a real difference, but as far as informing the general public of the issues, it has. I think it is important for people in medicine to actively take part in community affairs because, on the whole, they are better able to view problems analytically, and that because of their training in the physical sciences. We can present the pros and cons without emotionalism. I feel the community is better off with the participation of we physicians (Rhine and myself). More of the doctors should become active in politics: get on the City Council, School Board, and the P.T.A. The scientific method should be brought into the social scene. If you're honest, the method releases you from group pressures."

Sheridan belongs to the same national, state, and county medical associations mentioned above (for Rhine), and he makes it a practice to attend one of the two bi-annual meetings of both the state medical association and the Academy of General Practice. He is in "the process of joining the state and the American Association of Anesthesiology, since I'm developing a specialty." Rhine is "developing General Surgery as a specialty" and has taken steps for board certification.

> "These professional associations have an internal political purpose, basically, and I don't like to attend the political meetings. I am a county representative to the state association.
>
> I don't always agree with the A.M.A., state, or even county associations because they are so often failing to recognize significant changes or trends in the nation.

> If these associations do any good, it is in terms of the betterment of one's own professional standing and in getting a rounded view of medicine. The Academy is political even here: it requires 150 hours of 'advanced training' every 3 years in the form of seminars, lectures, and attending A.M.A. meetings. You get more out of the literature, it seems to me."

In responding to question(s) MS 1, the doctors paid little attention to describing the hospital's chart of organization. "The Medical Staff is not employed by the hospital nor as subject to the administration as other departments; to that extent we are guests, yet we are an autonomous part of the hospital, too", explained Sheridan. Rhine and Sheridan both saw the major responsibilities of the Medical Staff to be "to actually administer medical care and to supervise the giving of patient care in the hospital". Co-ordination of hospital activities was seen by them to be the main responsibility of the Administrator. Rhine commented: "He makes sure that the things and people are there when and where needed. He handles the routine administrative tasks, allowing medical and patient care to be carried out in the best fashion possible." The Board was seen to be legally and financially responsible for the hospital's operations. The Nursing Staff was regarded by the doctors as the most important segment in the hospital because of its responsibility over patient care -- "the most important function along with medical care". The other departments "are all contributing in one way or another to aiding the two main functions of medical and patient care," said Sheridan.

Rhine stressed the point that the five local M.D.s "work as a whole on just about every medical staff problem, even though for efficiency of our operation we have set up various committees to ease our handling of the different but related functions and to record the proceedings properly." [MS 2.] One evening once a month the whole active staff

meets as the very important Tissues Committee and as the Medical Records Committee -- "our aim being to police ourselves on the quality of medical treatment we offer." The pathologist is the chairman and "serves the roles of critic, judge, and instructor as selected cases in which tissues were surgically removed are gone over" by the Tissues Committee.

> "The Medical Audit or Medical Records Committee is also a quality control unit, now to be chaired by the new M.D., Hardt. The most important part of its function is to audit the charts of the Medical Staff in order to pass judgment on the standard of medical care offered. Three charts of each man on the staff are selected at random by the Medical Records Librarian for the audit. This is also done to satisfy the accreditation people. The main difficulty with charts is getting the necessary infomation down on paper. We don't have enough time."

Rhine is the chairman of the Joint Conference Committee and as such meets with the hospital's Board. It is he who transmits the Active Medical Staff's recommendations to the Board on "administrative, construction, financial, and hospital medical equipment matters." As the chief local surgeon, Rhine is on the courtesy staff of a hospital in the state capital and a consulting staff member of the county hospital and one other hospital in the capital.

Sheridan's information and remarks on the committee makeup and functions of the medical staff dovetailed with those of his colleague. Having been the former chairman of the Medical Audit (Records) Committee, he underscored the prime function of that group:

> "The review of charts to see they are properly done is one way of ensuring adequate medical treatment and the safeguarding of our reputation. The history of the patient, his physical examination, the admitting diagnosis, and the discharge diagnosis have to be there. We must make sure all the diagnosis is there. This largely determines whether adequate treatment was given or not. We ask why adequate treatment was not given."

The policing functions of the Tissues Committee were viewed as extremely important by Sheridan. Sheridan, by the way, has a courtesy staff membership in the county hospital.

Both men -- stressing that they spoke for the other physicians as well -- saw the major goal of the hospital to be to provide the best medical and patient care possible, with medical care being the exclusive province and the major goal of the medical staff. Sheridan stated:

> "Adequate patient care is an all-encompassing proposition. We on the Medical Staff play a very major part, it is true, but by no means the major part in attaining that goal. Our major goal, and part in the total picture, is determined by the physical capabilities -- that is we care for most medical and surgical problems on our own or through the consulting specialists. But the nursing, and the other administrative and medically-related departments play important parts. Modern hospitals require all the people you mentioned. The ancillary or medically-related departments serve the diagnostic function primarily."

The answers of Rhine and Sheridan were similar in meaning. They both felt that they (the doctors) could not make any decisions properly in the authoritative sphere of the Board's activities. These included all the broad hospital policies and decisions made by the Board based on legal and financial considerations. Sheridan commented that: "Although we can't properly make the kinds of decisions the Board does, nor establish their broad kinds of policies, we can influence their policy-making and decisions by the technical information we command." Rhine declared that the doctors had

> "clear responsibility for disciplining action when anything to do with patient care comes up, and a lot of responsibility to discipline medical care given by oneself and one's colleagues. We can and do discipline R.N.s, L.P.N.s, aides and other departmental personnel as their work negatively affects

> the welfare of our patients. Usually, this is done through the Administrator to ensure non-repitition of the offense. It has not been necessary for we doctors to discipline the members of the Lab or X-ray departments."

Both felt that the doctors should act with prompt, vigorous, and even autocratic decisiveness in any emergency or medical procedure or closely related activity involving life or death matters. They felt that they had sufficient authority delegated to them by the Board to do their jobs. They did not feel the need for more authority. No significant changes in authority relationships were noted by either doctor. Both were aware of some people in the hospital -- on the Board and in various departments -- who resented their medical authority, but both declined to identify them or the circumstances. Rhine claimed: "It doesn't bother me; I try to get along with everyone who does his or her job."

Sheridan felt that in the case of the hospital: "There is no such ranking of departments; one can't operate without the other." Rhine, on the other hand, ranked the departments from most to least important with regard to attaining the hospital's major goal of patient care, claiming he was doing it on the basis of the direct and critical nature of the respective departmental contributions: "Nurses; Lab and X-ray tied; Administration, Dietetics and Maintenance; I rank the Business Office last." Sheridan off-handedly mentioned that "the front office (Business) possibly has an over-inflated notion of its importance and there is contention in the hospital created there; some of their girls have felt the hospital is there for them." There is a slight tendency

> "for lay administration in hospitals to try to dictate the type of care to be given. Professional people shouldn't do administrative tasks. I'm thinking of

> the nurses in particular; many have stayed on past the 5:00 P.M. quitting hours to finish paperwork they couldn't do on their turn of duty. This is the problem of the Administrator and Board. They should provide someone to do the paperwork. They (front office) want the nurses to get too much information on admission. We need these people to cover two 8-hour shifts and weekends; we can't afford to lose our R.N.s."

Rhine summed up the significant organizational changes which he had seen occur as a basic shift in the hospital organization of the community.

> "The shift from the Morton to our present institution has been a big one indeed. We have more people in a better administration which in great part has meant a better possibility for us [doctors] to give good medical and patient care by releasing us from some of those burdensome chores. We have become a more professional organization. We've a much bigger load of patients than before, which testifies to our improvement."

Rhine and Sheridan both stated that all the active staff doctors were aware that a basic change most probably would take place in 5 to 10 years in the direction of geriatric specialization. Said Rhine:

> "Our Chief of Staff and Coachman see this development positively and are especially concerned. There is a large old population in the community and environs. No firm plans have been made yet, however. It will all hinge on the future expansion plans of the Board as to whether a geriatrics ward, separate hospital wing or building for the old patients will be built. We'll definitely be adding a chronic care function to our present, mainly acute care function. We younger doctors aren't sure this is the right direction we should take, although we recognize the need."

Sheridan contacted the Nursing Staff most often in an official capacity. Besides the operating room personnel, whom he saw as the regular anesthetist on the surgical team, he saw the R.N.s and other nursing staff personnel daily, as required with regard to his personal patients' care. He also saw the Lab and X-ray personnel -- usually heads -- for reports on his patients, most often on a daily basis.

All the interactions were described as informal -- "It has to be so in a small place. I have a joking relationship with a number of the R.N.s. The majority of the nurses are very good. Oh yes, I see the Administrator once a day usually. We discuss professional problems. He's very good."

Sheridan and Rhine both were largely satisfied with the personal and occupational qualifications of the semi-professional personnel they had direct contact with. Although they were less knowledgeable about the lower echelon's personnel on either score, they made some uncomplimentary remarks about the intelligence and performances of some dietary and maintenance workers.

Rhine was more specific than Sheridan as to the persons whom he contacted:

> "I see the Head Surgical Nurse, daily, in O.R.; I also see the Floor Nurse, as required, and the Supervisor of Nurses, daily. All of them are R.N.s. I see the Administrator as needed -- sometimes several times a day, other times only perfunctorily. Of course, I see my colleagues, daily, at the clinic and the surgical team here whenever I am operating or assisting. I don't really keep track of the times; I'm too busy -- I just follow the appointments made. All my contacts are on business, but they are informal. I'd say things go smoothly; they have to."

Neither of the two doctors considered any of the medical staff members or others in the hospital organization to be their superiors -- immediate or otherwise. Both mentioned the Chief of Staff position as the highest, but described it primarily as an honorary post bearing little real authority. As Sheridan put it: "Being full-fledged doctors, we have a colleague relationship here. As professionals, we are basically responsible for our own individual behavior as doctors. We do seek advice and consult with our colleagues and experts, but ultimately we individually must make our own professional choices."

Rhine gave as one major reason why he sought active staff membership at the Mills Springs Community Hospital the fact that he detested "the politics" in big hospitals. "It's really bad at Crow Hospital where I have courtesy privileges. My brother is a surgeon there and he has told me some really eye-opening stories which have confirmed by personal impressions." After relating some of these, Rhine continued in this vein . . .

> "What has kept me in Mills Springs and a small hospital has been the steady progression I witnessed at the old hospital year by year. From what was really little more than a glorified nursing home, we have progressed to what we have now. We've built something fine here despite some unpleasantries.
>
> I've been able to keep up with modern medicine. I'm developing a specialty in General Surgery; Sheridan's developing Anesthesiology; Hardt's an E.E.N. man.
>
> You know, the specialists from bigger places like to come here. They like our diagnostic facilities -- the Lab really impresses them.
>
> We need to expand our hospital capacity to 50 beds or more. This is not a health problem increase, since we could actually reduce our care on the number of patients we take on; from our point of view [doctors'] it is a political one. You need a bigger load of patients for the Blue Cross and insurance funds: that's what helps you maintain a decent standard of care, let alone better it."

Rhine felt it would be advantageous to him personally as a practicing physician for the hospital to get a bigger medical staff.

> "We need a bigger staff. Sheridan and Hardt agree. The others are not so aggressive. But if the hospital expands, it will come. More cases and specialists coming in means increased practice, and, from my point of view, with more opportunities for surgery I can do better surgery. To an extent, quality comes with quantity. I'm doing surgery now we used to have a board man come to do in the old hospital.
>
> My brother is a board man and he comes over to do the major surgery, at which I assist. He's far superior to the others coming in.

> We (Sheridan, Hardt, and I) want to double the membership of the clinic in 10 years time. We feel we can keep quality at a pace with quantity. Basically, we want all G.P.s on the active staff so as to give better family medical care which is 98% of our practice today. If the function of a specialist is needed, we should call for it through inviting in our consulting staff and courtesy staff. This set-up would still allow a local man to evolve a specialty internally. Our pattern is really the Mayo Clinic. We see the clinic-community hospital more closely related in terms of practice than it is now. We'd like more room for experiment. To allow for this, I think we'll need more professional management then -- someone actually trained in hospital administration, and we'll need a more efficient bookkeeping outfit."

Both doctors considered themselves and their colleagues to be fairly well qualified and successful staff members. They agreed that a doctor "should know his job well and get along with people. He must have a feel for patients."

The doctors did not think a doctor should be a member of the Board or have a vote "because a doctor could gain favoritism on his own behalf," explained Sheridan.

> "The Board decided what ought to go in the new hospital. The doctors should merely advise the Board on medical matters.
>
> A good, comprehensive, monthly report to the Board should consist of the new procedures the Medical Staff has taken up, the hospital's medical equipment needs, and recommendations in such areas where medical opinion or information are called for. The staff representative should educate the Board on the need for better care in terms of the facilities, staff, and other things needed." [Rhine]

The doctors stated that the Administrator should "get the things that we and the R.N.s need to do our jobs. He should handle the administrative details -- scheduling, paperwork, co-ordination." [Sheridan] Rhine added that "the Administrator and we have to work together to convince the Board that we have to double the patient load to keep the hospital operating." Repeating a summary of the consequences of such

expansion, Rhine went on to state that "this expansion in operations will be a boon to us doctors in other ways. As it is now, we are overworked. We'd be able to take vacations of three months, if we worked it right. The community needs to realize the hospital and clinic reputation is bringing in outside money and hospital insurance premium money here."

Rhine and Coachman, in the former's words

> "socialize somewhat. We have a fine personal relationship. We fish, plant trees, and drink beer together. Edwards and I were also friendly. He was more of a 'personality' fellow than Coachman and an organizer and team worker. We did a lot together to educate the Board on certain phases of hospital organization. Coachman tends to take individuals more to task when they 'goof up', whereas Edwards used the human relations approach, you know."

Sheridan did not socialize with the Administrator. "For all intents and purposes the Administrator is a liaison member of the Medical Staff, as is the Medical Librarian for that matter," claimed Sheridan. "Still, he's only a layman. We decide which committee meetings he should attend. We feel a medical administrator should have some medical training. As it is, Coachman can't judge the medical problems we may have. We have to, of necessity, police our own affairs."

The doctors did not appear to be particularly concerned with, or too knowledgeable about, working conditions in the hospital as a whole. Rhine commented:

> "I don't know about those persons I don't work with, but in my area they seem to be satisfied. They're good people. They like the family atmosphere that prevails here, yet they are professional about their duties. If there is anything they like least, it has to be the pay, followed closely by the physical layout of the hospital. It was badly planned by Warrington."

both doctors said they thought that the majority of the people in the community were "very well satisfied" with the hospital. Sheridan put it this way: "They know they're getting better care than in most communities. We make a real effort. We get verbal reports from patients or their families or friends, both directly and indirectly. The referrals are a good index, as are the outsiders coming in. Our specialists pass the word too."

Both doctors felt that their original medical training did little or nothing to prepare them for the "business or financial problems" they encountered. Rhine clarified this by pointing out he meant "the business problems in the clinic and not in the hospital 'bug' me more. Edwards and I figured out an adequate operating budget for the new hospital, and Coachman and the Bookkeeper and her staff have been good in refining their methods and setting us on a more rational basis. Still, we've got a way to go as do all hospitals in the area of finances." Speaking again of the clinic, Rhine continued . . .

> "We have no executive head here in the clinic, however. The help runs to Sheridan or myself whenever there's a business or personal problem. I would love to get the business administration off my neck. Bert won't give any opinion; Herman is reluctant.
>
> We have personnel problems: our telephone service is not good; our bookkeeper wants all of October off for vacation -- it's a mess. Maybe we could get one of the hospital training understudies from the U. of M. to work here for a time and help clear things up a bit."

Rhine and Sheridan claimed that they regularly read the A.M.A.'s Journal and other scientific, medical literature in their special areas of interest to aid themselves in carrying out their functions as medical staff members. They reported that their colleagues read these materials at a minimum. Rhine also read regularly the journals Medical Economics,

Modern Medicine, and Medical World News. He was the most widely read in this respect; Herman Roos least so.

Rhine's friendships and influence with hospital co-workers were the most extensive of any of the doctors. He was aware that in general most people in the organization did not get together informally as friends. Besides the Administrator, Rhine saw the Chief X-ray Technician as a friend, although they associated together less frequently and on a cooler level than did Rhine and Coachman. Occasionally, he would meet the head of the Maintenance Department, whose whole family, practically, worked in either the hospital or the clinic, on friendly outings, usually for beer. Rhine was not entirely convinced of the desirability of having friends in the same organization one works. "Yes and no. You can get favors done more easily and quickly -- and that's to a doctor's advantage -- but it can also cause jealousies or enmities at all personnel levels."

Carlyle, the local industrialist and new hospital board member, the two partners of a local insurance agency, and Rhine met often with their families -- mainly at each other's homes -- "For informal dinners, for small talk. We go out on summer outings together whenever our schedules permit." Family relationships are also quite important to Rhine, but he feels he associates enough on the job with his relatives-colleagues so that he tries "not to get into that rut of seeing the same people constantly."

On his part, Sheridan definitely tries to avoid

> "complicating my work life and my friendships. My closest friends are young business and professional people in town, whom I've met through church affairs. My family takes up the bulk of my free time. I would say I'm closer to Hardt on a personal or friendship

> basis than with any other doctor. You can say I recruited him. Rhine and I are friendly enough, but we like to go our own ways personally."

Since Rhine was the more actively involved and articulate of the two doctors interviewed intensively on the various aspects of hospital policy-making and decision-making, the bulk of the following information quoted consists of his pertinent answers, excerpted from his remarks on the various subjects tapped.

> "As I see it, policy refers to the general principles formulated upon which the hospital operates, particularly with respect to the public at large.
>
> I feel that the most important factors to be considered in formulating and developing hospital policy at any level revolve about giving the best medical care that can be had in a hospital of this size. All considerations -- whether they be financial, legal, or otherwise -- should have this aim at their core.
>
> I think that the co-ordination or weaving together of activities to realize policy aims is a matter resting squarely in the lap of the Administrator. It is a matter for the administrative head. Formed policy should come from the Administrator's office. Of course, he has resource people to help him. The people to participate very closely with him are the heads of the various departments, such as the surgical unit, obstetrics unit, etc. These people do, as a matter of fact, participate actively. Edwards was very instrumental in putting together this form of organization and in detailing the working out of policy -- putting it into effect.
>
> His (the Administrator's) efforts are colored by the state health laws and regulations, as well as by inspections. They are colored by Medical Staff and hospital Board demands." [MS 18.]
>
> From the Medical Staff, Sheridan and myself are most actively involved in helping the Administator form policy. We constitute the Administration Committee. Before any changes in procedures -- such as scheduling operations -- are made, all the people concerned are told and asked their reactions. We on the Medical Staff have a hands-off policy as far as administrative goals go.

The Board's major policy concern is in eliminating bad debts and plant expansion and improvement. I'll come back to them later.

Some examples of policy directly related to, or affecting, the Medical Staff are the following. It is Emergency Room policy to see to it that a doctor is available each day, 24 hours a day. An outpatient comes in on emergency and he is asked by the Admissions Office who his doctor is or his preference, which person, if available, is called. The patient has a choice. This policy was established here in the clinic and the hospital Administrator goes along with us.

Another policy, established by the Administrator, to which we adhere, is that any order or whatnot must be signed. Other policies are in our 'Bylaws'.

There are 2 policies established by the Administrator which are not wholly agreed upon. Scheduling for surgery is one. The rule is that a patient must be admitted by 2:00 P.M. for a work up. Herman does not agree with it. The other is that an O.B. case must register for hospital care on the first office call -- again, to allow proper scheduling. Some of the doctors feel this is too confining. Yet, I can see the Administrator's position.

The Medical Staff certainly influences the Board on staff appointments. We are the ultimate judges, even though the Board's O.K. is needed. We've had absolutely no trouble on our recommendations. We also influence them on medical matters having to do with purchases of major equipment. Sometimes they ask us about things the Administrator is asking for in the medical area.

The Board has provided us with general policy formulations. I suppose the situation is best left this way, as it takes people actually working with problems, cases, and details to figure out their implementation.

The various rules flowing from the policies should be strictly interpreted for the most part, although there will always be emergencies and special cases. I can't really say specifically which ones should be liberally, which ones strictly, interpreted -- it depends on the circumstances and the unique factors affecting the judgment. [MS 21.]

We examine an applicant's competence, his record, and qualifications. Besides his training, we rely on personal recommendations and the information supplied

by the county and state medical associations to arrive at an evaluation of the man's suitability for staff appointment.

No, we do not let factors such as race, creed or the like affect our selection of a staff member. But since this area is pretty much W.A.S.P., we do get more applicants of the same background.

Probably I should say something in this connection about the osteopaths. One reason we kept Barnes off the staff is that until they are organized themselves and are recognized by the A.M.A., we don't want any of them. It's a matter of quality control. We want them integrated first. We feel they are rapidly improving their standards. They are better than foreign M.D.s, certainly.

The Administrator can't make staff appointment recommendations because he has no medical background to do so.

All in all, I think we've got a good bunch on our medical staff.

I feel that the training and personality of personnel are the two factors which contribute most to attaining and maintaining the quality of medical and nursing care (which I feel are inextricably tied together.) The willingness to work and learn -- to adapt -- are important too. We M.D.s control medical care, whereas the R.N.s, under the Head Nurse, control nursing or patient care. Of course, we work hand-in-hand.

The Administrator runs and co-ordinates the X-ray and Lab. He's in direct charge of our diagnostic services. He takes care of timing the various events needed to give adequate medical and patient care. He gets people and equipment together at the proper spot and time. He also supplies other services when and where we need them.

Through direct observation and supervision, we control the quality of our own work. Of course, the pathologists and the radiologist who supervise our diagnostic services are in a sense an external check on our professional competence. Through our committee reviews, each staff member's performance is evaluated.

Only that information which the Administrator can understand and which is useful from his point of view -- which should be to help him run the hospital as a whole -- should be interchanged between him and us. We informally pass on pertinent information and he is invited to participate in a limited way on those committees I mentioned before.

We have been educating him to our needs and those of the Nursing Department. He's pretty good and learning rapidly. On his part, he (as Edwards before him) is good at showing us his problems of co-ordinating operations and in asking us to modify or accommodate our ways of doing things from time to time.

We rely fairly heavily on the reports of our special consultants -- the pathologists and the radiologist -- to evaluate the medical operation of our hospital. But, then, we have all been trained ourselves to recognize good practice from bad. As in any scientific field, so in medicine, the general and specific standards and procedures have been developed over a long time by the profession as a whole. The staff and consultants have been exposed through their own training to these traditions, you might say, and, of course, we try to keep abreast of new developments through reading, attending meetings and lectures, and taking refresher short courses. Official accreditation standards are an outside source of evaluation. We ourselves have certain limits set by the nature of the work we do. We don't handle cases beyond our competence or ability to treat them. We try to be very careful in meeting the standards set internally and externally.

The Board and Administrator are not that directly involved with the problem of medical care. The Administrator is the more involved of the two, however. He funnels information to us (the Medical Staff and nurses) about problems of quality which touch on actual medical and nursing care.

Better leads to determining the quality of care come from the Medical Staff and R.N.s and from the Lab and X-ray. This information is contained in written and/or oral reports from the various sources just mentioned.

The Board and Administrator get occasional verbal complaints from the patients and, when they involve us, they are passed on to the Medical Staff and Nursing Department. We then meet informally together -- whoever are involved -- and discuss it. [the problem or complaint] The doctor has most to say about it usually, although the rest of the professional personnel are pretty knowledgeable. We determine whether the situation or complaint is serious or not.

We've had occasion to deal with two medical staff cases reported by patients. One had to do with a personal problem; another had his privileges removed due to incompetence. Both were courtesy staff members from X community. We have had occasion to have an aide removed

because she spoke to outsiders about the confidential aspects of a case. It was a P.R. problem.

There are no alternatives to suspension or revocation of staff privileges for doctors or others. We control these matters strictly. We have to -- malpractice insurance is going up steeply. There is more public awareness of the legal implications of care -- of the hospital's responsibility and liability and that of the doctors. We just can't afford to be lax!

The closely related purposes of both our medical records -- the office and hospital records -- are to protect ourselves in connection with the things we've just been talking about and to ensure we have an accurate account of the case at hand. The office record consists of the date, diagnosis or impression, treatment, and formal history (not necessarily in that order); the hospital record (recommended by the Joint Committee on Accreditation, by the way) consists of the date, diagnosis or impression, complete history, and lab record of admission and X-ray, nurses' notes, daily progress notes of the physician, and a summary of the case at discharge. Since I see 30 - 35 patients per month in the hospital and spend an average of an hour per record, you can see why it is hard to keep on top of the paperwork. Then you add office case records to this!

I feel I've answered this question already. The generally successful outcome of our medical and nursing care testifies to the quality of our ancillary or diagnostic services, I think.

Hospital standards are not developed by the government or state as such. Government is more concerned with safety, with seeing to it that buildings and equipment are satisfactory, with fire and explosion protection and prevention -- things like that. It's another group which develops standards. Medical detail men of the various professional organizations, such as the A.H.A. or A.M.A., or of the various specialty groups, develop standards. They rightfully should be, and are, involved in developing hospital legislation. Government bureaucrats should stay the hell out! They can ruin medicine. Military medicine stinks because of such interference.

The Board of Trustees mostly authorizes the purchase of all equipment we feel absolutely assential to the provision of good medical care because, I feel, most of them are genuinely interested in providing the best service possible. Costly items (over $200) are subject to review. This policy -- like a lot of them -- is understood, even though unwritten.

Yes, I personally investigate these purchase requests as the Medical Staff's consultant to the Board. No, I don't allow price to be the sole determining factor in the purchase of medical equipment or supplies. There is usually a wide range of choice in these matters so that an individual doctor can professionally decide what he wants, within limits naturally. The Board may decide if a choice is presented wherein the only difference between items is price -- again, usually in favor of the cheaper item.

There was a slight disagreement (or two) on the Board's part with some of the technicians' requests on equipment needs and over price. You can ask them about it. Sheridan wanted a particular piece of equipment -- a new anesthesia machine -- badly. Some members of the Board saw it as superfluous to equipment already on hand and postponed the matter, until Sheridan finally put the money out of his own pocket for it. No, they didn't prevent him from getting the machine for his own use. They see it as a laudable donation.

They [the Board] have allowed the Administrator quite a bit of authority in this area. They've been fairly liberal so far. There are, besides the equipment fund, contributions from certain groups, such as service clubs, and individuals, such as Carlyle or Sheridan.

The equipment, and other suppliers, for that matter, supply a wide range of information in the form of brochures and demonstrations. We've been able to get equipment at considerable discounts. An operating table which was used only for display purposes at a convention was a real bargain.

Our hospital P.R. have suffered only minor setbacks due to 2 local veternarians: one who complained a bit vociferously about the hospital and doctor's bill presented to him; the other complained about a $10 X-ray fee. Our biggest problem in this area is with patients blabbing about their stay and other patients. It's hard to maintain confidentiality in a small town hospital like this.

Every patient gets a return postcard to fill out when he is discharged to indicate his impressions, suggestions, and criticisms of the hospital. Coachman says we get a fair return and that the remarks are mostly favorable.

We medical men sit down with our patients ahead of time and try to explain their disease, its treatment, or the operation, if required, for their understanding and security. We do this also to soften the blow of the bills.

As far as I'm concerned, there are no similarities between labor unions and the organizations you mention. They are professional organizations.

There are quite a few differences. Education, skills, and techniques used are obvious differences. They are of a higher order in the professions and will be accordingly compensated. There is no need for professionals to bargain collectively. Except for maybe a few of the hospital employees, an individual basis for bargaining over wages and conditions is sufficient.

At the lower, unskilled and uneducated level -- where there is a need and motivation for money -- there are usually attempts to bargain collectively, but, I feel, the strike tactics of labor unions have no place in the hospital setting because of the critical and vital service it offers.

I think things will get better as far as salaries for hospital employees are concerned. Of course the employess can resign if they're dissatisfied, but many here won't because they are dedicated to service.

The key people in the community -- some of whom are on the Board -- Warrington and others, are in the position to best influence the hospital's policies. The powers in any community -- basically the big money -- will try and fairly well succeed in dictating general policy.

There is a shifting of power and money to the younger, more progressive people in the community. Smith is one of the older group who sees and is adapting to the new, developing situation. Of course, Warrington has done a lot for the community generally, and the hospital in particular, but he is, frankly, a bit senile now. The Old Guard will die off in 10 years and the community will change quite a bit, barring any unforeseen events.

I'm afraid that a social security type of medical care insurance will probably mean setting our private medicine system back -- to the low level of military medicine. Our working hours will probably be different by lessening the time we spend with our patients and increasing the time spent on paperwork. Incentive will be lost. Room rates will be set by the government. I don't like to contemplate it. Advances are made by dedicated men who are free to act and who place finances in a secondary position.

Administrative Structure and Activity

The Mills Springs Community Hospital has had two administrators in its brief history. It was not possible to interview the first administrator, Edwards, as intensively as the current one, Coachman, due to his many and pressing professional and personal commitments. Nevertheless, even though he was no longer a member of the organization, Edwards was quite willing to devote some of his valuable spare time to discuss his part in establishing and administering the organization. The basic information supplied by him was found to either complement or duplicate much information already given by others, especially by Coachman, and it will be incorporated herein as part of the information supplied by the latter.

Edwards was approaching 36 years of age at the time of the interviews. Married and the father of 3 children, he had been born and raised in a medium-sized city in an adjacent state, the son of a skilled factory worker. After graduating from high school and working at various odd jobs in several hospitals for three years or so (while in high school and during summers, he had worked as a hospital aide), Edwards enlisted in the U.S. Army and embarked on three years of intensive training in service as a clinical laboratory technician. Liking his job and assignment very much and thinking he could gain invaluable experience, he reenlisted in the Army for an additional 3 years and was, in time, promoted to head the diagnostic laboratory at a large Army hospital. Upon his discharge, with the rank of Staff Sergeant, Edwards took his first position as Hospital Administrator/Head Laboratory Technician in Mills Springs, which job he held for a little over 4 years, before moving on to a more responsible, challenging, and much better paid position at a considerably

larger hospital in the area. Edwards continues to live in Mills Springs and had been consulted informally now and then by Coachman, with whom he is on very friendly terms, on hospital matters.

Charles Coachman was 32 at the time of his interviews, married and the father of 4 children, and had been Administrator for a little less than one year. He, too, had been born and raised in the adjacent state, but in the central part. His father had been a machinist. After graduating from high school and spending one year studying in liberal arts at a small university, Coachman enlisted in the U.S. Air Force for 3 years, wherein he served as the administrator of a photographic laboratory, being discharged as a Staff Sergeant. He also took a year's college credits in service, so that he had 2 years of formal education beyond high school. While he was still in high school, and after graduation, but before his military enlistment -- for a total of some 4 years -- Coachman, through correspondence with a trade school, was learning to be and had worked as a commercial photographer. In service, he began to search for an occupation other than commercial photography to go into, which would allow him "to be of more service to people." Having heard about the need of hospitals for laboratory and X-ray technicians from a friend of his -- the latter occupation which he felt was a job not too far removed from his previous experience -- Coachman decided to seriously look into the possibilities of getting such a job after his discharge in a hospital in which he could train in that field. Through a medical placement bureau, he contacted the Mills Springs hospital and he was hired by Edwards on that basis. His basic training in 4 years with the hospital actually consisted of diagnostic laboratory

training, as well as X-ray work, as the organization grew and developed. Before his appointment as administrator, he had served as the head of the then combined Laboratory and X-ray Department, before another head X-ray technician was hired.

Coachman has lived in two large cities (stationed there while he was in service), but he definitely prefers a small town like Mills Springs, where he knows most of the people in the community and where he feels he is pretty well integrated.

Coachman confided, "I feel I should move on when I can better myself financially and in experience. I'll probably need to work in my present position for 4 - 10 years to get good experience and to thoroughly learn my job." He considered 8 - 10 years to be an ideal training time for hospital administration. He thought he would move to another small hospital when he moved, "but maybe to a little larger one." He felt too many large hospital administrators are "too showy -- they delegate all the work to their subordinates yet take all the credit. (There are some exceptions.) I feel an administrator should learn all the areas in the hospital -- especially in the administrative areas. He should become as familiar as possible with every operation or procedure."

Coachman's active participation in both community and professional organizations and associations was not as extensive as was Edwards' before him, for reasons he went some lengths to explain. He was a member of two professional associations, the Michigan Hospital Association and the Southwest Michigan Hospital Council. He attended the meetings of the latter very regularly; the other, less regularly. He saw the significance of the activities of these organizations to be basically alike.

> "I benefit from them. Their meetings and available literature, especially, are worthwhile and help me to do my job.

> These organizations have you looking years ahead in hospital developments. The Southwestern Michigan Hospital Council is a geographic, church-affiliated hospital council whose aim is mainly to band hospitals like ours together to enable purchases of large quantities of supplies at discount. Its main functions are educational and political. They hold sessions on hospital administration (one was held at the U. of M. on policy-making.) I feel there is a long way to go in the hospital field."

Coachman is a regularly attending member of the local Rotary Club, about which he was enthusiastic:

> "I feel our activities are definitely significant. Our meetings give me greater insight into the operation of business and government and interesting programs are presented which relate to industry. Community projects are explained, and I get the different sides of administration in other organizations. It's a good channel of communication for me to the community about hospital problems. Rotary and all the service clubs donate money freely to the hospitals with no strings attached."

He is also a member of the Community Chest wherein, again, he sees himself as a resource man to inform the public about various hospital needs and problems, but also, and especially, about "the Red Cross and what they do. I have talked a lot about Red Cross life-saving programs and the blood program. A lot of adverse, poor information has been spread about the work they are doing and what they spend. I find the 38-20 year old group most misinformed. I try to show them the good side of Red Cross."

Nominally a Republican, Coachman stated, "I stay away from all politics."

Coachman is a Third Degree Mason and a "member-in-good-standing" of the Methodist Church on whose Board of Stewards he serves. He had held the "Chair Office" in the Masons. Of his church activities he

said, "It ties me into the community. Through informal church activities, people get a better understanding of the hospital. There is definitely a welcome here."

Although Edwards had in the early stages of its development attempted to keep an organizational chart of the hospital, the task was soon given up due to the press of time and many changes constantly occurring. Coachman appeared embarrassed to admit that he had not thought of doing so, even though, he stated, he was aware from his Air Force and hospital experience that it was an aid to systematic thinking about one's own organization. Nevertheless, the Administrator was able to present a most detailed picture of the structure and functioning of the hospital's organization -- by far, and not too surprisingly, the most complete of any of its members.

Coachman cited "Edwards, the Board, and Rhine" as those "most responsible for the policy set up here." He described the responsibilities of the Administrator as follows:

> "The administrator has his fingers in all the departments; he must keep on top of the total situation. His main function is co-ordination of the hospital's operations.
>
> Although not all of our policies are written out, it is understood that we have them as guideposts. For example, in talking about administrative responsibilities or functions, I am in charge of purchasing equipment and supplies, both medical and other. Some purchasing, I (and Edwards before me) have delegated to department heads whom I have learned I can trust to do a good job; it also relieves me of one more burden or detail.
>
> Another function of administration is the budget which I have worked out with Mrs. Montgomery, our bookkeeper. A less detailed budget had been worked out by Edwards, Rhine, and Montgomery.
>
> Hiring is one of my functions. I have final approval to a certain extent. The department heads interview their own people and make recommendations. The final decision

> is a joint one between us. The salary scales had been set up by Edwards and the Board to keep pace with the average of those hospitals in this area. I follow that policy.
>
> Medical care and patient care are administrative responsibilities or functions in that I definitely try to police them. I'm vitally concerned with patient care generally.
>
> Maintenance is another administrative responsibility. I make recommendations to the various department heads. Along with the head of maintenance, I police cleanliness, and with the Nursing Supervisor and the Head Surgical Nurse, we make sure sterile conditions exist wherever they have to."

Coachman emphasized repeatedly that he actively solicits and voluntarily "gets suggestions and recommendations from both department heads and personnel about problems that crop up in their areas." He added . . .

> "I believe that lay people and the hospital administrator often can't intelligently make decisions in certain areas without the advice of the technical people involved, who know more and have a better grasp of the fine points of the problem and operations of their specialties. I feel that these people are not consulted often enough. I believe in, and try hard to maintain, a democratic free flow of communication and information.
>
> Nurses, especially, must complain and voice their opinions, if we are to have improvements in patient care. The staff read a lot to improve services in their areas and make beneficial suggestions."

The Administrator cited several examples of suggestions for improvements by R.N.s: one head shift nurse had designed a medicine cabinet for more efficient dispensing of medicine; another had suggested the use of paper covers for surgical gloves which allowed for faster, more efficient, and inexpensive use (no more laundering of cloth covers, nor need for repairs of same previously used); still another R.N. in O.R. had suggested that tubing on the oxygen machine be changed to allow for greater flexibility and mobility range; and a young nurse suggested the

establishment of a selective menu based on a 21-day cycle which would allow patients to select their diet from a menu listing alternatives.

Coachman stated that the Board has "very little direct responsibility." As he sees it, "they exercise most direct authority over building and grounds. Most of their suggestions are in this area, especially Warrington's. We buy equipment of all types. As long as they [the Board] hear nice things about the hospital, they don't bother us. We don't bother them with many things." In this vein, he continued. . .

> "Just recently we bought a $500 oxygen machine. We had the money; it was for patient care, so it was done. The doctors give suggestions as to equipment needed, but they also ask for advice and suggestions.
>
> We have an excellent relationship here between administrators, board, and medical staff on this score. On some other matters, there are problems.
>
> The Board is primarily concerned with the financial end of things. As long as we're in the black, they leave us alone. Actually, we're in pretty good shape now; we made a $9,000 profit for the last year of operation. We have a good accounting system which we have improved and are improving.
>
> Our write-offs were only $10,000 last year, which allowed us to be in the black for 12 months -- pretty unusual really for a hospital of our kind. This can be a problem, however, and was here. It still might be. Across the street (at the doctors' clinic) they wrote off $35,000. We try very hard here to have the payment policy explained to people who don't pay. About 20% non-payers are repeaters in that way. Of these, 45% were previous patients last year. If we could get 99% of the charges, we could raise the pay of both our experienced nurses and new R.N.s substantially. We'd be in a much better competitive situation.
>
> The Medical Staff is, of course, directly responsible for medical care: diagnosis, treatment, etc. We (administration) try to see that they get what they need to properly carry out their jobs.
>
> The nurses are responsible for patient care. They are very important because they are with the patients

> constantly and their skill in observing and caring for them is vital to the progress and well-being of the patients. They report to the doctors the conditions of the patients."

In addition to his regular, invited attendance of board meetings as the hospital liaison man, the Administrator serves on, or attends the meetings of, a greater number and variety of hospital committees than any other member of the organization.

He is the Chairman of the Administrator's Committee which meets once every other week during the year, with the exception of three months in the summer, at which time it meets once a month. It is essentially a meeting of section heads and is attended by the "Head Nurse, one of the 2 R.N. Floor Supervisors (they alternate attendance), the Chief X-ray and Laboratory Technicians, the Dietician, the Head of Maintenance, and the Comptroller." The Administrator sets the loose agenda. No minutes have been recorded, although they will be taken down in the future. The basic purpose of this committee is to review and evaluate the departmental operations and to discuss departmental (inter- or intra-) problems, and to receive the suggestions of the various sections or departments as to bettering the whole hospital operation as well as their own areas. No voting takes place at these meetings.

Coachman also attends the monthly Nursing Staff meetings at which he makes occasional comments and suggestions from the point of view of tying in the nursing section's functions into the overall operation of the hospital. "The show is the Head Nurse's", Coachman explained, "and the business is concerned with patient care procedures mostly." He is not a voting member.

The Administrator attends several of the monthly Medical Staff committee meetings upon their invitation. He has no voting rights.

Those committees, to whose business he has in part been exposed, are the Tissue, Surgery, Audit, and Sterilization Committees. He participates fully in the meetings of the Education Committee. Minutes are taken at all of the Medical Staff committee meetings and the basic business transacted consists of reports by the doctors and reviews and comments of cases. These minutes are not freely available to the Administrator or others. Coachman arranges for movies to be shown and scientific talks to be given at the meetings of the Education Committee by local and outside speakers. He has never been invited to the meetings of the Executive Committee which meets twice per month; "It would be beneficial to attend that committee's meetings," Coachman confided. . .

> "... as I feel that the relationship of the doctors', hospital's, and administrator's policies need to be better co-ordinated and open discussion is essential if certain problems are to be solved. This area of co-ordination of activities is slighted by the doctors and the Board doesn't help much here. I have to personally buttonhole the staff members singly to discuss problems of scheduling, admissions procedures, operations, filling out of forms, etc. It wastes a lot of my time. I think it would be better to have these things out in the open."

Another medical staff committee to whose meetings he is not invited, but which he would very much like to attend, is the Medical Records Committee "since accreditation of the hospital relies so much on this point."

Of these committees immediately outside administration, Coachman has the following to say: "They are all vital, if only indirectly, but most are of direct relevance to my job and the main aim of the hospital."

"The major goal of the hospital," according to Coachman, "is to provide the best medical and patient care possible." In this regard, all departments contribute importantly, the Administrator claimed.

"My main concern as the administrator is with our need to expand, to be able to continue to give high quality care to more people. Our occupancy rate has been above 80% for quite some time now. I think we should plan on doing something about it now. It's a serious problem.

In the continual striving for better medical and patient care, I have to, and do to the best of my ability, keep abreast of new drugs, devices, and aids in this area. I'm most interested in the diagnostic lab procedures being further developed and in the latest equipment being introduced and used fully. I send people to school to learn the latest techniques.

In the area of actual care, I make sure the nurses get the opportunity and time to attend refresher courses, conferences, etc. Our operating room is as well-equipped as any in the capital. We have 24-hour coverage in emergency.

The Medical Staff's major goal is the better practice of medicine and this is really at the core of the hospital's major goal. All our doctors are members of the general practice association. They are required to spend so many hours in seminars. They meet their obligations. All of them are board qualified in their areas, but none are yet diplomates.

The nurses' major goal is to provide better patient care, while the goals of the other departments are to aid, in their respective ways, the attainment of better medical and patient care."

The Administrator stated in answer to question(s), that, "I feel I have quite a bit of authority. In using it, though, I do a lot of consulting."

"Only the Board has the authority to approve or disapprove medical staff appointments", answered Coachman to the question asking on what kinds of things he could **not** make decisions.

"They do the censuring of doctors. The Medical Staff and I can respond to the Board. Actually, the Medical Staff has censured prior to consulting the Board and Warrington got very angry about it. There is one man on probation now; he's from X community. As a whole, however, there are many loopholes. The doctors have a tightly-knit group and they never testify against one another. I wish I could have more say in this area.

> I'm very careful in making any hospital decisions; I weigh the alternatives. You have to feel you've made the right decision. Of course, you have to admit mistakes.
>
> I have the responsibility for disciplining action in all those areas in my jurisdiction, which amounts to just about everything but board and medical staff matters.
>
> There are very few circumstances in which I have had to act autocratically, It's not really necessary, given the type of work and people in the hospital.
>
> Yes, I feel I need more authority in those areas I talked about relating to medical care. I don't have it because the doctors are too powerful, and the Board doesn't really understand the problem. It takes time, I guess."

Coachman stated that he had witnessed or experienced no changes, significant or otherwise, in authority relationships in the administrative area. "I have just stepped into Edwards' shoes; things run now about the same as when he was administrator. He had the same problems, generally, that I do." Edwards confirmed this evaluation of Coachman.

Coachman, at first, denied that there were any people in the hospital organization who resented his administrative authority, to his knowledge, but then voluntarily offered "the guess" that the Chief X-ray Technician "might harbor some resentment."

The Administrator was reluctant to rank the departments or segments of the hospital from most to least essential in attaining the hospital's major goal.

> "Well, if you could exclude the Medical Staff, whose contribution is most basic to the hospital's major goal, you could say the Nursing Serivce is most essential. Without nursing service you have nothing; the allied and secondary fields can't operate without good nursing and medical care. The Lab and X-ray Departments, along with Surgery, are essential. You have to diagnose the patient's condition accurately; it's necessary to know what to do. You need all the

> office services to supplement . . . No, it can't be done: all the departments have to work for this common goal of patient care. At the present time, all the departments we have are absolutely essential. We could nurse patients on a custodial or convalescent basis, but our goal is active medical care."

Coachman discussed a number of organizational changes in the hospital which he saw as significant.

> "I put the laundry and housekeeping sections under the supervision of the Head of Maintenance; they were separate before. They did not tie in to central supervision as they should have.
>
> I've made it a policy that personnel and personality problems that crop up, must go to the indicated department head before coming to me. This saves my time, as these things can often be handled at that lower level O.K. I've made it a point to either tip the supervisors in the various departments first, before I initiate any policies, procedures, and equipment requests, or ask them for their recommendations or suggestions on such matters. This is a good way to increase involvement in the organization. I encourage the supervisors to do the same. This helps partly in reducing personnel or personality difficulties.
>
> Before I came here, and for a time after, there was an assistant administrator working (one of those on-the-job trainees). He had it so that a person had to have a written request to him on just about everything; it was just too damn formalistic and especially bad for a place this size. His personality and method of communicating with people were poor. He had other problems besides. A good means of communication is most important to good personnel relations. You must listen to their opinions and explain things to them.
>
> I can give you a good example. There was one R.N. who continuously complained to all the nurses, but to the Head Nurse, about things. Getting wind of it, I finally told the Head Nurse to channel all complaints to me on paper or by word of mouth. That nurse has since made many suggestions in written form and has accepted suggestions in return. Her safety suggestions were very valuable. As a result the nursing service is easier. All supervisors now take written and oral suggestions which are discussed at the supervisors' meetings.

> Our facilities for the aged (our geriatric patients) are not good; they must be changed. Our old people can't take care of themselves readily; they need more medical attention and nursing care. Most convalescent homes are not very good (some few are); their atmosphere is dismal. This is really a national medical and moral case against our society. We just have to care for them.
>
> This will mean our nursing service will have to improve. We will have to increase the living standard up to where it should be; we must raise nurses' salaries. You have to pay for the best medical care. I feel we will be able to get such personnel. We will not need a great number of R.N.s -- we will need more L.P.N.s and aides. R.N.s will have to, more and more, do the paperwork and give the really technical care. Our nurses -- like most -- hate administration, but they realize, I think, that's how we have to use them. We can't possibly handle large numbers of patients without aides or practical nurses.
>
> I don't foresee any other major organizational changes, unless we really expand in size, type of medical practice, or build a new hospital or wing for geriatrics. It is all up in the air at present."

Coachman was hired by Edwards, as was said previously. His was one of six applications for the position of X-ray technician. The contact was made through a medical bureau in Chicago, which lists positions available and rates hospitals for doctors, nurses, technicians, and other hospital personnel applying for jobs. The detailed information* supplied Coachman on the hospital, its personnel, and the community made for "a very good rating" in his eyes. He felt "this new hospital would be a good place to get in on the ground floor; you can prove yourself and get along with people." His expectations were fulfilled. His aspirations for his job were "to see our hospital grow in terms of beds and services."

> "There is always more room for improvement in medical care; I feel strongly about this. Too many hospital administrators look only at dollars and cents or are

*Interesting as they are, responses having to do with other than policy- and decision-making are included in Appendix C.

> personnel conscious. Any time you can better patient care you should act to get the equipment to work with. The Administrator should stress and push for the best care possible. We do make our patients more comfortable and get them out faster than other places do. Our doctors do not keep people in unnecessarily; they get them up and around and out. The sooner you get them back to their livelihoods, the better off they are -- the patients will be happier, if they feel well that is.
>
> You have to be dedicated in any area of work to do a good job -- be it teaching, medicine, the ministry -- you must love your job. I like this job; I feel the service I give is important; it gives me self-satisfaction.
>
> I don't especially like the money end of my job. Collections are a problem; I have had to turn people away. Of course, emergency admissions will take care of them in really serious cases. I don't like to see chronic users of society to 'use' us. I meet these people who 'use' the hospital and they're a sad lot. On the other hand, there are two cases -- both are paying -- whom we haven't sent a statement to. It will take them years, but you know they will pay. That's how some people are ... they meet their obligations."

"Policy", according to Coachman, "means setting up and developing rules and regulations which will guide us in the efficient and good management of a department and the entire hospital." He went to some length to underscore the necessity of the total approach.

> "The overall goal of the hospital -- good medical and patient care -- should take precedence over the goals of any particular section of the hospital. As I see it, the role of the administrator is to educate the hospital's personnel in this direction. One must balance these central needs with the financial ability of the hospital to attain them.
>
> The Board, of course, is definitely very important in the development of policy in the overall sense. The Medical Staff and the department heads are important in their areas.
>
> The Board does actively participate, as do Rhine and Sheridan; the other doctors are reluctant to. The Head Nurses are very active in their area. They sometimes make helpful suggestions to others, such as the doctors and other department heads.

> We try to involve as many people as possible in determining policies by which they are affected. Generally, the department heads are most involved, although some individuals within a section can make suggestions."

Coachman felt that much work had to be done yet in the "formalization of board and other policy -- by that I mean we have to write more of these policies down and put them down absolutely. This hasn't been done enough. I'm all in favor of clear-cut guidelines." Edwards had had mimeographed a handbook for the employees of the hospital containing personnel policy; still being issued, it was in need of revision.

Coachman complained that "we've inherited problems of personnel policy." In the Dietary Department "there are too many chiefs and not enough Indians." He thought that,

> "The head of Dietetics needs to be replaced. She's at the age of retirement. We have inherited too many old people there from the old hospital. The cook, for example, is 72. She's very forgetful -- an excellent cook yet ... I have gotten rid of others from the old hospital in maintenance, or they have quit. Our new laundryman is a 'crackerjack'.
>
> The problem with the old people, in addition to their age and lack of vigor, is their poor educational background. They don't seem to understand why certain things have to be done in a prescribed manner, in a technical sense. Yet, some members of the Board and Medical Staff feel we owe these people something. I guess we do in a way. Still ...
>
> We need experienced people and we took quite a few from the old hospital. Seventy-five percent, I would estimate, are now new people.
>
> There is another personnel problem. Every year we face a deluge of high school students wanting summer jobs. Should I hire part-time help or get a full-time man in this area of maintenance of grounds? In terms of cost, efficiency, and our real needs, we are better off with a full-time man. But prominent people in the community have put pressure on Edwards and myself, through the Board, too, to hire their sons and daughters. I feel

> the administrator should be the judge of the hospital needs in this regard.
>
> In the monetary field, the administrator should try to influence the Board in establishing policy. This is its prime area, also building and grounds. But what they decide on finances affects us all, directly or indirectly. So we should have something to say, and we do.
>
> We have helped the Board to formulate the policy of not allowing debtors to return to the hospital for routine treatment. By using the Board's authority and pressure to make collections, we have had definite success in this. Warrington is really good for applying pressure.
>
> Other examples relate to the recent change we discussed in the oxygen system. We made the change. (By using lower pressure, we operate more safely and more efficiently than before.) In the matter of care and beauty of the grounds, we made an impact: who mows it (contracting mowing), with what kind of mower, and so on. If we have the money, we can get action, and vice versa."

Coachman mentioned that the Medical Staff and other departments which developed policies were "probably better off in having formalized their operations somewhat." He referred to documents produced by the Medical Staff, Nursing Staff, and X-ray and Lab Departments.

> "The doctors have their own by-laws based on accepted rules of practice. The Nursing Staff has ward books in which procedures and techniques to be used are spelled out. So do the Lab, X-ray, and, to an extent, Bookkeeping. Dietetics is lagging.
>
> The Board is not too interested in these aspects of running the hospital."

Coachman, although very much for "formalization of policies", nevertheless admitted that such policies would have to be strictly or liberally interpreted according to the situation.

> "It depends on the individual problem or the case. Not all are cut-and-dried. One should be prepared to be liberal in some areas and make concessions; there are always exceptions to rules. I really think bill collecting

> has to be pushed, however, or the abuses will ruin us. We have had to be strict about this. Emergencies will create liberal interpretations."

The Board, acting with the Medical Staff's recommendations in mind, was cited by the Administrator as the party chiefly responsible for determining the privileges to be accorded applicants for positions on the Medical Staff. Coachman felt that the Medical Staff should rightly exercise their great influence in this respect because "no lay member has the knowledge or competence to do so [appoint or recommend medical staff members] without the technical aid of the doctors." He did not feel that a hospital administrator should take part in this process of recruiting medical staff "for the same reason I just gave: I haven't the technical knowledge." As far as he was concerned or knew, factors such as an applicant's race or creed did not affect the decisions involving selection and determination of staff privileges. "Ability and willingness to cooperate with the immediate, active medical staff are the main factors used in considering the suitability of applicants. Their competence has to be tested; that's why they [appointees] are on probation."

Coachman devoted considerable thought and time devising an answer to the question of what factors determined the quality of medical and/or nursing care provided in his hospital. His first remark was to the effect that "all the doctors demand a good standard of ancillary medical services and nursing care. They demand it or get it elsewhere. If you do supply these services, they will continue to use your hospital facilities." Coachman affirmed Edwards' statement that the physicians set the tone for quality of care generally. Coachman summed up the matter in this way ...

> "In short, all the doctors, and the professional nurses, govern medical and nursing care in a real sense. The fact that we are adding more specialists

and consultants to our staff is an indication that we are faring pretty well on these points.

The training and experience of the staff and nursing personnel, and the availability of same and of good technicians, are the factors ultimately responsible for quality care.

As for my controlling the quality of professional work done by the Medical Staff or nurses, I can call attention to the needs for proper scheduling, procedures, medical records, and the like -- what we've discussed already -- but I can't really do much as matters now stand. More with nursing, though. I would like to be in on the staff's executive committee meetings to actually discuss certain cases, but I can't force my way in.

The Board -- being legally responsible overall -- has greater leverage available to it to exercise control over the quality of medical care, if it would or could. Malpractice suits scare them a lot, as they should. Warrington, especially, is aware and concerned about this problem, having been a board member at the county hospital. Still, he sees medical care quality as a partial, legal problem. There is no really effective way we (the Board and I) can put pressure on the doctors. The county and state medical societies are window-dressing to a great extent in this respect. Quality of medical care is mostly self-enforced.

I think much more information than is presently should be exchanged between the doctors and myself. Malpractice suits are becoming more common and we should protect ourselves in advance by planning ahead. But I can only use those channels we have established; I'm not in the most powerful position in the organization by a long shot.

I think that the best way to develop and maintain good relations with the Medical Staff now is to fulfill their individual expectations and to use persuasion. indirectly bring them around to view things in a different light.

I use what I've learned from Edwards, reading, meetings and conferences as standards to evaluate the hospital's operations. Hospital administration manuals, articles, hospital administration services; the U. of M. and M.S.U. (somewhat less so) conferences have helped.

If the quality of medical care doesn't meet our established standards, we find out about it fast enough. The doctors

> won't beat around the bush. They tell us where improvement is needed; ditto the nurses. It is up to the administrator or department head to make the improvement indicated or to recommend it. (I'm speaking of the services surrounding the core activities now.)
>
> In cases of malpractice -- by medical personnel proper -- the doctors usually advise the administrator what to do. I have asked their advice about certain nurses and dietary service personnel involving problems of health. Stealing problems I've referred to Warrington. I accept the doctors' word as to whether employees are fit to work. Every six months we have a physical examination of the dietary people. Yearly, everybody takes a physical and all get chest X-rays every six months."

Coachman soft-pedaled the question of whether any medical staff members had in fact been removed or how, stating, "I wasn't involved in the cases; you'd do better to talk to the Board, doctors, and Edwards about that." Edwards pictured the procedure of expulsion as the Board's primary responsibility (with the counsel of the active staff), although he himself had initiated the dismissal of his former administrative assistant (not a M.D.) for "incompetence and a narcotics addiction problem." Probation was seen by both as the alternative to suspension or revocation of medical staff privileges.

Coachman had already commented upon and discussed the importance of medical records in connection with quality operation of the hospital. He added that they were "damn important and more should be done than is in this area to bring about accreditation of our hospital." He indicated that the quality of the records completed was fine, but that the Medical Staff was far behind.

> "They complete them after awhile by dictating them into machines we've bought. The records are checked for completeness and quality by the chairman of the medical staff committee and by our pathologists and radiologist -- consultants. I keep 'bugging' the

> doctors. I check the matter periodically. I hope we can lick the problem."

The Administrator said he relied upon his departmental heads, who had been in their positions sometime before he assumed his current administrative duties, to aid him in evaluating the qualifications of the members of the administrative staff.

> "By advertising in the appropriate professional and technical journals, we recruit our personnel. We also use personal contacts a lot. I consult with the department head who has a need for people and we interview the person together, check his background, and references. Final approval for hiring comes from the Board.
>
> Salary or wage rates had been established by Edwards with the Board's approval. The policy is to match the average of hospitals in this area. Any subordinate -- by this I mean department heads and key personnel such as nurses -- must be efficient and personable. We have had problems with the X-ray Chief Technician and a floor nurse. Smith is not personable, Joyce is 'bitchy', a complainer; they're hard to get along with."

Nursing Structure and Activity**

This section is devoted to an analysis of the responses to a series of questions -- by-and-large interchangeable -- formulated in the "Departmental Heads Questionnaire" and presented to the heads of nursing, ancillary, and various administrative departments, and to personnel of the lower echelons therein. In part to relieve the monotony of presentation, to spare the reader possible boredom, and for the sake of brevity, but also -- in greater part -- because the following material is more readily amenable to such treatment without losing significant content than was

**As in the cases of the Board's and Administrator's responses (partly), the responses of the Departmental Heads presented here will be largely addressed to policy- and decision- making. Other materials of interest are included in Appendix D.

the case with the previous material, the analysis shall be abbreviated. It was found in pre-testing the questionnaire that some questions (later eliminated) were not eliciting information or not eliciting significant answers, primarily because the questions asked were evidently tapping knowledge beyond the ken of the respondents. This was especially so with the personnel in the lower echelons of the organization, but in regard to certain questions, of certain departmental heads too.

A "Supervisory Manual" issued to all personnel in the hospital spelled out formally the organizational structure and functions of the nursing service department. From actual, extensive observation, it was found that this document fairly accurately portrayed the operations of that branch of the hospital.

According to the Administrator and M.D.s, the positions of Director of Nurses and Surgical Supervisor were the key ones. This was confirmed by the nurses themselves. The persons occupying these positions were better informed than the others about the overall operation of the Nursing Department and the hospital. These two women were older than the other R.N.s and had more experience in nursing and administration.

The Director of Nurses or Nursing Director at the time of the research was Mrs. Kedzie, R.N. Born on a farm in a small town in Iowa 49 years previously, the daughter of an automobile salesman, she was raised and attended school in the community of her birth for all but her senior year in high school. That year she spent in Mills Springs, the home of her grandparents, to which town her parents had moved. Upon her early graduation from the Mills Springs High School, she took her nurse's training in a nursing school at Rochester, Minnesota and worked a short time thereafter in the Mayo Clinic, before marrying a Mills Springs man and moving back.

She and her husband had lived there for some 30 years. When alive, he had worked for the state government in the capital. One married daughter was also a resident of Mills Springs.

Mrs. Kedzie had held the position of Director of Nurses for 3½ years at the time of the interviews. Prior to that, she had been Director and Chief Nurse at the V.F.W. National Hospital in Mills Springs for 8 years, and had for several years before been an office nurse for the local doctors. On and off ever since 1933, she had worked as a staff nurse in the local and area hospitals, except during World War II, when she operated a drill press in a war plant in the capital "because I could make more money there than in nursing."

She claimed that she liked the community very much and was settled there for the rest of her life. She was impressed with the new school and bigger hospital, and hoped that more people and industry would move in because "I personally welcome the advantages expansion and growth would bring the community. It has been backward in the past." She stated that she felt well-integrated and had a wide range of friends and acquaintances in the community. Her participation in fraternal, social, or religious organizations was "somewhat limited due to my occupation", but she did belong to the Order of the Eastern Star, Rebekah Lodge, and Methodist Church. She had held offices in the Eastern Star for 10 years. She felt that these organizations were "good" and gave her a sense of "community belongingness", and she enjoyed the social life they afforded her. She did not feel these kinds of organizations should be used as forums for nurses or hospital people generally. "I go to forget our business in these organizations. I was trained in nursing school not to speak of our business which is too often so tragic. In my opinion we shouldn't advertise

our business or talk about it; it is not ethical or legal to do so." Mrs. Kedzie restricted her participation in the State Nurses Association and American Nurses Association to membership and committee work (on the state level) and attendance of national conventions. She preferred to "work at my profession and not get into politics."

Mrs. Johnson, the Surgical Supervisor for 4 years, had been born in a small town some 10 miles from Mills Springs 44 years ago, the daughter of a carpenter. Married to a Mills Springs dairy farmer, Mrs. Johnson, her husband, and four children had recently moved from Mills Springs to a new dairy farm they had bought in a small town some 15 miles away. After graduation from her home-town high school, she had trained and earned her R.N. from a nursing school attached to one of the 2 major hospitals in the capital. Additional, specialized training in the surgical management of people and in sterilization practices was given her when she was sent by the hospital to New York City. Off and on since 1945, she had worked as a nurse in the old hospital in Mills Springs.

Mrs. Johnson stated that she liked her new community much better than Mills Springs "because of its better school system." One of her 2 daughters was a slow student, due to an inherited defect, and received better training in school there than she had in Mills Springs. She also felt that the 4H activities there were better organized. Her sons enjoyed themselves more. Disadvantages to living in the new community were that she was always commuting and her children had fewer playmates. Her social activities were severely circumscribed by the nature of her job and her work at home, she stated, but she did find time to participate -- albeit irregularly -- in the P.T.A. and Presbyterian Church activities in her new community. She described her husband as "a dedicated farmer, not a

joining man." Although she was interested in the P.T.A. and church activities, for the sake of her children primarily, she also was interested and involved in the church's Blood Bank program. With her marriage and need to raise the children, she had become less and less involved in professional nursing associations. She belonged neither to the state nor national nurses associations.

The roster of members of the Nursing Department fluctuates from time to time, seasonally, and with emergency needs of the hospital. According to the Nursing Director, the total number of personnel varies between 40-50 women and consists presently of the following: 3 full-time Surgical Nurses (R.N.s), 17 R.N.s in Obstetrics, Nursery, and Emergency (among these are 3 full-time), 5 L.P.N.s, and 20 nurses' aides. It is the largest department in the hospital.

> "Because we practice partnership nursing," claimed the Director of Nursing, "one can take up where the other R.N. leaves off; they've been with us so long that part-timers present no problems and most of our R.N.s do work part-time. Almost all of them are young married women and have their families -- husbands and young children -- to care for. The same applies to the L.P.N.s and aides. Their average age is in the mid-20's. They are supplementing their husband's incomes. All the R.N.s get full-time advantages."

Although there are 8 full-time Registered Nurses on the staff, not all of them are working at the same time. Two of them are assigned to each of the 3 shifts the hospital runs. (There are two wings to be covered.) Two R.N.s are assigned to the operating room which is used only on the day shift. One particular R.N. is always on call for duty there. The Surgical Supervisor stated that the surgical nursing team is composed of one R.N., and one aide, besides herself. The other, part-time R.N. is called in every 3 weeks, usually, or as required by the surgery schedule. The 2 R.N.s were trained in the two hospitals in the capital, one in each

of them; the aide was trained locally. The medical staff completing the surgical team is made up of Rhine (the surgeon), Hardt (the assistant), and Sheridan (the anesthesiologist); Herman Roos gives spinal taps and anesthetic. Miss Evans is a trained attendant and often scrubs up too.

The Director of Nurses described her responsibilities as mainly consisting "of employment or hiring and firing of nursing personnel, co-ordination of nursing jobs, attending short courses to enable me to better educate the nurses and to improve the hospital's nursing care, and to smooth out medical staff and nursing staff relations." She referred the interviewer to the "Supervisory Manual" for more detailed information.

She saw "complete patient care" as the main function of her department. "Keeping the patients comfortable and accurately performing the prescribed treatments placed in our hands are our functions. We try hard to give the most adequate -- the best -- care we can. I feel we have a very good standard of nursing care here."

The Surgical Supervisor viewed her main responsibility to be "to see that everything goes smoothly. I circulate, others scrub. I do the counts -- sponge and the like, intubate -- in general, oversee the whole operation from the nursing end of it. We're there to aid the doctors and perform the necessary technical jobs connected with surgery."

The Director of Nurses claimed that she did not attend very many committee meetings, although her department held them. "Of course, I attend regularly the department head meetings the Administrator holds." She did not think too many committee meetings were necessary because most nursing business was transacted informally. Nevertheless, of all the committees in nursing -- Hospital Steering Committee (function, methods

improvement), Nursing Personnel (personnel policy), and Auxiliary Nursing Personnel -- she was chairman. She felt that each of these committees contributed in helping her to fulfill her responsibilities in one important respect.

> "Because we R.N.s come from different schools and have been trained in different methods, we have the committee meetings we do now only to insure that the basic things done are commonly understood and performed uniformly. To that end we have devised a set of Ward Books wherein standards and procedures are spelled out, and we hold training sessions for the aides and auxiliary ladies."

Mrs. Kedzie and the other head nurses had trained the 20 aides over a year's period in weekly sessions.

> "The problem with our training program is the participants ask 'is it on my time or your time?' Actually, we have had pretty good attendance and want to renew the series. I am particularly interested in education and we will have the medical library available to all our personnel shortly."

The Surgical Supervisor attends the meetings of the Committee of Department Heads as they are scheduled. This is the only committee whose meetings she attends regularly. The others "are few in number and not really necessary. They are more or less standing committees. The business we now need to handle is done informally." She described the business transacted by the above committee as consisting basically of "the ironing out of various gripes." From the point of view of the Nursing Section, generally, and of the Surgery Section, particularly, the matters dealing with the complaints of patients -- coming out of or recuperating from surgery -- about surgical preparations, catheters, care offered on the 3 - 11 P.M. shift (a critical time for such patients), and with the brusqueness of treatment sometimes given by the X-ray and Lab people, are of paramount concern. She has had to speak directly to

the Floor Nurses on occasion about the necessity to be more understanding and solicitous of patients recovering from surgery. On other occasions, she has had to report some people to the Administrator through the Director of Nurses to get remedy.

Mrs. Johnson saw the major goal of the hospital to be "to serve the community the best we can." The major goal of her department "is to get our patients back alive. We have done so well, so far. Our job is to do good surgery." She expressed great confidence in the surgeon, Rhine.

> "He is a good surgeon and improving all the time. The doctors here spend more time with patients than any other place I know of.
>
> We really need another surgery, however. This one is inadequate. Planning was poor, in that emergency and central supply have had to be located in the basement, which is too inconvenient and wasteful of precious time. That was Warrington's error. He didn't consult the doctors or ignored their suggestions. We also need an elevator to transport our patients between floors. Ramps can be dangerous."

The Director of Nurses felt she had the authority necessary to make the final decisions over the hiring and firing of, placing, and assigning duties to, all nursing personnel.

> "Because this is a pretty close community, other things -- although they may relate to nursing in some ways -- are handled by the Administrator, Medical Staff, and the Board. I have some authority in settling personality difficulties. I try to teach tolerance of others. In a few cases, I have had to pass matters on to Coachman and the Board.
>
> We do the best we can with the present physical facilities, but they are inadequate in a technical sense. They (the Board) didn't ask the professionals how to build the hospital. They didn't consult a hospital architect. There was quite a bit of poor planning in the physical layout. The kitchen is in the wrong place; the O.R. is inadequate; and central supply and pharmacy room has to

> be located in the basement. It is inefficient and a bother.
>
> I feel I should have more to say on the contagion bit. We have to be stricter and police this situation better. The laundry workers and others coming into contact with soiled materials and equipment need protection and need to be made more aware of observing the proper procedures in handling such items.
>
> Edwards and the Medical Staff had worked out the overall authority relationships before I took this job. All in all, I have no complaints. I feel I have their respect and support and that of my subordinates."

The Surgical Supervisor saw her authority to reside primarily in the booking of surgery and in handling details in preparing the operating room and getting necessary supplies on hand. There had been a proposal by the Chief of Staff to have certain surgery performed on Saturdays or Sundays, but she had demurred. She informed the other nurses of the proposal and "it went over like a lead balloon." She then informed the Medical Staff of the unanimous disapproval of the nurses on this matter. "I pointed out to them that to do justice to our work, no Saturday or Sunday surgery should be done. As it is, our nurses are on call; we prefer to handle only emergencies on those days. Nursing can't be all a married woman's life. After all, I live outside surgery." It is her additional responsibility to supervise the other nursing personnel and aides in O.R. Her remarks on the freedom enjoyed and the initiative left to her and her staff confirmed the results of R. L. Coser's study[6] of surgical nurses.

> "We have quite a bit of freedom and our initiative is encouraged by the doctors on the surgical team. We are a very compatible group -- we have to be. One has to be alert and capable of carrying out certain tasks then and there, often without being asked. Certain things have to be anticipated. To be fresh, therefore, I schedule operations for the mornings -- 8 A.M. on. On occasion surgery is scheduled for after

> lunch. We usually operate the whole morning. Summer is a little slacker than other seasons, but we've had 459 operations over last year during July and August -- a 50% increase."

The word "policy" for both women meant to set up rules and regulations to guide in making decisions. "In making a policy one should say that such should be thus and so," said Mrs. Kedzie. In setting up or changing policy, both felt that all the people involved in or by it should be notified. As Mrs. Johnson put it:

> "The people involved in making decisions and carrying out tasks efficiently should have some say in how these things are to be regulated -- policies should be drafted from the technical vantage point. Those whose job it will be to carry out various nursing tasks have the knowledge to formulate the rules. We nurses have devised ward books which spell out the responsibilities, proper procedures and techniques for the various tasks."

Materials prepared by U.S. Army and other nursing groups were used by the nurses and Edwards, with the doctors in consultation, to tailor the Ward Books to their own situation.

The Director of Nurses pointed out that

> "even in a small place such as this, you can't get all of the R.N.s together, we couldn't because of time conflicts -- they had to work in shifts. Therefore, then -- when setting up our unit anew -- and now in changing or setting up new policy, the Administrator, the doctors, Johnson, the nurses, and I get together. We still get the suggestions of the others. Consultants have been brought in from time to time, and they will be used more often in the future, what with expansion."

They both declared that the nurses themselves should try to, and did, influence the bulk of policy development in nursing or patient care.

> "Good patient care is our chief concern," said Mrs. Kedzie. "Our slogan is 'the patient is our most

> important product'. The new Administrator is as vitally interested in our improving techniques and securing equipment for us. He is encouraging us in revising the Ward Books. He gives us our head. We have received policy improvements or suggestions from the M.D.s on how to handle obstetrical deliveries and how to treat tonsillitis patients. A recent policy governing medical staff-nursing relations has been established, which has to do with the nurse signing a patient's chart only after getting the doctor's counter-signature."

X-ray and Medical Laboratory Structure and Activity

The two youngest departmental heads were Smith, the Chief X-ray Technician, and Barrett, the Medical Laboratory Technician. These men were 27 and 22 years of age, respectively, at the time of the interviews. Smith had, until quite recently, lived in the capital where he had been born, raised, and educated. Barrett had lived in Mills Springs ever since he had arrived to take his position. Both men were married and had children: Smith had 4, Barrett 2. Barrett had been born in a medium-sized city in Ohio and had lived and been educated in Indiana. The fathers of the two were, respectively, a toolmaker and a printer.

Smith's educational and occupational background was the more varied of the two. He had graduated from high school with a pronounced interest in engineering and, for some time afterwards, had attended the General Motors Technical Institute (for 9 months) while working for an automobile plant, micro-filming blueprints for its engineering section. He subsequently enlisted in the U.S. Army for 3 years during which period he was trained as a X-ray technician. Being quite proficient, he was made an instructor of X-ray technicians in the Medical Corps attached to a large Army hospital. After leaving the service, he spent 2 additional years in X-ray training at two hospitals -- one in a capital hospital and one in the Capital County hospital. Smith had held his position for 4 years.

Barrett had graduated from high school in Indiana, and had worked summers on the Indiana Turnpike and in the laboratory of a sanatorium in Michigan, while attending a branch of Indiana University for 2 years, majoring in laboratory and X-ray technology. He had earned his medical laboratory technician's certificate there, valid in all states but New York and California. He had held his position for 22 months, but he estimated his total experience in laboratory work to amount to five years.

Both men had mixed feelings about Mills Springs as a community. Smith said he preferred life in a small town in that it permitted one to know more people his own age more quickly and extensively, but that he did not care for the school system or the domination of the town by a faction of old residents.

> "I don't agree with these older people as to how to go about building schools. They haven't done enough for education. Older people have run the town too long. It has been dominated for 2 or 3 generations by the same faction. Warrington has called the J.C.s young punks!
>
> By-and-large it is hard in this town to get to know and be accepted by all the people in town. Anyone with new ideas is suspect, and it is hard to get one's ideas across. I've seen this in the recent school and hospital experience.
>
> Who you know, not what you know, is necessary for advancement. Things are changing slowly but evolution is rather too slow."

On the other hand, Smith feels very well integrated in the community with people his own age. He would move to another job if the opportunity were better than what he had. "I wouldn't hesitate to move immediately if I could advance to a job as the administrator of a small town hospital."

Barrett felt that there were "a lot of nice people here. You can get to really know people. It's an easy town to join in. There are some

cliques which are hard to break into. The 'Old White Fathers' run the town. I expect some change to come from the J.C.s and the younger executives in the paper company and so on."

He described the school system as "not adequate enough (though progressing). Shopping for many things is also inadequate, so we have to go to the other towns and cities nearby. (So does Smith.) Food prices are a little high."

Barrett commented that, "personally, in the last year and a half, I've done exceptionally well here for one so young and inexperienced. By being in the hospital you can see people and be seen. My wife is in the Literary Club which helps us be known too. The J.C.s and Young People's Club in the Methodist Church are real aids in making yourself known."

Barrett said "I'll probably stay here, but it depends on how things in the hospital materialize. Since Coachman moved up, so have I. Expansion will make for a nice salary increase. I won't move unless I get something better in my line of work. I'm doing O.K. here."

Smith was evidently very proud of his active membership in the Junior Chamber of Commerce, of which he was currently Treasurer and board member. He had previously held the offices of First and Second Vice-President in his 4 years in the organization.

> "To the extent I am an employee of the hospital, I serve as a public relations man for it. I've often been asked by the Administrator to serve as such for the hospital. The new doctor, Hardt, and I handled the Health Guard Program in the J.C.s. We talked about such things as fluoridation, poisoning, drowning, and immunization to them.
>
> I think we in the hospital should do more in the area of P.R. The hospital seems to be an island of its own. Most people feel those who work in hospitals are oddballs.

> Yet we're just like people in any other business. Personnel reflects the quality of service. We have to 'sell ourselves'; give good information to a lot of people. That way we'll get better support.
>
> The hospital should be more concerned with the health of the community, in preventive medicine. I have not known the hospital as a unit to take a stand. As a matter of fact, the hospitals' Board of Directors were mostly anti-fluoridation; all the doctors were for it, but not all spoke up. We should draft petitions to bring fluoridation up to the public and spell out how it should be put into effect. We should put pressure on the city commission. Without real pressure, they will vote it down. One problem is you can't explain such matters to the laymen in this town in medical terminology. Too many have low mentalities. They can be easily swayed by emotional appeals from Warrington and other rabble-rousers."

Although he professed increasing interest in politics and wished to be more involved in such activities, Smith said he had "to be careful." His parents were described as "diehard Democrats. I guess I'm a Democrat, too. The M.D.s here are diehard Republicans -- most of the townspeople are. So I have to be slower to argue about political things. I have a more liberal slant on things than the others in the hospital."

Smith is a Catholic and attends church regularly. He is the senior church organist. He is also a member of the Holy Name Society. "Being a Catholic doesn't help in this town," he remarked.

Smith is a member of both the American Registry and the American Society of X-ray Technicians whose national meetings he attends irregularly. He is also a member of the Michigan Society of X-ray Technicians and the Southwestern Michigan Society of X-ray Technicians. "I attend these meetings as regularly as I can, being I'm tied down on calls so much." He was the Convention Site Chairman of the former association.

Barrett's participation and interest in community affairs were slight. He was an irregularly attending member of the Junior Chamber

of Commerce.

> "I am on call and get there when I can. They do an awful lot of good. They sell fruitcakes for charity, get needed baseball equipment for little leaguers, and have bought a number of crosswalk signs for the town. I haven't been in the organization long enough to really do too much."

His other major interest was in the local Investment Club.

> "I am able to get out once in a while for a night and play cards and socialize with these fellows. We mainly meet to discuss how to buy stocks, however. It's educational and our savings program. We belong to the stock exchange in the capital, have by-laws, and are incorporated. The membership is made up of young men in the 22-30 age bracket: a local pharmacist, a jeweler, a carpenter, a few management people, a construction engineer, and an insurance salesman, plus myself."

Barrett would like to participate in the activities of the school board and city government but he has no time. "I'd like to join the Masons, if I could. I've talked to Coachman about it. I don't know too much about what they do. The community looks up to them and say they do good. It's another way of finding more friends, even if they are older."

Barrett is a nominal member of the national American Technologists' Association. Although he has attended the state society's meetings, he is not a member.

The organization of both departments was among the simplest in the hospital, in terms of numbers of personnel employed and structural complexity. In terms of the technical complexity of the tasks performed, however, and the number of these, the X-ray Department approached, the Laboratory in some respects surpassed, the Nursing Service.

The X-ray Department was licensed by the state under the name of Dr. Short who was the senior radiologist. He and his junior partner,

Dr. East (both from the capital), read all the X-rays for diagnosis and prescribed radiological treatment when they felt it was indicated. The rest of the staff consisted of Smith and his young, female assistant -- a local girl who was receiving her training from Smith. She had been with the hospital for a period of a little over 2 years, since graduation from high school.

Smith viewed his department as responsible to the hospital (through the Administrator) and to the radiologist for everything done in it.

> "Anything and everything to do with X-ray -- all procedures within the range of our equipment, but basically E.X.G.s. The radiologists use radioactive material, but we have no external therapy machine here. Some internal therapy is done here, but most of it, and all external therapy, is done at the 2 major hospitals in the capital."

The range of departmental duties covered getting the patient ready to filing films and reports. Smith himself did the bookwork and the intricate cleaning of the equipment. Both the technician and his assistant -- either singly or together -- took the X-ray pictures. Complex procedures required two people.

There were no committees in the department. "The structure is not big enough for that."

"Service to the community" was cited as the major goal of the hospital, as Smith saw it. "That breaks down to service to the individual patient. The hospital as a whole has to serve the community. The community is served at a remove."

Smith saw the X-ray Department as "primarily a service unit for diagnosis. It is not to cure but a tool in diagnosing the ills of patients. More and more that is the prevalent function. It is becoming the doctor's right arm."

Smith felt that he had limited authority to make certain decisions in his department, which he seemed to resent somewhat. Major changes in departmental policy were not in his sphere of activity. The radiologist Short had to approve any such changes. He readily gave approval for minor changes, however. The radiologist, former Administrator, and Smith had collaborated to set up basic policy from the founding of the hospital. However, there was no overall, formal set of rules or regulations spelled out. There did exist a book, developed by the department over the years, standardizing procedures, and a set rule regulating dressing and undressing of patients, prominently displayed on a plaque hung in the dressing room.

A change introduced by Smith had to do with using Gevaert instead of Dupont film. Being a faster film, certain technical procedures had to be altered as a result. A change initiated by Coachman in the purchasing of X-ray supplies resulted in Smith's submitting written orders to Coachman who then actually placed the orders; formerly Smith did both. He welcomed the change. Another unwanted responsibility, of which Smith was relieved after 2 years, was the medical and surgical supply room.

Smith described the day-to-day operations of the department as his responsibility.

> "Gripes about the department are brought to me and ironed out with Coachman, if necessary. Strictly within the jurisdiction of the department is seeing that errors are not repeated. I have successfully trained my subordinate on that point. The day-to-day disciplining of the operation is mine."

Smith felt he had learned a lot in running a department at the county hospital where he had trained.

> "There were much better relations with other departments visible there. Problem-solving took place in the various departments. Here more is done by, or through, the Administrator. Here X-ray is more

> separate from the lab. There, there was a dual responsibility to the pathologist. I prefer that."

Smith described the "understood, general policy" in his department to be

> "that we run by a technique chart for consistency's sake. I have set up a pattern to be followed for quality control of the film -- stored, processed, filed, etc. Most of the rules are technical. This department is almost wholly technical."

A procedural feature he emphasized and insisted upon was

> "our working rule of thumb ... that when you put a patient on the table, that patient is then a mechanism -- a part of which you are X-raying. You don't look at the individual as a human being. Otherwise you run into problems. A forearm is a forearm. You have to maintain a certain distance."

Basic, departmental, personnel policy has become Smith's responsibility. He himself now screens the personnel to be hired.

> "We have had to bring in new people. In the first 2 years here, there were 3 different girls working for me. Two left because of personality problems with the patients, and they did not meet my exacting standards; the other one was good, but she went on to college and nurse's training."

Smith excused Edwards' "mistakes" in hiring the 2 unsatisfactory girls as "due to too much on his mind. More duties were delegated by him as time went on."

Smith viewed hospital policy to consist of "general rules guiding decisions to be made -- when, where, how, and why. Essential, grassroots, hospital policy is contained in the pamphlet You**** and in other written form prepared by Edwards or the medical staff." He did not have sure knowledge of the existence of any written board policies or of their content. "I am aware that the Board and Administrator have worked out understood

**** See Appendix K.

policies. The heads of departments have developed a kind of inter-departmental policy which is not written down. I feel we need more of this here. One recurrent problem has been that some nurses blab about what happens on their shifts. This should be prevented." He said that he strongly represents his department in the inter-departmental meetings.

> "I had a change in handling X-ray requisition forms instituted so that the Nursing Supervisor passes it on to the nurses, giving us a double check. Short and I designed the forms ourselves. Yes, I do influence overall policy a bit, but I hadn't thought of it in just that way."

Smith pointed out that "the doctors do, to a certain extent, provide the department with detailed and specific policies. They indicate to us the specific examinations to be made and demand that they be done in specific ways." He cited the policy that all admissions must have chest X-rays. "This is a good medical staff policy. It's good preventive medicine."

Smith was not happy with the Board's policy of passing on major equipment purchases for the whole hospital. "The difference in quality of X-ray equipment is tremendous. As far as the type of equipment and working with it goes -- in convenience and doing the job right -- this should be up to the technician or professional involved to determine." Smith characterized the Board's primary concern to be monetary value.

> "Lately, we bought a mobile X-ray unit -- a Picker; I wanted a G.E. Both are in the $4,000 range, with the G.E. running $200 more. The Picker is clumsier and in size half again as large as the other. Our machine was bought strictly on a low bid basis. The Board never asked for my opinions and Coachman went along with them, even though he knew my preference and the reasons for it. They got $1,000 in trading in the old Picker unit. For a measly $600 they made on the trade-in, we got 'shafted' in terms of inconvenience and lessened efficiency."

Smith was impressed both with the quality of medical and nursing care being provided by the hospital.

> "I'm impressed with the individual attention each patient is given. Quality must be exceptionally high because personal attention to each individual's problem is evident on the part of the doctors and nurses. They really listen to the patients' woes. The patients clearly feel they are treated well. Our consulting staff is impressed too. They feel our active medical staff and nurses are very good.
>
> There are a few aides whose care I would question. We have different levels of personnel in hospitals. I'm not in the position to judge, however.
>
> The problem, again, has to do with ethics. They don't know when to keep their mouths shut. But there is some attempt made by Coachman to have employees keep quiet about confidential things."

Smith identified the Medical Staff and Nursing Director as those most responsible for maintaining quality control over care.

> "I get the feeling the Medical Staff is not agreed. They have their personality differences.
>
> The doctors have a lot of power and it's needful that they have it. Our Lab and X-ray are extensions of their practice in a way, so they treat us very well; we rarely have difficulties.
>
> Dr. Bert is slow to recognize anyone new from outside the community. Once he knows and likes you, he's really behind you, but recognition from him comes slow. Sheridan is quick to speak up; he's aggressive and progressive. Herman Roos sits on the fence. Rhine and Hardt are outsiders, I feel. Rhine is quiet, but he's good. Sheridan is more showy. He had anesthesia revised. Because the Board refused to, he bought his own intubation Fluorthane machine. It set him back $1200-1800, I'd say."

Smith expressed little knowledge of the situation of medical records. "I make it a practice to keep our own reports, files, and film records up to date."

The questions dealing with grievance procedures and union membership elicited little response from Smith. "I doubt that our hospital's employees

would join any union. Grievances are handled individually, as I believe they should be."

Coachman and Smith had discussed the matter of a departmental budget together, but Smith claimed nothing came of it.

> "I haven't seen it. I'm a firm believer in a budget. I get paid once a month myself; without one I could not keep track of my finances. It's the only way a person or an organization can know what they have and where they're going. Not only do we need departmental budgets, we need a firm, overall one for the hospital. Out-go and income of the departments could be better compared. I would like to see us get the business equipment and to keep such a set of books. I don't know what procedure the administration follows now.
>
> I know X-ray is the largest income maker for the hospital. I don't feel all the profit from X-ray should go into pay raises for nurses. Each department should be self-sufficient, ideally. Other hospitals depend on lab, X-ray, and pharmacy for expansion.
>
> I've made a rough comparison of the diagnostic departments on expenditures as related to their gross incomes on my own. The Lab is spending almost 50% of its income; X-ray 62%. Forty to 45 percent of our gross income goes to the radiologist. The pathologist gets paid per autopsy and specimens examined. I feel I deserve a raise, and have asked for an increase in salary. I'll use these figures in my behalf.
>
> Coachman and the Comptroller determine pay raises. I can recommend them for my assistant and bargain for mine.

Smith regarded "payments from insurance plans of patients for care and services rendered and donations" as the two main sources of hospital operating funds. He was critical of the Board's credit and collection policy and practices, "what little I know of them." He underscored his view of the hospital as a service organization.

> "This Board has a business enterprise in mind and not a service organization. The obsession with staying 'in the black' pushes the hospital into using unpleasant tactics to get poor people to pay their bills.

> A hospital has to have a liberal write-off policy. Coachman, however, seems to buy their approach wholeheartedly.
>
> I haven't expressed myself on this because it really is not in my jurisdiction. Nevertheless, I think that service should be uppermost in the minds of all. It doesn't appear to be for the Board, from where I stand. Government aid could be used to make up any deficit. It will come to that eventually, I believe."

Smith estimated nursing turnover in the hospital to be minimal.

> "It's fairly stable. It seems other personnel (on the lower level) turnover more. It's due to little pay at that level. Better opportunities and social life in the larger towns and cities have attracted a number of our younger females."

In Barrett's description of his department, he placed himself second in command to the 2 pathologists, Drs. White and Load. "Although the Lab is licensed in the name of the former, the latter is really the head. She does most of the tissues tests and comes in when needed; he comes in every 2 or 3 months." Another male technician -- a close friend of Barrett's -- and a part-time, high school girl completed the staff of the Medical Laboratory.

The actual work -- consisting of such procedures as blood, urine, feces, spinal fluid and other sera tests, making up various cultures, checking hemoglobin counts, cross-matching blood types for transfusions, and the like -- is done by Barrett and his male assistant. The girl cleans the glassware, keeps the books and charge slips (billing) straight, answers telephone calls, and performs some of the simpler procedures taught her by Barrett. "She handles the little things. She's thinking of becoming a lab technician or a school teacher."

"As department head", Barrett's responsibilities were "to set up working hours and schedule the procedures." He had to make sure "that we have plenty of blood on hand and I deal personally with the Red Cross on

that matter. I'm here to answer any technical questions of my assistant and the girls."

In case Barrett runs into some unusual situation, he goes to Coachman or the pathologist for help. "Coachman has taught me a lot. The active staff doctors ask both of us a lot of technical questions all the time. We check for them. Of course, we also check the books and manuals on hand -- the U.S. Army lab technician's and pathology manuals."

Barrett singled out diagnostic aid as the function of his department. "Our work is investigation and it takes up almost all of our time."

Barrett's attendance of committee meetings was limited to the monthly inter-departmental administration meetings. Nor did he show an interest in participating in other hospital matters. "Problems and money are discussed. We hear personnel complaints mostly." He was less concerned than Smith with the rest of the hospital structure. "We mind our own business in our department. We informally discuss the patient cases and do our work."

Questions related to policy and policy formation within his department or the hospital generally elicited meager response from Barrett. I haven't thought much about that. You could say we establish some on our own in the department, if you mean regular rules or procedures." After some minutes he continued ...

> "For example, if a patient is to have a gastrectomy or abdominal or vaginal surgery, we have to have blood. We make it a matter of course now to check with the anesthetist about blood supplies, and if he has forgotten or didn't think of it, I call the patient, draw a blood sample for the cross-match and it's done in 40-45 minutes. We set this policy up for the doctor's convenience. It's efficient and reduces the stress and strain on them.

> Another policy is that we technicians are the only ones looking over the cross-match. We're responsible for it. No one talks to you while you're doing it. It's a critical procedure and we have to watch -- no talking or goofing around is allowed."

Barrett waxed eloquently in extolling the virtues of the Laboratory ...

> "We run a profitable operation. From running 800 procedures per month in the first year of the hospital's operation, we now run 1400-1800 procedures per month. The rate has gone up 200-300 per year. (And at Blue Cross rates for service.) Coachman built up the lab to what it is today. We make anywhere from $100-500 or 600 per day.
>
> We are really up to date and surpass many larger hospitals in terms of sophisticated equipment and tests we run. Any new tests are investigated. Our doctors and Coachman are all for it. The 5 doctors are for it because it's a good check on their diagnoses and helps improve their practice."

Barrett stated the major goal of the hospital to be "good care." His department contributed to good care, he felt, through the diagnostic aid.

> "We want to give the community a fair return for what they've given us so we try harder to please. In a big hospital you're just a number, but not here. Our patients are given personalized care and service. The customer is always right. We aim to please. The increase in patients treated shows they like our better care."

Barrett was of the opinion that not everyone was or should be involved in policy formulation.

> "Of course, everyone should like and go along with a good policy. The department heads are consulted. But if the administrator in a hospital has enough authority (as he should have) he can make policy himself. Edwards operated like this. If they don't like it, others can go someplace else. I don't ever question any of the doctors or nurses here. It's a matter of professional ethics."

As far as establishing and extending the quality of medical and nursing care were concerned, Barrett made some oblique references. He was

> "all for better control of contagious diseases. We have to have an isolation ward. There also are no male orderlies in the hospital yet. The X-ray or Lab Technician has to prepare male patients usually. In a pinch Coachman pitches in."

Barrett had no statements to make in response to other questions asked of him.

Business Office, Dietetics, and Maintenance Structure and Activity

The remaining three departmental heads are: (1) Mrs. Montgomery, the Comptroller (age 49), (2) Mrs. Kimball, the Dietician (age 65) and (3) Mr. Rupert, the Maintenance Supervisor (age 56). All 3 are married and have 2, 2, and 9 children, respectively.

Mrs. Montgomery, a native of Capital County, has lived in Mills Springs since 1939. Prior to her marriage, she had lived in the capital. Her father had been a millwright. Her husband worked for the Smith Dairy Company. Mrs. Kimball, a native of Mills County, where she had resided for 53 years, was the daughter of a farmer and was married to a retired, local, shop foreman. Mr. Rupert, a native of Milwaukee, was the son of a mechanical engineer and has lived in Mills Springs for 19 years. Prior to that time, he had been posted with the U.S. Army in many communities across the country.

Of the 3, Mrs. Montgomery had the most formal education. In addition to graduation from high school, she had completed 2 years of a secretarial training program in a business college in the capital and had completed a number of short courses in hospital accounting offered by the U. of M. Prior to her present position (which she had held 4 years), she had worked for 4 years as the Accountant-Secretary for the local doctors and the old hospital, and had been in charge of the accounting departments of a depart-

ment store in the capital (3 years) and a local dry goods store (7 years). One year she spent working for an insurance office.

Mrs. Kimball had completed 8 years of schooling, and in addition to being a housewife, had spent 3 years as a bean picker with an area bean and grains elevator company. For 10 years she had worked as the cook and then manager of the school cafeteria in a nearby township, before her 4 years in her present position.

Mr. Rupert had a varied and checkered career. He had completed 2 years of high school before he "got into trouble" as a juvenile delinquent and was sent to a vocational-trade school for 2 years. While there, he took "a short course in floriculture". Upon his release, he enlisted in the U.S. Army. During his 22 years in active service and the National Guard, he was a member of the artillery, air force, and infantry. Rupert spent World War II as a Warrant Officer with the Adjutant General Corps. After the war, he was an administrative assistant and Division Bandmaster with the National Guard. Rupert has worked in maintenance for the hospital 1½ years, one in his present post. For 3 years previously, he had worked in maintenance for an aerial instrument compnay in the capital, 5 years as a vehicle inspector and airplane mechanic for the National Guard in the area, and 2 years as a service engineer for a machine company in Illinois. His longest period of employment was for 17 years as a tool and die maker for an automobile manufacturer in the capital. He lost that job when they discovered his juvenile record. In the course of these many years, Rupert has moonlighted on a number of jobs (out of necessity to support his large family) and he has done electrical wiring, interior decorating, landscaping, green house work, plumbing, cabinetry, and housepainting. His wife has had to work sporadically to help make ends meet.

Mrs. Montgomery has come to enjoy small town life since she has been working in her present position. "I get more recognition in the community now." Still, she prefers the capital. "I know more people there, and the amenities of city life are more readily available." Mrs. Kimball has known no other way of life and feels a part of the community. "We mind our own business. We're little people." Mr. Rupert has lived in Mills Springs approximately 19 years and prefers a small town. "The only big city I have liked was Seattle." He was the only one of the three to comment on the town critically. "The politics here is something fierce. It's a cliquey town." He went on to offer some insightful observations.

> "One small group tries to run the town. A very few families have held the reins and try to hold them now. But it's harder for them because the place is changing. Warrington, the Sampsons, and the Kingstons have been the 'top dogs'. Even in spite of that, Mills Springs is a good town to live in.
>
> In a way, I and my family don't fit completely. I mean if you're not born here, you're still somewhat of an outsider even if you've been here 20 years. My wife works in the I.G.A. We're fairly well known. Personally, I feel my children get more benefit from Mills Springs than we do. It's a very happy situation for children. We like the schools. This is the place we're staying, finally."

Of the three, Mrs. Kimball participated the least in community activities. She and her husband irregularly attended the Methodist Church. In her younger days, she had been a member of the Eastern Star and a women's church group. The bulk of her social life rotated about her family and a small circle of friends. She had no professional affiliations whatsoever.

Mr. Rupert had served as a scoutmaster in the capital when his children were younger, but he has discontinued this activity. He was proud of being a 32nd degree Mason and a member of the degree team. Besides faithfully attending the meetings of the Masons, Mr. Rupert regularly attends the Methodist Church and sings in its choir.

He described his activity in the Orpheus Club as his most enjoyable and saw himself as representing the hospital in it. "I have called them to sing here for the patients at holidays." He expressed interest in joining either the Rotary or Kiwanis clubs, but remarked "I haven't checked into their qualifications. It seems to be hard to get into them. It would help me become a better member of the community." He felt he could perform a public relations function for the hospital in these organizations.

Five of Rupert's family work in hospitals. His son-in-law works in the X-ray department in a capital hospital, a daughter is an aide in the local hospital, one daughter is an aide in another capital hospital, and two sons work with him in maintenance and in the doctors' clinic.

Mrs. Montgomery was very active in the Business and Professional Women's Club, locally and regionally. She had been president of the local branch for two terms and headed the county branch for two terms. In her 4 years as a member of the Western Michigan regional division, she served as president 2 terms and as secretary-treasurer. Numerous committee chairmanships and memberships were described.

> "This activity is very important in helping me with my work. The experience of others and their problems helps me a lot in finding solutions for problems in my job. I learn about other professions and meet other women. Public relations for the hospital is accomplished better across the dinner table. It's a fine cultural organization."

Mrs. Montgomery was especially enthusiastic about the accounting institutes held by the above organization. "We have had short courses in cost accounting and general advanced accounting. It's helped in budgeting. Indiana University and the American Association of Hospital Accountants have sent representatives to our meetings." She also "enjoyed very much

the course of workshops in uniform accounting given by the U. of M."

Mrs. Montgomery is a member of the American Association of Hospital Accountants and of the Mills County Chapter of Medical Assistants Society -- both of which she attends regularly. She is a member of the Publicity Committee of the latter organization.

She was a regularly attending member of the Methodist Church where she at one time sang in the choir and was a member of the women's church club. At one time -- while her children were younger -- she was Secretary of the P.T.A.

Mrs. Montgomery described her department as "the Hospital Accounting Department. Our general responsibilities are admitting patients, billing them for hospital charges, issuing statements to the various insurance companies, and collecting the accounts." She personally supervises the Receptionist, Accounts Manager, Posting Clerk, and Medical Records Clerk -- all young, married women. The Receptionist "answers the telephone and operates the switchboard, as well as receiving patients and visitors. More importantly, she collects all across the counter cash." The Accounts or Credit Manager "takes care of mail cash, handles all patient interviewing and agreements on bills collections, takes care of posting, and maintains one set of our two accounts upstairs to give us a double check." The Posting Clerk, under the Accounts Manager, "actually posts all in-patient and out-patient accounts by machine and monitors charges and cash." The Medical Records Clerk "transcribes the X-ray reports, takes the dictation from doctors, files and records the charts, and keeps records and compiles various statistics." A registered medical records librarian "set up that part of our department: the numbering system, how charts are set up, and so on. She has a more general knowledge, and specific too, of medical records."

Mrs. Montgomery summed up her work as consisting of "doing all that an accountant is supposed to do plus supervision. I do the accounts payable, payroll, write all the checks, keep the general ledger, and handle the Blue Cross billing." She established a machine billing form for the latter operation. "We handle only in-patient Blue Shield billing; the doctors' clinic help do the others." With the approval of Coachman, she hires and fires departmental personnel.

Mrs. Montgomery attends the meetings of the departmental heads' committee only. "Of late I have been taking notes and am the new Secretary. My job is to handle the financial end of inter-departmental business. We are attempting to set up a budget and a cost accounting system. We should have used it earlier. I'll be doing the cost accounting myself." The other business of the committee was described as "none of my concern."

"Good patient care really comes first here," the Comptroller claimed. "If we have to cut down, we never cut down on things directly related to the patient. The welfare of our patients is the major goal of this hospital. We only aid in expediting business matters efficiently and effectively."

Mrs. Montgomery appeared to be satisfied with the authority delegated to her by the Administrator in the areas "I just mentioned." When making major procedural changes, she consulted with Coachman so that he could give his approval and be prepared to inform other concerned departmental heads and personnel. He signs all orders and does major purchasing. "I only purchase necessary things for the department. In buying our $4,000 National 31 accounting machine, Edwards sat in on the meeting requesting this of the Board. Warrington gave us the loan without interest, since

we did not have the cash on hand." She felt she was "influential in getting Coachman to see that if we expand, we should buy certain essential business equipment early so we have it later on." Otherwise, her work was described "as routine and as such concerns making assignments and supervising the help. I rarely have to discipline my co-workers."

The Comptroller defined policy as "a set of rules and procedures." Finances were cited as conditioning all hospital policies, but that patient care comes first of all. "Finances should be bent to meet that priority. I would say, from my vantage point, that that is the case here." All the departmental heads participate in generating policy and informing their personnel in setting up particular departmental policies. Coachman and I do for accounting. I try to influence policy only in the workings of my department."

Mrs. Montgomery characterized the main policy of the Board to be "to effect a pay-as-you-go basis for all major construction, renovation, or equipment purchases. Other policy flowing from this has been left by the Board in the hands of the Administration. They consult only in large matters." The Board sets room-rates by looking at other hospitals in the area. "Payroll is the Administrator's responsibility." Coachman has followed Edwards' lead in this matter by using area hospitals as standards. "Pay for our personnel is on a par or better than others' in the area." Questioned about credit and collections policy, Mrs. Montgomery admitted that the Board "heavily influenced Edwards and Coachman on this. For the last 4 year period we have brought our accounts receivable down to a 3.6 percent charge off of our income, irrespective of the welfare loss. That's not bad, but it could be better."

Questions concerning medical and nursing care were not answered by Mrs. Montgomery -- the reason being given, "These matters are not in my area of competence. I hear care is good though."

The Comptroller evaluates the qualifications of her staff on the basis of "can they do their jobs. Are they trained or can they be? The pay for them is set up by Coachman and myself. The girls have to be able to deal with people and work responsibly since they are always in public view in the front office." She personally checks references and background experience and then makes her recommendations. Unionization of office personnel or others in the hospital was not seen as a problem at all. "Grievances about pay and working conditions occur seldom; policy is to handle these matters individually."

Patient income and, occasionally, donations were identified by her as the main source of the hospital's operating funds. "Dr. Short and the auxiliary have donated funds for equipment purchases."

Mrs. Montgomery felt that

> "it is essential that the hospital consider the ability of a patient to pay for services. We have been stung in the past. Now we extend credit stingily. We require a deposit if a patient is known as a credit risk. Of course, a flexible evaluation of the individual case is necessary. Emergencies are another matter. Our credit and collection policy has been produced and exists on a trial-and-error basis. First thing, we see if an individual has insurance and how much it pays."

The Comptroller stated that there was no effect of payment from insurance companies or governmental agencies on the amount of hospital rates and services charged.

> "The rates for room and services are set on the basis of what it takes us to operate. Blue Cross pays us on the basis of cost. Based on our cost formula at the end of this last year, we have taken a slight loss

> on Blue Cross patients. Some insurance companies pay better. The Mills Stamping Company insurance plan is superior. We stick with Blue Cross because we know payment is coming twice a month."

Mrs. Kimball, the Dietician, supervised the work of eight women, including: a Food Service Supervisor, 3 cooks, 3 aides, and a kitchen helper. With the exception of the aides who were middle-aged, the staff of this department were in their late 50's or older. The mean years of education completed by this group was 7.4 -- the lowest of any department in the hospital. Next lowest was Maintenance.

The Dietician described herself as responsible "for making up regular and special diets of the patients. I purchase supplies for the cafeteria, and make sure the kitchen is in order and sanitary. Also, I am in charge of the storeroom -- the general management is in my hands." Mrs. Kimball supervised the actual preparation of food and she herself prepared the food for special diets. "Mrs. Jones visits the patients to check on their reactions to the food and she supervises the serving of the food." An informal division of labor has been effected in the department on this basis, so that the Food Service Supervisor has been delegated authority to give orders to the aides.

The only committee meetings attended by the Dietician were those of the departmental heads. From her department's end, benefits in improving and planning food preparation and service resulted from these meetings. "We discuss anything not properly taken care of." Tray service to the patients, better arrangement of the kitchen, and improvements in varying the diet were suggested there and adopted. "Co-operation of the nurses with the aides in conveying food to the patients was accomplished."

The major goal of the hospital, as Mrs. Kimball saw it, was "to make patients well." Her department's major goal was "to give the patients the

best food we can to help them in their getting well." The more important goal of her department, she felt, was "to do some enlarging. We've had a full hospital and we had serious problems in the kitchen then. The kitchen needs improvement in facilities and working conditions. It gets too crowded." Inconvenience -- resulting from having to have women carry heavy supplies up to the kitchen from the basement -- was a sore spot in the department. Mrs. Kimball thought that the kitchen should be placed in the basement to alleviate these conditions. Once again, the lack of proper planning in designing and building the hospital was brought up by a departmental head.

Mrs. Kimball follows the strict orders of the doctors in preparing the diets. "I have studied at M.S.U. conferences of dieticians on it. Doctor Rhine and the others help out. I'm really not a trained dietician."

The biggest problem she faced, she confided, was the bickering of her personnel with one another. "The cooks give me a lot of trouble over time schedules, and they do not like each other too well. The head cook contradicts my orders and, on occasion, Mrs. Jones has interfered with my work."

Policy to her meant

> "a matter of the way things are prepared in the kitchen, setting up trays, times of delivery, special diets: we serve stuff at certain times. I set up the times at first, but we have had to change them to accommodate the nurses. If they make changes, we girls in the kitchen meet to discuss and notify the staff of the differences."

Most changes come from the Director of Nursing. "Our policy is to run the kitchen to the best of our ability. Because of the stress of doctors and nurses on sanitation and cleanliness, we really bear down on it. They have commended the kitchen very highly for this." Mrs. Kimball

restricted trying to influence policy to "only my area -- the only one in which I am a bit competent. I've tried and succeeded in having wages raised."

The Administrator, Medical Staff, and Nursing Supervisor were those persons identified by her as setting policy for her department in terms of finances, diets, and cleanliness. All questions related to medical and nursing care were answered as "being not in my area" or "I don't know."

Mrs. Kimball checked the qualifications of her staff after their employment.

> "I look to see whether they are good cooks or helpers. They should not waste food, be careful with preparation, and so on. I find you can't change people and how they behave. I think the job they do is more important, although I can't take all the squabbling. Actually, the administrators hired all the help."

Grievances overwhelmed her, and she said she passed on complaints she received directly or from Mrs. Jones to Coachman. The possibility of the unionization of her staff or the other hospital employees did not loom large or important in her picture of the hospital.

Mrs. Kimball appeared to be satisfied with the amount of money allotted to her by Coachman for purchasing food items and replaceable items of kitchen equipment. "It runs to about a $1,000 a month. I usually keep within the budget; sometimes it goes over that. We deal with 5 wholesale outfits. The heavy equipment was bought by Edwards under the Board's direction. I've asked for a dishwasher, but there's no money for it, I'm told."

Mrs. Kimball felt able to comment upon two other items relating to professionalization of hospital personnel and personnel turnover in the hospital.

> "I see more clearly now than I ever did before why more professional people are needed in the hospital. Things are complicated and you have to know a lot before you can do a proper job. R.N.s are really important. Even though the pay isn't as good as it might be for everyone, the nurses and others stay here because they like the work. You feel you're doing something important for people who need it."

Including himself, Rupert's department numbered 10-12 people. Usually, two boys were hired during the summer to help the lawn boy and maintenance men with repairs about the building. The division of labor was as depicted on the chart with 3 main subdivisions of tasks indicated: Laundry, Maintenance, and Housekeeping. Rupert directly supervised the maintenance crew of 4 men; a male Laundry Manager supervised his male helper; and 2 female housekeepers were supervised by a Head Female Housekeeper.

As departmental head, Rupert had several responsibilites. It was interesting to learn from him that he had been informally made the purchasing agent by Coachman. This unusual duty assignment consisted of "purchasing everything but drugs and medical supplies (which is in care of the nurses in the storeroom.) They send orders up to Coachman for medical supplies and he deals with drug company salesmen." Large equipment purchases are made by conferring with everyone concerned:

> "Any purchases approaching several hundreds or thousands of dollars go to the Board and Administrator. I have tried to get a new washing machine purchased, but it's quite expensive ($7,800), so we'll have to be content with the old one. I have bought polishing machines and the like. Coachman leaves these items to me because he trusts my judgement."

Hiring and firing are partially his responsibility.

> "My word is seriously considered in these matters. If I were going to add somebody, I would have to check with the Administrator. I have the authority to discipline the whole department. Personnel problems come to me through my assistants and then I handle them. Rarely do they need to go on up to Coachman."

Rupert outlined his responsibilities over each of the subdivisions he supervised.

> "Our laundry does the hospital and clinic linen. (The doctors pay for the service.) My laundry supervisor is efficient and gets out the work. I only have to check occasionally.
>
> Maintenance of grounds and the building is up to me personally. I maintain our present general equipment. I help in, or supervise, the construction of cabinets. Actually, I handle all the physical facilities. There is a great deal to do and I have to do a lot myself.
>
> X-ray and special equipment is mostly handled by the technicians involved and repairs or special services by the company service men. I clean the oxygen and other machines routinely. In emergencies or for minor repairs, I am called.
>
> The problem with purchasing is in trying to anticipate demands and to keep inventories down as much as possible. There are shipping problems involved as some companies are 2 weeks to a month behind in shipping our orders. In this case I have to plan ahead and go to several sources to get similar supplies. I've reduced the number of similar items we buy. For example, we had been purchasing different brands of germicidals and cleaning compounds for the surgery and hospital in general. There were no essential differences between them, so we buy the one that is cheaper.
>
> Co-ordination in purchasing was a problem sometimes, but things are better now since I run a check on purchases overall.
>
> I am responsible for keeping the department's payroll on an even keel. I have to decide the work load and whether we can get on with fewer people. Saving money is important, but I have to have a reliable crew to call on in emergencies. There is plenty of work to do for all our people.
>
> I have had one problem with a girl. I had to release her because the doctors wanted her off. She was a gossiper and was caught spilling the beans about several cases.
>
> I don't have a budget; we expect to go on one in all departments. We should have gone on one in June. I don't know what administration will do. My own personal idea, from the purchasing angle, is to keep inventories down;

> money on the shelf is wasted. Planning for regular needs and emergencies should go hand-in-hand."

Rupert attended the monthly meetings of the committee of departmental heads. From his viewpoint, those meetings were most valuable in that they were "a means for the Administrator to educate department heads as to the requirements of the hospital and the proper timing of all events or activities. These people get along together awfully well. Problems between their departments are ironed out over coffee." Maintenance business is accomplished on "a very informal basis. Requisitions are no longer used. The mignight shift leaves notes for me. I set the priorities. Mrs. Kedzie acts for the nurses (the group we service most often) by calling and asking me to get certain things done." Rupert saw the Administrator's committee deliberations as vital to fulfilling his job.

The Maintenance Supervisor saw the major goal of the hospital to be "patient comfort. My department provides or helps to keep the best possible facilities." Keeping conditions as aseptic as possible was described as his main aim. "If a patient requires special equipment, we try to supply it. Just recently a patient with a broken neck said she'd like to read, so we rigged a mechanism to allow her to do so. Our department is allowed to make such improvements for the patients. My son or I make these kinds of things."

Rupert was satisfied with the amount of authority he was permitted to exercise. "I have enough [authority] for the proper functioning of the department."

"Policies", in his view, "are general procedures. In our department they refer to mechanical timing of doing the floors and rooms or in the hours the personnel will work. Ours are not written; it's not necessary because the department is small and not all that technical." Rupert was aware that

written policies for the hospital as a whole were available and referred to several of them in detail. He seemed to be satisfied that these should have been set up by the Administrator in conjunction with the Board. "At present I am not involved in overall policy, but I see a need for co-ordination of all services to attain the primary goal of the hospital. I feel we must bend department goals to fit that larger end." Rupert said he offers suggestions

> "at the Administrator's committee meetings to benefit my department as well as the whole hospital. The matter of requisitions was one. I suggested a morning deadline for their presentation (8:00 A.M.) so that I could fill orders by 9:00 A.M. Emergencies are another matter. Before, people used to send them whenever they felt like it and expected immediate delivery. As this place gets bigger, we will have to write down more of the policies which are more or less understood now."

Rupert felt himself to be incompetent to judge medical or nursing care matters. "They seem O.K. to me."

Rupert described the situation in his department with regard to grievances as "not a problem. My people get a fair shake from me, and if I can't handle a gripe, it goes to Coachman who decides what to do." As for unionization of his or other employees --

> "I don't foresee union difficulties. Personally, I don't like unions. I've had to belong and I hated that. Some reasons are purely selfish. I have never been over-awed by people I've worked for; I've gone up to them and spoken for myself. My father was a plant supervisor and anti-union. He was shot at by union members. I fought the union in Rockford. I was holed up in the plant during a strike at Olds. I can pull my own chestnuts out of the fire."

The Incipient Issue of Hospital Expansion

Much detailed information on the need for the Mills Springs hospital to expand has already been presented in the above context and appendices from the points of view of the various members of its organizational components.

At this point, therefore, it should not be necessary to repeat that material extensively.

The internal points of view, although differing in diagnoses and emphasis of problems and impacts, nevertheless were basically in agreement as to the solution. Allusions to a parallel, less detailed, but nevertheless important, composite viewpoint or position expressed by certain individuals and groups in the community were made above in passing, which views had been transmitted primarily to the hospital officials but also to a few of the lower-ranking, supervisory personnel directly. The latter, external position needs to be presented more explicitly because it posed a serious constraining influence on the initiation of a financial drive for expansion in the community. At the time of the research, hospital expansion was not yet a full-blown issue in either the hospital or in the community. Rather, unorganized and disjointed discussions and half-hearted activities on the part of the leaders characterized the situation.

Virtually all of the interviewed members of the various components of the hospital had identified what they thought the most pressing problem(s) facing their organization and/or departments were. In a less detailed or superficial manner, the informed, influential community members were aware of the same problems on the basis of their personal experiences or from discussions held with hospital representatives in meetings of various community organizations, such as the service clubs.

Reduced to their essential characteristics, the related problems were variations on the following themes: (1) the prolonged and critical condition of high patient occupancy rates resulting in the overcrowding of the hospital; (2) the conditions of strained services and facilities for both inpatients and outpatients confronting several departments (very closely

related to the preceding); and (3) the inadequate or poor initial planning of the physical plant and technical equipment facilities by the Board, but especially by Warrington, contributing to perennial, relative inefficiency and resulting, at least, in added and unnecessary work. (The last was common knowledge among the professionals and semi-professionals in the organization.)

Internally, it was the Administrator who most clearly saw the interrelatedness of these problems and their combined impact. The Medical Staff tended to view these matters as did the Administrator; however, they focussed more on the impact of the first and last problems. The heads of various departments were more concerned with the limited impact of these problems on their particular bailiwicks. The Board members were more aware of and concerned with the first problem and its impact (with the exception of O'Toole and, to a lesser extent, Smith and Evans) as were the informed community influentials. Overwhelmingly, these members of the community were critical of the hospital's treatment of greater numbers of "outside" patients.

The root causes attributed to these problems by the members of the various hospital components varied somewhat. To the degree that excuses for the conditions noted were offered, these differences in interpretation of the problems and their causes can be considered to be rationalizations or self-justifications. But, in larger measure, the differences can be better regarded as the relative limitations imposed on one by his position in an organizational component and that component's relative place in the total organization, which can produce blind spots.

Members of the Board (almost to a man) saw the problem of high occupancy rates to be due largely to the unforeseen and unforeseeable conse-

quence of increases in local and area demand for hospital patient care. The more perceptive among them saw that the expanding practices of the local doctors -- spurred on by the younger members -- were substantially responsible for this increased demand, but they viewed it in positive terms. The professional and semi-professional personnel of the organization underscored the failure of the Board to consult with them or other professional consultants in setting up the new hospital to allow them to handle increased numbers of patients in the area who were sure to come to a more conveniently located facility. Theirs was a very persuasive argument.

Notwithstanding these differences of interpretation and their relative merits, the basic problem facing the hospital was fairly well-recognized by all of the hospital people. More important to them than the reasons or assignment of responsibility for the problem was the solution obvious to all in general in the form of a critically-needed hospital expansion. But the method to be pursued in financing the needed expansion and which services should receive priority were not definitely agreed upon nor as well understood by the members of the different segments of the organization at its different levels.

Since such high policy decisions were clearly revealed not to be in the sphere of activities of those people at the lower supervisory levels (as indicated in the previous interviews and other materials), a specific questionnaire was devised and administered to those parties at the upper, overall policy-making levels of the organization (the Board, Medical Staff, and Administrator) in order to more clearly delineate their positions and activities to that date relative to expansion and to tap the extent of community involvement in this incipient stage of a possible hospital community issue.

It had been clear, from the previous materials, that the anticipated impact of expansion on the hospital was viewed differently, by-and-large, by the various levels of the organization. Although there were a few exceptions to the rule, generally those at upper, policy-making levels of the organization were more cognizant of the prime potential of expansion for drastically transforming the basic function of the organization, and of the ramifications on its internal structure -- the transformation being from an acute, short-term general hospital to one in which chronic patient care would become more important, with its attendant shifts in emphasis. Such a contemplated change was welcomed by the Administrator and the older doctors who were willing to assume the responsibility for caring for more geriatric cases. Such a contemplated change disturbed a number of the hospital people, primarily younger doctors and O'Toole the Board member. Other Board members had no clear-cut position, pro or con, on this point. Lower-ranking members of the organization were more clearly aware of, and more interested in, the implications for their particular departments and missed the significance for the whole hospital's character. These aspects were not well known in the community.

The key members of the Board, the Medical Staff, and the Administrator were those better able -- because of their positions, knowledge, and experience -- to identify the individuals and/or groups in the community who would have to be most actively involved in order to finance the aim of expansion and whose desires would have to be considered in setting the priorities. They were also better able to articulate the difficulties in generating the process of decision-making in this instance. Lower-ranking personnel -- those with less status (not to mention lesser influence, power, and authority) and less knowledge and experience -- with few exceptions, were not at all certain as

to the actual mechanics of such a decision-making process and of the community people who would have to be involved ultimately. The developing outlines of the issue and the procedures necessary to resolve it were clearer to the former set of people, but the definite and necessary steps had not been taken and would not be until certain obstacles were removed. A stalemate situation existed due primarily to the lack of unanimity or clarity as to what the priorities should be and as to what the relative financial contributions of the hospital and community people were to be.

The results of the interviews dealing with the developing issue of hospital expansion revealed that it had been only informally broached and very briefly and tentatively discussed among the implicated components of the hospital. Reports of the communication that had taken place among the upper level people, although seemingly inconclusive, nevertheless revealed the following basic positions.

A semblance of consensus had been arrived at among the members of the Board. The key influentials on it had arrived at a definite stand which varied but slightly in the alternatives to action some of them were willing to contemplate. Lead by Warrington, the key influential members of the Board were all agreed that the local doctors should first contribute in the neighborhood of $10,000 - $15,000 a piece (the actual sum to be subject to negotiation) in any financial drive for expansion. This would produce between $50,000 to $65,000, or half of the $100,000 - $150,000 estimated as needed. All of the key influentials were aware, however, that only the older doctors were easily able to do so and that the younger doctors could not do so immediately, unless they sacrificed certain "non-essential" elements of their life styles. The top influentials and other members of the Board followed the lead of the key members in this regard. Evans was not

at all in accord with them on this provision, however, feeling that the local doctors had contributed and were contributing a great deal in other ways -- primarily items of equipment and free professional services to the hospital and community. Before any definite steps toward expansion or the involvement of the community were to be taken, such a commitment on the part of the doctors would have to be made in any event. Warrington, Kingston, and Rowlands stated they were reflecting strong community sentiments to that effect in their adamant stands. Smith and O'Toole contemplated an alternative -- that Warrington (as well as others in the community) might leave a sizeable legacy to the hospital), and this would eventually get the younger doctors "off the hook". The Board was in no hurry to expand.

Warrington had unofficially contacted Dr. Bert Roos and put the above proposition to him. Roos, speaking for his nephew and himself, expressed great reluctance, if not outright unwillingness, to do what the Board and the public opinion they reflected demanded. He curtly informed Warrington that he saw no immediate necessity to expand the hospital, as he and his nephew preferred not to see the hospital's operations increased nor the practices of the local doctors further expanded. He also pointed out that they (Rooses) were against the new hospital in the first instance and, since he personally was due to retire, he wanted no additional work or responsibility of the kind he presently bore. He was prepared, he said, to entertain the notion of setting up a geriatric division or building in due time, however.

The key influentials on the Board suspected that the younger doctors could probably be persuaded to come around to contribute some money eventually, as they increasingly felt the pressures of inadequate hospital facilities

on their practices and as they realized they would get a handsome return on their investments. (The doctors received specified percentages of the gross sum brought in by the clinic's group practice, with the older doctors receiving larger shares.) All of the Board members indicated that the community pressures would rise and be felt more by the doctors. To a man, the Board reported that people from all levels and segments of the community had spoken to them about the necessity of the doctors to contribute substantially and financially to the hospital before they would consider giving again to the expansion drive. They felt that the doctors had not contributed what they should have in the first drive. These same people were concerned with the need to balance new contributions to the hospital against the pressing needs of the school system. They demanded what they considered to be an equality of sacrifice from the doctors, who, they felt, were benefitting very greatly personally from the hospital.

Should this prime obstacle -- in the form of the older doctors' obstinance or reluctance and the younger doctors' hesitation to contribute financially -- be removed, the Board were agreed that the following community groups and individuals would become actively involved in achieving the goal of expansion. (Of course, they included themselves in contributing according to their relative abilities.) In the order of their estimated importance of contribution and/or involvement, they cited: (1) the "City Group" co-ordinator (an "ace" solicitor in the previous hospital drive and a generous contributor), (2) the C.P.C. -- leaders in local business and industry, (3) the service clubs, and (4) influential citizens and the general public.

The younger doctors were both agreed that in any expansion 20 - 30 beds were needed. They facetiously stated that they would prefer a new

hospital altogether be built due to the many deficiencies in the present one, but seriously, since that would be impossible, they spent considerable time spelling out the hospital's needs based on continuing the current, short-term, acute hospital function. Two private rooms to be used only for severely ill patients -- not for social or prestige purposes as some influential citizens of the community wished -- were indicated; more importantly, the rest of the rooms needed were to be mainly semi-private, excluding a 6 - 8 bed ward. A new emergency room, operating room, X-ray laboratory capable of handling radiotherapy, central supply room, and a kitchen were needed since all of the present ones were short of space and ill-placed. Both doctors felt that it was the responsibility of the Board to sit down and plan expansion and, for a change, they should consult the doctors, departmental heads concerned, and the Administrator for suggestions and advice. Other consultants were to be brought in as needed.

The doctors were well aware of the Board's and community's provision that they contribute substantial sums of money toward expansion. But they countered that they would rather donate equipment as they had in the past, that the Board forgets that two of the doctors have only recently started their practices and can't afford to contribute such large sums as demanded, having to pay back money borrowed for their educations. They also mentioned the high overhead on their new clinic building and services. Finally, they pointed out, in prepared tabular form, that the local doctors were charging patients considerably less for their services than all other doctors in the area and that they had written off many debts owed them by community people.

When pressed on the matter, they both agreed that the doctors, even the Rooses, would be willing to contribute $5,000 - $6,000 each but only if someone is in charge of planning the hospital addition who knows how to build

one. At a minimum, an elevator was seen to be absolutely essential.

The Administrator largely duplicated what the doctors had reported. He had spoken to the doctors and the Board informally about expansion. He was aware that the Rooses were reluctant to contribute at all but felt they would come around once the drive was rolling. The doctors were better able to identify the community people who would become involved in the expansion drive than was the Administrator. The list was the same as that of the Board.

CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS FOR FUTURE RESEARCH

This is the appropriate place to make as explicit as possible the heretofore largely implicit conceptual framework of organizational theory and methodology which have guided this case study. It is in terms of such an eclectic systhesis that the following general conclusions and implications will be presented. (The synthesis of the abstract concepts of community theory and methodology used in this case study have already been presented.)

Because, in Huxley's terms, we are still in the early or descriptive stage in organizational research for the most part, it is necessary to be eclectic to be comprehensive, at the risk admittedly that any such synthesis or case study following such a guide will be somewhat loose and general. Nevertheless, the synthesis and case study are predominantly informed by the structuralist perspective a la Etzioni and the open systems approach. Each of the other approaches consulted and previously criticized has contributed valuably if variably in some way or other, as has been demonstrated and will become more apparent.

Much preliminary time and effort was spent in observing actual patterns of policy- and decision-making behavior -- directly as in the Board meetings and Business Office operations -- primarily reflecting

power-authority and influence relationships; but other relevant organizational behavior was as well observed in M.S.C.H. Sequences of behavior were also observed and documented, so that the historical context was preserved throughout. Together, these may now be labeled the organizational performance or activity structure. This controlled observation and documentation were but two of the qualitative, case study techniques used in the research.

In order not to unduly obstruct the essential operations of the hospital components studied, documented observation was supplemented by the extensive application of pre-tested questionnaires, the gathering and critical inspection of other relevant documents, and the repeated, informal interviewing of a number of key informants. Even in a hospital as small as M.S.C.H., it was found that the performance structure was quite complex.

It was necessary to subdivide initially the activity structure into smaller and smaller observable units on the basis of formally clear-cut departmental boundaries. Information contained in the requested M.S.C.H. organizational charts (of a formal and ex post facto nature generally) tended overall to be of limited value in this regard, being unrepresentative largely of the "true," current state of affairs. It was found necessary to constantly tease out the significant interrelationships among and within these units, thereby to arrive at the informal elements and the "real," underlying authority-power structure. It was found that in M.S.C.H. informal elements predominated in its operation at all levels over time. These informal elements were formalized ex post facto by the respective hospital units and the total organization.

The fairly lengthy descriptions and analyses by departments presented in Chapter IV and the relevant Appendices were felt to be indispensable as well as convenient. Short cuts to displaying patterns and sequence of behavior are dangerous in that oversimplification and the slighting of documentation can result. From the methodological points of view of certain ethnomethodologists and symbolic interactionists, such as Herbert Blumer et al., the organization as viewed and lived by the persons directly involved may be lost sight of through the researcher's premature imposition of more abstract and "alien" categories of analysis. Thusly, the "subjective" questions were asked in the respective questionnaires and interviews and critical observations were exercised to check out the resultant information. Yet more abstract concepts do have a place in presenting results tersely and were anticipated in our overall research design, with the view to limning them in Chapter IV with immediacy and here at a more abstract level of analysis.

Still, these were shorter accounts than might have been the case because our focus was largely on the work flow or task process to arrive at a clear and comprehensive picture of organizational activity and power dimensions. Relying more on the system-model to reproduce actual behavior, rather than relying exclusively on the goal-model or prescriptive and formal charts of activity, made the accounts necessarily lengthy. Using the system-model, it was made problematical what degree of correspondence there is between observed behavioral patterns and sequences and participants' ideas or those of experts or others about what the behavioral patterns are or ought to be ideally.

Process, or the sequence of interactions with common content, which occurs repeatedly,was isolated in observation, interviews, and documentary examination. Task processes were extensively delineated -- i.e., those sequences of behavior related to the central organizational tasks as well as more peripheral ones; but, as well, ideas about organizational goals -- desired future states -- were also ascertained so as to afford a contrast and some indication or gross measure of effectiveness and the direction of changes in the organization. Although the qualitative and concrete or descriptive level was predominantly emphasized, consideration was also given to the more abstract, analytical level. Activities of many persons and all the departments of M.S.C.H. were analyzed in terms of a central set of variables or processes, thereby. Performance structure was further subdivided implicitly into other processes than task.

Explicitly, and without repeating what has already been presented substantively in Chapter IV, rates and patterns of task performance (especially of policy- and decision-making types), degree of task specificity, etc., were among the implicit categories used as operational variables of actual behavior, as well as for the contrast with ideal and prescriptive statements. Task processes were seen to not be confined to organizational or unit boundaries. The initial and pervasive emphasis on the organization as an open system, not surprisingly, was confirmed.

"Task environment" and demands therefrom were implicated in the internal and external interrelationships described and analyzed: involving especially suppliers of materials, labor, capital, equipment, and so on; competition for both resources and markets; and regulatory

groups, e.g., governmental agencies, associations, and unions; less attention was devoted to patients (customers or clients) because of limited research time and finances. These "environmental demands" also included, but more importantly, those of the C.P.S., which were spotlighted. As a whole, the environment was seen to be composed of a multiplicity of structures, some spanning boundaries as in the case of key members of the C.P.S. on the Board of M.S.C.H.

Maintenance processes -- or activities meant to keep the organization on an even keel -- were dealt with, mainly in terms of the sub-processes of recruitment and socialization. Communication processes, examined extensively, revealed a multitude of channels -- in the main unofficial, but increasingly attempts to make critical communications official, written or formal. The decision-making processes, again, were explicitly addressed as were co-ordinative processes, both meant to maintain a complex network of interrelated events. Questions addressed to how the various organizational unit members conceived of problems -- internal and external to them -- how priorities were assigned, awareness of constraints on their behavior, etc., were posed and answered. Control processes, closely related to co-ordination, were isolated. Finally, adaptive processes and conflict processes were addressed.

Employing the traditional sociological emphasis on normative structure, the entire array of social norms constituting the rules of organizational life was reconstructed, with major concern given to the formulation and implementation of policies, written or official norms. It was found that unwritten, official norms or policies were quite as significant, and more numerous. Unwritten or unofficial norms which

were ambiguous or contradictory were discovered. It was these ideas and values (about how classes or categories of persons ought to behave in specified situations, varying in degrees of specificity and sanction) that were seen to inform the many kinds of decisions made and to reveal relative power positions and which were implicated in all the processes studied. These norms were attached to the statuses-roles of groups or units specified by department and for the whole organization.

The interpersonal structure or sets of relatively stable person-to-person understandings and orientations, non-categorical, not related to positions enacted, was tapped, explicitly and implicitly. Not personality, but functions of relationships between persons -- such as like-dislike, trust-distrust, respect-disrespect -- by which additional means one judges others and oneself were seen as essential and studied for groups, departments, and the whole organization.

The resource structure or the physical resources currently used or known to be available by organizational people at the various levels and ideas about the proper usage of persons, space, buildings and equipment, and information -- technology in short -- was addressed.

These three abstract categories -- normative structure, interpersonal structure, and resource structure -- were seen to together capture fairly neatly the complexity of interaction and activity observed and documented over time and to set the stage for the stress and strain confronting the organization, departments, and units at all levels. (Organizational stress refers to inconsistencies among and within the above categories and strain refers to the degree of discrepancy between (1) demands and capacity of units and organization and/or (2) their relevant environments, inside or outside the organization.)

These were examined at length.

Organizational and group or unit norms were seen to have a variety of sources. Some were carried in by the unit members and were derived from their previous socialization, training and education, and from their community statuses and experience. Impinging on the hospital and especially important to internal activity on all levels were the norms of the various regulatory agencies and those of the local C.P.S., represented immediately on the Board. Other norms or policies and resultant decisions were generated within the organization itself, among or between units and departments, on a trial-and-error basis mostly and at first, although increasingly later on a more orderly or rational basis, in its search for satisfactory solutions to repeated or new problems. The values subscribed to by members of the respective units and feeding into policy- and decision-making and other processes were addressed at all levels.

Conclusions

Specifically, the main problem of this dissertation has been to explicate how the key organizational activities of policy- and decision-making in M.S.C.H. were directly and indirectly affected by its organizational structure, especially its power dimensions, and its environmental relationships, again largely power phenomena.

It was found that the hospital's Board of Trustees, in the persons of key influentials of the community -- all with established status and power, some economic dominants as well -- exerted the greatest authority and power in setting up and enforcing the broadest and most comprehensive of policies for the hospital. Being the "keepers of the keys and purse strings," they set effective limits to the hospital's

operation of a wide-ranging nature and at all levels. It was they who initially designed, built, equipped, staffed, and maintained the hospital with some assistance and advice of others and who were legally and morally responsible to the community and state for its sound management financially and medically. Over time they still retained key financial discretion and decided at a high level on closely related matters, but delegated authority over routine financial, medical, and related matters to the Administrator, Medical Staff, Nursing and ancillary services. In other words, the Board policies and decisions, largely financial, were broken down into lesser and more specific policies and decisions of a more technical nature and enacted at appropriate lower levels.

The basically conservative values of the Board (as of the community at large) were seen to be implemented quite often in their policies and these and relevant high level decisions made by the Board were challenged only gingerly and very seldom by the other units or departments in the hospital. The great authority and power of the Board, deriving largely from its collectively superior economic position, was all too obvious. Future plans for hospital expansion hinged primarily on the Board's wishes and financial considerations, also on their collective assessment of the community's sentiments and demands. Increasingly the Board was found to have to rely on the other departments or units in formulating technically-related policies -- meaning mainly medical or patient care matters. Still, their power to veto or restrict activities of all sorts because of their financial control basically was acknowledged by all the other units. Community demands, sentiments, and values were funnelled into policy-formulation through

the Board and received due consideration. The Board tended to resist, as they could, demands upon them from regulatory agencies of the state and elsewhere. Only when forced to, however, did they accede fully. The Board essentially controlled the resource structure which was found to be most important for all other activities directly or indirectly.

The Administrator was the agent of the Board whose function basically was to translate their broadly-formulated policies and decisions into more detailed policies and decisions (which could become quite technical and various, although still fundamentally financially-tinged) and see to it that they were implemented at the appropriate levels. His was the key position in the co-ordination of the complex mix of hospital activities. His authority and power were considerably less than that of the Board, but he was granted considerable discretionary power by them. His main obstacle for the smooth accomplishment of this co-ordinative, least well-defined, function was the Medical Staff which excluded him from key medical committee meetings having to do with evaluating medical care. Their technical expertise carried with it an authority and power he could not challenge directly.

Etzioni's broad characterization of general hospitals' structure as normative or dual and the observations of Zugich, Smith et al. on their dual authority structure were herein confirmed. The Medical Staff, the main practitioners of the major goal or purpose of the hospital, were outside the administrative chain of command. The Administrator largely controlled the co-ordinative functions. His authority was, however, derivative and his skills and knowledge required were of a more circumscribed nature than of the Medical Staff, or Board, for that matter.

The Medical Staff, at the core of the hospital's most technical and main activity, was not in the regular chain of command, yet it had overall more authority (of a professional origin) and power than the Administrator; but it ranked below the Board formally and financially. In relationship to the Board, the Medical Staff exerted considerable influence deriving from its technical expertise and from having Board members as personal patients. Policies formulated by them were scrutinized but superficially for the most part by the Board, and Medical Staff decisions were self-controlled largely. Theirs was the key contribution to the performance structure and they largely controlled it; if not directly, then indirectly.

Nursing and the other ancillary services contributed to the overall performance structure at various levels of importance and technical competence in a complex division of labor, but in each case as supplementary or complementary to the Medical Staff's activity. The Nursing Service's patient care was the most directly related of these to Medical Staff activity. All these units were subject to the authority and power of administration, but Nursing Service, X-ray, and Medical Lab were more directly subject to Medical Staff authority, power, or influence than the other units, such as Housekeeping or Dietetics. Policies or decisions made soley at these levels were of a technical nature and quite circumscribed; their co-ordinative policies or decisions were made in consultation with the Administrator mostly.

External factors bearing on policy-formulation and decision-making for the Medical Staff, Nursing and ancillary services, and administration were brought into the organization by the members of the respective units as part of their prior socialization. Many in the more

technical units kept abreast of developments in their specialties and were members of professional or semi-professional associations. It was they who tried to innovate in the organization with a modicum of success on the basis of such knowledge.

Implications for Future Research

Etzioni's view of organizations as groups of people (units) in a complex division of labor striving to attain specific goals (interlocking and multiple) or organizations as process, has found resonance and been demonstrated in this case, as can be seen in Chapter IV and summarized very briefly above.

Changes in direction of this collective, multiple-goal striving was posited as possible by Etzioni. Again, this was found to hold in our case. In seeking satisfying solutions to internally generated problems and to external demands, delegated authority was used by the Administrator and departmental heads following increasingly established but not quite final policies to this end. More randomness and less rationality than envisioned by Weber, Etzioni, and Caplow in their ideal-typical conceptualizations were found to exist in M.S.C.H.'s search for satisfying solutions. Haas and Drabek and open systems researchers are more realistic in their views and studies of organizations as being adrift much of the time, especially when facing unusual situations.

A prime example of drift, irrationality, and randomness in behavior occurred at an early stage in M.S.C.H.'s design and construction. There was unanimous agreement by all but a few of the Board members that the key influential on the Board, Warrington, had ill-planned the physical plant, causing all sorts of inconveniences and

problems later on when the hospital opened its operation. Too many complications were unanticipated. Warrington's overbearing power and authority and major financial contribution overrode demurrals and objections of others party to the designing and building of the physical plant.

Power, as suggested in Etzioni, was seen to be the prime organizational factor. The various power centers -- Board, Medical Staff, Administration -- performed many functions, however imperfectly, the most important being control of the concerted efforts of the organization and direction of the organization towards its goal(s). Appropriately, at various levels, continuous review of organizational performance occurred. Re-patterning the organization's structure and functions with a view to increasing effectiveness and efficiency were also observed at all levels. Substitution of personnel was another important function addressed. Again, these functions were not dispatched fully or rationally at all times. The pace-setters in fulfilling these functions were the key power centers mentioned above -- the key policy- and decision-makers -- and in Chapter IV extensively.

Caplow's general remarks on the size of organizations affecting all aspects of their functions need testing for this and other sets of normative and other kinds of organizations. Etzioni's remarks on goals and their displacement were found to be generally accurate and invaluable in formulating observational protocols and questions for the interviews. The views expressed by the M.S.C.H. Board, Medical Staff, and Administrator on admissions policy were on the ideal level it was found. Upon close examination they were found to contradict actual practice. Consistency in the treatment of charity cases did not exist.

Particularistic treatment was the rule, universalistic treatment of such cases the exception, yet nearly all questioned affirmed the latter, in effect saying all people in need would be admitted for medical care and their costs written off.

Etzioni's correctives to Weber's contentions on bureaucracy in general and in normative organizations in particular held up in this case as far as they went. But as Weber's, Etzioni's conceptualization (and hunches of bureaucracy in normative organizations) is still at heart ideal-typical and deductive. We need more inductive studies of organizations, of this and other types, to ascertain in gross terms the similarities and differences present. As Huxley emphasized, the natural historical phase of description preceded the construction of a sound taxonomy in biology. So is sociology in sore need of such a natural historical description and taxonomy of social structures and their functions. Collecting such data and constructing a valid taxonomy is a tedious, time-consuming but essential task.

Etzioni's lead on studying the forms of power and compliance could be further and profitably pursued in this regard. On the basis of our study, the lower level personnel, unlike in his contention, were not seen to be coercively, nor utilitarianly controlled. Their compliance was more normative than expected, which means that they were amenable to appeals to organizational loyalty and their special, humanitarian task -- aiding in giving medical care. The lack of union sympathy on their part (as well as on the part of the power centers) indicates that there may be differences in labor forces of normative organizations, even of the same set. But then, again, size of the organization (Caplow's concern) may have an influence. Are the personnel

on lower levels in large hospitals more difficult to control normatively because of union sympathies or other organizational and/or community factors? Why are they more susceptible, if they are, to coercive or utilitarian compliance methods? Too late for other than fleeting mention herein has been a recently published collection of research concerned with this and related matters, edited by Etzioni.[1]

Professionals, such as M.D.s, do carry great prestige, informal power, and a modicum of authority overall in general hospitals, it was found, and this bears out Etzioni's hunch. Also, their policy- and decision-making largely is uncontrolled by others, but this generalization (also buttressed by Zugich, Smith, Harkness and Holloway) applies most correctly, it would seem, to the U.S. scene today. Increasingly available evidence on certain European and other medical care systems shows this is not the situation there. Ministries of health, or the like, police and control medical care from outside the particular hospital. Within, direct control is usually exercised by other M.D.s-administrators. In the U.S. the general hospital appears not to be completely a professional organization, as Etzioni would have it.

Let us now step back a distance from what we have been considering up close in this case study of a general community hospital for an overall perspective on the problem posed and to see what the future research implications are for a comparative study of general community hospitals and for organizational theory generally (Huxley's tactical step two).

What we do see actually going on in an organization, any organization at all, at the most fundamental level? In terms of the

previously criticized perspectives, too often what is seen is colored by what the particular researchers pre-select to see, built on a foundation of limited assumptions and too often a paucity of prior descriptive studies, and the data so collected are deductively and prematurely made "precise." But the findings are largely left unconnected to other data collected with other underlying assumptions and their limitations. Is there a more fundamental perspective which may help to order or put into place seemingly disparate sorts of data relating to organizational phenomena? On the basis of the findings of this case study, of others in the area of general community hospital research referred to, and of, to this point, implications in the synthesis of organizational theory loosely structured as it is here, it is suggested that a minimal number of inferences can be drawn and suggestive hypotheses can be presented.

Subsystems or groups can be identified within organizations and their respective activities distinguish each from all the others. There is interaction among the groups which involves the movement of physical objects and of messages, including instructions, requests, and reports. There are observed variations among the groups as to their size, as to the types of physical surroundings, and as to the equipment they use. But, and this is crucial, only a few strategically-placed groups specialize in preparing directives (making policies and decisions) for the activities of the other groups, (even on a day-to-day basis) in any organization of any size. Thus, it is hypothesized that only a very few groups make decisions at a high and general level involving finances, personnel, space and equipment for all the other groups. At varying intervals almost all groups must prepare reports on their activities and submit these to other groups and especially to the key

groups for review and some sort of evaluation. Close observation shows that over extended periods of time some groups may dissolve, some new ones form, some grow in size and spheres of activity, whereas others decline in these respects.

It is suggested that at any organization's structural and processual core what is paramount is a continual struggle by each group for authority and power -- autonomy, and that, correspondingly, security of the unit by its members is sought, and that prestige of the unit is pursued fairly assiduously.

But these observations and general hypotheses require corollaries, since in the functional interdependence among the groups one finds that the activities of each group are directly dependent on the activities of some of the other groups and indirectly dependent on most, if not all, of the remaining groups. Autonomy, power or authority, of a particular group, then, is posited to be limited by the fact of dependence. Whenever this interdependence throughout an organization has been recognized (as it invariably and early is, though it may subsequently be lost sight of), some mechanism is established to try to assure co-ordination among the interdependent activities, hopefully on an optimal but in reality usually on a satisfactory basis. But this mechanism may vary among organizational sets as Etzioni suggests.

The survival potential, or security, of a group or organization is threatened by scarce resources and by notions, held by those in superior power positions principally, of the functional importance or significance of its activities. Participants in the respective groups can be expected, it is hypothesized, to try to manipulate, as they can, the normative expectations that others -- especially significant others --

hold about the importance of their group's activity for the security of the organization as a whole. Authority or power held, and perhaps prestige of the respective group, will likely bear most heavily on the relative success or failure of any particular unit's attempts at such manipulation.

Any specific group's prestige rank may be hypothesized to directly depend on the ranks of the other groups within the organization, so that all groups aspire to higher ranks, within limits to be discovered (lower participants, too), and no group aspires to a lower rank.

This competition, maybe even conflict, open or sub rosa can be seen as a major driving force shaping intergroup interaction. In a nutshell, these are the dynamics, it is suggested, underlying all organizational life, at its most fundamental level.

Etzioni, somewhat obliquely, has focused on this continual struggle by each group for autonomy, security, and prestige, as have Haas and Drabek more directly. These dynamics underlie any particular issue confronting organizations internally, but also, it is contended, they underlie relations inter-organizationally, or externally with other systems.

One contribution of this dissertation has been to point out the complexity and subtle richness of the substantive overlay, discussed above and in Chapter IV, of a particular normative type of organization's activities that too often may obscure this fundamental reality. It is as such a modest contribution toward the development of a valid taxonomy of organizations cutting to the heart or nub of their makeup, yet preserving intact the organizations' relationships with their

environments -- as open systems.

Much remains to be done in this area of research. In particular, for the study of this set of hospitals we need comparative studies done in terms of such an ordering principle. It is our considered opinion that variations in the size of surrounding communities and their hospitals of this type will not preclude the use of this model. In a large metropolitan community there may be found more than one power center (C.P.S.) and more than one hospital -- a range of sizes may occur -- but the dynamics we have tapped certainly will be operative if as variations on a theme and contrapuntally more complex. Hopefully, we can then move on to attack the tactical levels Huxley outlined for use in a scientific strategy -- namely differential analysis and constitutive integration. More work in this vein is required in the contextual area, in the area of community studies, but the same basic strategy and tactics are indicated. Warren's attempt has been a significant contribution in this direction.[2]

APPENDIX A

BOARD RESPONSES IN DEPTH INTERVIEWS AND QUESTIONNAIRE

The major goal of the hospital was viewed by the whole Board to be a variation of the following theme: "The best medical service it can offer to the people of the community." Warrington added that "The major goal of the Board of Directors is to see to it that objective is carried out; and we see to it that the financial and other means or resources to carrying out that goal are present to the best of our ability." The function of general supervision of the hospital's operation by the Board was stressed by O'Toole in this connection, with special emphasis placed upon "making sure the hospital is kept properly staffed." This task is delegated to the Administrator

> "who as a specialist has familiarized himself with the qualifications necessary for the various positions in this area. He and the Medical Staff recommend medical staff appointments to the Board which we approve. Things are going along so smoothly now that the Administrator actually runs things. Our board committee structure handles the money and facilities end of things. The public is informed of the hospital's needs and general operation by our public relations officer, the President."

The immediate major goal or objective of the hospital for O'Toole was,

> "to become accredited by the A.H.A.'s Joint Conference on Accreditation. The last step is the development of our medical library. The Board has contributed everything it could to the attainment of the hospital's major goal: it built and equipped the hospital in an up-to-date fashion. In terms of general practice, the Medical Staff has attained a high standard of medical care and our reputation is quite good for a small town hospital. We have adequate equipment and facilities and a specialist staff, mostly from the capital and one other community. Our first Administrator supervised the whole administrative development program and he has done a beautiful job in setting up and establishing procedures and processes across the board of hospital activities."

One of the major functions of the Board, as Warrington saw it, was to make sure that "the employees of the hospital feel an intense loyalty to it."

They (the Board and the Administration)

> "would not keep anybody on who is not loyal. There have been some clashes of employees with each other (3 or 4 times), but this is due to some people who just don't like authority; some can't dispense it. In the first 3 years of operation, this situation has been successful. We've (Administrator and myself) only had to remove an administrative assistant who turned out to be a dope addict and sex pervert; and a nurses' supervisor -- who did not like our small town life and a small hospital -- quit voluntarily. Yes, there is intense loyalty."

(The personnel involved in lesser squabbles were disciplined by the Administrator, Edwards.) Not only did he feel that the loyalty of hospital employees to the organization was necessary, Warrington also made much of the loyalty due the hospital by the Board members. He stated that he and the other Board members ...

> "felt loyal to the hospital as a community enterprise. I want to stress that this hospital is community-owned and must make its own way. All segments must see this -- that the hospital must keep itself in business. I think that through my efforts all employees understand this. This is an eleemosynary organization claiming no dividends or profits. Like a corporation, however, it has to report to the Secretary of State on its affairs. The only way we can continue to operate is through patient charges. We are in an unfortunate situation in this town because industry has declined and we haven't enough private money to support it."

Asked about the membership of the hospital Corporation and whether it was truly representative of the community, Warrington replied that "anyone contributing a dollar for the membership fee is eligible. There is also a $100 contribution entitling one to a lifetime membership. There are 6 to 8 of these -- all Board members. Some honorary Lifetime Memberships have been granted for outstanding services rendered. There are about 100 members in all." Warrington felt that "all segments of the community were fairly represented", but admitted, upon closer questioning about the proportion of members coming from the lower and middle strata,

that "there are a few of them; the more responsible citizens who are interested in the hospital belong. The leadership is a true cross-section of the community. The perpetuation of community ownership was the intent of forming the Corporation membership as it is now."

The major goal of the hospital, as Kingston saw it, was ...

> "to take care of all the people of this community, locally. We are doing things here now that only bigger hospitals are doing -- for example, major surgery. We would like to see the medical needs -- all the needs -- of all our people met. The doctors are branching out professionally and bringing people in. Our hospital has a good reputation, and is offering better medical care at cheaper rates than other hospitals in the area. Yet we don't want to crowd out local people. We do have a problem with space and with volume of business. In a way, the increased volume of business is a good thing as it reflects on the quality of care we give. X-ray and lab work has been contracted from us by hospitals and doctors practicing in some surrounding cities. ...
>
> The Board makes major decisions as to whether the hospital expands or stands as is. They will feel out the people who will give money for expansion.
>
> Actually the Administrator and doctors play the biggest part in the organization as far as carrying out the main goal is concerned. They carry the most weight as to what will happen in the medical area. The nurses give the patient care and they are O.K. We hear nothing but praise about them.

Smith saw the major goal of the hospital to be "to take care of the community's medical needs. From my point of view as a resident and an employer, this is an important and vital function." He saw the Board's contribution to the major goal to be "to act in an advisory capacity, mainly, and to set the broadest policies through which the Administration operates responsibly." He continued to underplay, more than the other Board members did, the importance of the Board ...

> "Of course, the operation is a combination of all of the sub-units of the hospital, so that the Board needs the information or advice of other such units to carry out policy or even to formulate it in some areas. The

> Administrator is the contact man between the Board and the public in this sense. He is supposed to initiate certain ideas in his area and to carry through ideas of the Board and Medical Staff.
>
> As far as our Medical Staff's contributions to the major goal is concerned, they are at the very core. Through their good treatment of patients, they've received real confidence from the people of this community. People are confident in the ability of the hospital staff generally to take care of most of their medical needs. We've had no serious mistake happen here as has occurred at the county hospital in the case of their anesthesiologist bungling an operation.
>
> Our nurses are competent and have good personal relations with the patients and doctors. They are business-like in carrying on their activities -- professional is a better word; and in caring for the patients, they are pleasing at the same time."

Rowlands saw the immediate goal of the hospital to be that it "collect the money in its accounts receivable which is getting out of hand. Some people want service but won't pay for it." He gave an example of one man who had just brought his wife into O.B. as an emergency case. He said that this man had a known record of non-payment -- not only in Mills Springs but in 3 other communities as well. Nevertheless, his wife was taken care of because it was an emergency. The problem of accounts receivable was seen as a delicate one "because emergencies must be taken care of and not sent away", but in cases of repeated non-payment, the Administrator was advised by the Board to get tougher. "In the last 4 years of the hospital's operation, we have accumulated approximately $66,000 in accounts receivable. A lot of tact has to be used in this area, but I feel the new Administrator can handle the problem O.K." Rowlands felt that "If anything, he is probably more business-minded than the first Administrator, although he was quite good overall. I'm sure that pregnancy cases could be refused most easily of the repeater cases." When asked how many families approximately fell into the

repeaters' category, Rowlands replied there were several hundred in the area.

> "There are instances of non-payment among some families in 5 or 6 admissions. Quite a few of these people live in the surrounding rural areas, although some local families fall into this category too. It's interesting how some people you wouldn't expect to pay (such as farm migrants from Mexico) are paying up in full. Others are trying to get something from the hospital by 'sticking it to' the hospital. These same people can afford to buy cigarettes and beer, however. These people will pay for other things, but will let their hospital debts slide."

Asked if any legal attempts were being made to collect outstanding bills, Rowlands replied that there were only 2 or 3 cases he knew of, in which the possibility of eventual payment had been judged by the Board to be good. He didn't know whether a bill collector was being used by the hospital. [He was.]

Rowlands neatly outlined the responsibilities of the Board as he saw them to be: "(1) hiring the Administrator; (2) checking the doctors on the staff -- that is, passing on them on recommendations of our local doctors; (3) making physical improvements in plant and equipment; and (4) finances -- making sure bills are collected." He made much of the last point:

> "The Board feels that this last point is important. The Administrator was relieved to hear that we wanted him to pursue collections more vigorously. We told him to put more steam in this effort. We don't want the hospital to get the name or reputation of an easy mark. Warrington and O'Toole feel that the doctors only lose their service when they don't collect their accounts receivable, but the whole hospital operation suffers (in terms of salaries not paid, overhead, etc.) when its accounts receivable are not paid.
>
> The Administrator carries out our policies and actually runs the hospital; he is responsible for its actual operations. The doctors actually deal with the patients and practice medicine, which is what the hospital is here for. I'm not too familiar with the actual responsibilities of the nursing or other departments. I think the nurses give patient care and the other departments are responsible for taking

> X-rays and lab tests and so on. It's really up to the Administrator to supervise those activities, whatever they are."

The most succinct summary of the responsibilities of the Board, Administrator, Medical Staff, and nursing and other departments with which he was familiar was offered by O'Toole.

> "As trustees of the community, the Board bears the financial and legal responsibilities of the hospital. The Administrator runs the hospital; he co-ordinates the various activities of the different departments: in short, he is the watchdog. The doctors actually administer medical and patient care. The nurses are more concerned with patient care; and are very good from all accounts and my personal experience. The other medical departments contribute diagnostic aid to the doctors. X-ray and lab services are vital, I think. Housekeeping and bookkeeping are less central but, nevertheless, important services in a hospital, obviously."

The series of questions dealing with the committee makeup or structure of the Board, its functions, and its authority and areas of competence elicited some valuable information.

According to Warrington, "the only 'live' committee" is Building and Grounds, and "even there there isn't much to do but care for the lawn and shrubs. Of course, it has done more work in the past." Mentioning various physical improvements and detailing some of them, Warrington continued:

> "Really, it doesn't have too much to do until enlargement of the hospital comes along. The Publicity Committee keeps the public informed. We put a note in the paper when the occasion demands it. O'Toole is pretty good at that. The Finance Committee has nothing to do but to keep track of the money. Bookkeeping does the actual work. We come in, for example, when people give us money or property. . . Actually, I'm just the spokesman for the whole Board and we work as a team, a unit. ... The whole Board would handle the new building program, if it comes up; the whole Board works together on all problems. The committees don't have a right to do anything except at the behest of the whole Board. They carry out our collective decisions. There hasn't been much we've done lately in committees, though.

> We don't have any real problems right now. We did in building and establishing the hospital."

The rest of the Board in general concurred with Warrington's description of how the Board as a whole and its committees function.

The financial and legal responsibilities of the Board loomed large in the Board's answers to the questions relating to Board decisions, their authority, and the qualifications required of a board member to function adequately.

"Without money, you have no hospital or anything", Kingston stated simply, "and it is the Board that best knows where and how to get the money and to supervise its spending. That is, certain people on the Board do." There was no place, O'Toole felt, "where the Board can't have the final say. We have enough authority to do our job well." Serious problems of disciplining all personnel are referred to the Board.

> "The Administrator has the authority to hire and fire all departmental personnel under his direct jurisdiction. Medical staff is excepted, naturally. He has some leeway, but cases such as malpractice or others which would imperil or damage the hospital's reputation would be referred by him to the Board. The Board would back the Administrator up. We have had 2 cases in which we have had to discipline M.D.s, but the Medical Staff was in on it. We had to remove the privileges of one. Still, the Administrator could initiate the procedure himself. A former assistant of his was removed because he was a dope addict and he had pilfered drugs from the pharmacy room to supply his habit. These cases were handled quietly to avoid any publicity. Warrington, our legal expert, was most intimately involved, along with Edwards. The Board would act decisively in any case, or area, the Administrator didn't grasp a situation and deal with it effectively."

Kingston felt that Board members are "able to make decisions and have ample authority on key financial matters, but, strictly speaking, medical problems are not our province." On all matters, the Board has "enough authority to fulfill its responsibilities and to effect discipline. Whenever the hospital's reputation and stability are in jeopardy -- such as in

cases of malpractice or scandals -- the Board members should act with prompt and vigorous effectiveness, but with discretion."

Smith was in basic agreement with O'Toole and Kingston on these matters, but he felt more than the others that "the actions of the Board should depend on the thoroughest consideration of the merits of the particular case." He was reluctant to have the Board act until all the information possible was in. "Discretion and good judgment are essential. The decisions made should be Board decisions, should be unanimous, and not the actions of one person. We should always protect the operation and reputation of the hospital."

Smith continued, "Any Board takes final action on the advice of qualified people. For example, the Administrator has called for 3 special Board meetings dealing with key personnel resignations and one dealing with a case of medical malpractice. Final action was taken on advice of the Chief of Staff and the Administrator, after a very thorough review by the Board in that case."

Rowlands felt that "the Board is able to make or influence decisions in all areas of the hospital's operation but in that pertaining to medical care.

> The doctors handle the problems dealing with quality of medical care and they have their own staff meetings which no Board members attend. When it comes to appointing members to the staff or granting privileges, the Board acts upon the Staff's and Administrator's recommendations.
>
> Buying medicine or medical supplies, minor equipment, X-ray film, laboratory items, etc. is up to the Administrator and his department heads, not the Board.
>
> The doctors and the Administrator, however, do bring requests for purchases of major equipment to the Board for approval. Some doctors -- Sheridan for one -- have even donated such equipment themselves.

> A major item recently bought was a bookkeeping machine which tremendously simplifies business operations. It was quite expensive, but it was approved and passed on when its clear advantages were spelled out. Certain equipment and supply companies offered us real help in setting up various facets of our operation, and with their suggestions and free donations of labor they have saved us money and time.
>
> The Board has plenty of authority and disciplining action is exercised through delegation of it to the Administrator to use in his areas of responsibility and to the doctors in theirs. Otherwise, the Board acts as a body and has equal authority in major cases of discipline. Whenever there is a threat to the hospital's reputation, the Board should act promptly and decisively, I guess. It depends on the situation. I don't think we've had much need to do so."

As to the important qualifications felt necessary to be a successful member of the Board, Warrington stated that ...

> "The membership of the Board should be diversified and represent all walks of life. They all should have demonstrated an interest in the hospital and the community. A Board member should particularly be interested. I don't know what abilities he would need; maybe business sense and judgment. I don't know what else.
>
> I feel I have both, yes. I've been a success because I have. Besides, I don't mince words; I speak up for what I believe and I am willing to fight for what I believe. As a Board member I am in the forefront, yes, but I wouldn't say I exactly direct others."

O'Toole felt a Board member should be willing to really work for the hospital.

> "He should know a little about business matters. His standing in the community is very important. Although no one on the Board has any particular or expert knowledge of hospitals -- Warrington has been on a hospital Board before -- still, a prospective member should be someone successful in his own line of endeavor; not a particularly forceful individual is required. I would want

someone who has demonstrated the willingness to work on community projects. Yes, I feel I am this type of person. Really, our Board works as a group and I don't think any of us directs the others."

Kingston felt that a Board member must be community-minded.

"He should be able to watch finances -- the hospital can't be a losing proposition. He shouldn't be too influenced by outside rumors, but should check all matters personally. They (the Board) should always be thinking of and serving people. Our Board for the most part fits this picture as do I. Miss Evans is the most medically-minded of our Board, I believe, and she has that experience and immediate contact with the doctors and nurses valuable to the Board. The others are mostly successful businessmen or farmers with common sense and good judgment. Sure, I can give orders; it depends on the task whether I like to. I can be a team worker when need be. The Board works together as a whole more often than not."

Smith stated that the most important qualification necessary of a Board member was the contribution of time.

"If you have any ability at all, you can learn what the position calls for. In this field you can't just have your name on the list. Our Board members are all able. Time and good sense are most important. I think you'd better be the judge of whether I fit that picture, rather than I. As to whether I'm one who gives direction more or receives it, let me say I try to avoid directing others; nor does one have to on this Board, seeing as we work together pretty well.

Of course, I've played peace-maker between Smathers and Warrington; also between O'Toole and Warrington. Warrington made amends to O'Toole, but he was instrumental in Smathers' not being re-elected to the Board. Warrington's like the good cow who gives a lot of milk but kicks the bucket over. Still, he has a good head on his shoulders. He's my legal advisor and we serve on the bank board together."

Rowlands' image of the successful member of the Board was ...

"Well, he should be community-minded, successful in his line of work, I guess. I think he should be able to get along with people. Maybe he should be interested in the hospital. He should have the time; maybe the money. Well, I don't know whether I have all these qualifications. Can't say as I do. I don't know why they selected me,

> really. As for giving or receiving directions -- I don't think its an either-or proposition. I'm pretty independent, if not too vocal. We really operate together. Of course, there are some members -- Warrington especially -- who have a lot of good ideas because of experience and so on."

Mrs. Evers felt that the majority of the Board members ...

> "should be prominent and knowledgeable people with experience in financial and legal matters. Most of the members fit into that category. As for Miss Evans and myself: I feel that she has had important medical experince; I'm here mainly as the Secretary and in a way, I guess, I represent the little people. I receive direction. I'm not in the position nor have the experience to initiate ideas or direct other people."

In response to the question B 7., "What significant changes have occurred in this hospital's organization since you've served on the Board?", Warrington answered by describing the elimination of the position of Administrative Assistant. A shift in administrative responsibilities was accomplished by the new Administrator to relieve himself of certain burdens imposed by the elimination of the assistant's position. The affair of the drug addict was quietly handled by Warrington and Edwards "who got onto the fellow first via a patient's complaint. The prosecuting attorney made the complaint and issued a warrant for the person's arrest. I saw the prosecutor and convinced him to suppress publicity for fear of scandal damaging the hospital's reputation."

The other changes Warrington saw as organizational were the replacements of two Board members. The first was a local florist who "could have been re-elected if he'd wanted to be, but he really didn't have any interest in the hospital once it was built; and he felt he wasn't contributing. He asked not to be re-elected." The second person, Smathers, was a candidate for re-election (Board members are automatically up for re-election) but,

> "he was defeated because he was on the losing side of the school fight. He shouldn't have been with the crowd behind the school superintendent. Yes, I was active in pointing this out to the Corporation members and I received quite a bit of support from the township residents as well as a number of Mills Springs people."

Asked "What changes do you foresee in this hospital five years from now? Ten years from now?", Warrington stated . . .

> "I see no changes happening in small hospitals in organizational terms 5 or 10 years from now. This place will remain small if my friends and I have anything so say about it. My [sic] hospital has the flexibility it should have. People are elected fairly and feel their responsibilities and perform their functions. The Administrator is told the hospital is his baby to operate as long as he functions according to the rules O.K. The Board has only had to intervene twice: once in the cases I told you about, and once when some food was being pilfered. The Administrator takes the operating burden off the Board, except for emergencies when we're needed.
>
> I can't think of a better system. If you have a disagreeable person working, you might have to get rid of him. Otherwise we may have no changes here. I don't know about other hospitals. You can't plan far ahead. How do you know what will happen? Who can say?"

O'Toole saw no real changes having occurred in the organization "except the elimination of the post of Assistant Administrator". The hospital "will probably get larger and with that more formal, probably. Still, it won't get that big or as formal as other hospitals."

Kingston felt that the Board had not changed much.

> "The Administrator has made little changes in the organization. (Both have.) He has shifted some departments around in the process of making for more room and handier operation for the help. The laundry, which was previously done outside the hospital, is now done on our own new equipment. We've hired new people for that. The operating room has been more fully equipped also.
>
> We won't change too much overall in 5 or 10 years because we won't become a much larger hospital. We try to follow as closely as we can what Blue Cross pays since we rely a lot on Blue Cross. We couldn't operate without them. Maybe the federal government will come up with some medical care

> plan that can change our organization with additional requirements for forms to be filled out and the like, and probably more help will be needed.
>
> I would like to see the Board run differently. It should be more money-minded. I also think we have too many things done at the hospital. We have too many employees and too much overhead. The hospital should specialize in medical practice rather than try to cover the waterfront.
>
> I can see the Administrator's point of view, however, that the hospital is a different kind of business organization. Most of the time we have an 80% average occupancy, or a full hospital. Still, I see a lot of nurses sitting around. It seems the peak occupancy determines the steady number of employees and you can't lay them off, as we do in our business.
>
> I can't see 3 or 4 maintenance men on hand, however. We should be able to get the wiring and plumbing done, as needed, by hiring local electricians and plumbers. Yet, the hospital man (A.H.A.) says they are needed. What we need in short, I think, is a better, business-like attitude -- we need more efficiency. I'd push for this."

Smith saw no changes that were significant. "The hospital will probably care more for older people. Geriatrics is to become a bigger part of this community's (and others') medical needs. Dr. Bert Roos and the new Administrator see eye-to-eye on this needed change. It will need more rooms -- we'll have to expand -- and we'll need more staff, especially nursing, to care for the older patients on a chronic basis."

Rowlands stated the most significant organizational change to be,

> "Well, the Administrator has changed. Edwards was a real good one for meeting and getting along with people in the hospital and outside... Coachman's coming.
>
> I really don't know about the future changes. I guess if we expand we may have more people working for us -- things like that. I don't foresee any radical or significant changes though. Things on the Board might change somewhat with Warrington gone -- he's pretty old now --

> I don't expect he'll be here forever. He's been a real sparkplug as far as the hospital goes. For that matter, as far as the community goes."

The various responses to question B 8., "What departments or segments of the hospital would you rank from most to least essential in attaining your hospital's major goal? Why?" were illuminating in the attitudes and values they revealed.

Warrington stated "We don't have to have a lab strictly speaking. The old hospital did alright with just ordinary urinalysis." Continuing in this conservative view, he went on to say ...

> "It depends on what you practice on. [sic] You need the Emergency Department and Surgery. Technically, we wouldn't need a maternity section, but we feel ours is the best in the state. I really don't know in detail. I follow the advice of the Administrator and doctors, although I'm suspicious of the doctors.
>
> Rhine doesn't know the value of a dollar. If it were up to him, we'd put in an elevator. But that involves inspections; the operation of it is expensive; and the initial expenses are great. We really don't need it. Still, I think we've got to keep up with the times. But carefully."

O'Toole saw the Laboratory as "the hub around which the hospital rotates."

> "I'm a firm believer in scientific analysis. The Lab is most important in this respect. It aids immeasurably in accurate diagnosis. Not only that, but the Lab and X-ray Departments produce ¼ of our operating funds. The whole medical staff is quite conscious of cancer detection: they have a definite X-ray program on all patients; O.B. and Surgery are both quite important and essential -- its a toss-up between them.
>
> Since we're limited on bed space, the doctors haven't been able to take on long-term patients. If they can run 17 surgery cases through 75 days patient time, they'll do that rather than take on chronic cases. We're just not set for geriatric cases right now. There seems to be a difference of opinion among the doctors on this point of medical policy, though. I'm inclined to agree with Rhine and Sheridan on this matter. We and the doctors

will have to do some basic thinking on what kind of practice the hospital will concentrate on.

Accounting is important on accounts receivables and the Operating Fund. It is setting up a depreciation factor for us, which should help in planning our future development on a sound financial basis.

All in all, I think we should aim for the highest possible medical standards; that we funnel more money -- as much as we can provide -- in those departments. I'm interested in quality care more than in growth."

Kingston stated that he felt

"all segments seem to be necessary. I still think we could trim down on non-essentials, however. The Laboratory is one of the most essential. It does many tests and we're able to have them make most all of them here. X-ray and the Pharmacy pay. We could do without so many girls -- in registering, medical records, and insurance. I think we could cut down in there. The others don't agree. Although we should serve the community, I still think the hospital should operate in the black."

Smith responded:

"I think you're asking a layman a question he can't properly answer. X-ray is now essential, but it wasn't before. The Lab is essential. I can't think of any of the services that are not essential right now.

These matters are properly for the judgments of the doctors and the administration or specialized departments. Medicine has changed tremendously and will continue to change. What is or will be essential probably is subject to further change as a result. Take the case of anesthetics, for example: 3 years ago it seemed to be satisfactorily handled with the equipment we bought for the new hospital. Just lately, we've had to change equipment and procedures. Sheridan is becoming an excellent anesthesiologist. He pointed out that the various gases used in the operating room are explosive and he recommended we use new connections even though others were approved previously.

Changes in this and other areas has been very rapid in just the 3 years of my Board experience. We seem to need en emergency ward and a new O.B. section (since we've

> got more welfare cases coming in.) I'm sure the doctors would say we need more things. On the Administrator's suggestion, we've installed a laundry. Our service is better, as it saves on wear and tear, and we don't lose linen as we did when we hired out our laundry needs."

Rowlands felt that

> "I think they're all necessary. As a layman, I can only take the word of the doctors and Administrator. However, things are changing in farming so fast -- new equipment and techniques -- and in medicine even faster it seems. So we have to keep up as best we can. Our lab tests are really advanced from what they tell me. Of course, you need X-ray etc. I'd say we have the essentials and then some, but it's all necessary for the hospital. We want a good hospital. The work we get from outside -- even the capital -- shows we're getting a good reputation for these tests. We're getting a lot of outside patients too. So it looks pretty good."

Miss Evans saw all the departments as essential and closely connected:

> "You can't have a good nursery without good O.B. You need both a good medical department and surgery. Pediatrics is now definitely improving. We must keep up with modern medicine and technology. Our X-ray and Lab are good and very important in this respect."

Warrington stated that he did not contact any of the professional people who contributed to the hospital's operation significantly or directly in an official capacity. Most of his contacts of this type were with the Board at the monthly meetings. However, he does see the Administrator quite regularly but informally (3 or 4 times a week). He also sees the Board members Kingston and Smith frequently on an informal basis regarding the hospital; he sees O'Toole less frequently so.

> "Sometimes, as in the cases involving the wills or in cases of complaints from patients of noise or disturbances, these contacts of mine with the present Administrator are important to my function as a Board member. Sometimes the meetings are not very fruitful because he could better handle the situations alone. It might be O.K. for him to do without consulting me. Again, in the legal instances, he does call often and

> I'm glad to advise him. On the whole he is as good an administrator as the other fellow. I think he's weathered the job. He's not especially worried by the responsibility. He does his work and we do ours. We'll tell him if something's wrong. Actually, I had a lot to do with hiring him to replace Edwards. We expected his application and he was strongly recommended by Edwards and Rhine.
>
> We got another application from the Chief X-ray Technician. He is very boyish looking, though, which I felt was a handicap. I had to make a choice -- it was a delicate quandary because both seemed intelligent and eager enough. The old Administrator, doctors, and the Board shifted the burden of choice to me. I chose Coachman because he was an older man and had an older look. This factor of looks definitely helps in establishing confidence."

Warrington felt that the Administrator should only be called upon by Board for information and advice. "He should be able to run the hospital and call on us when we can help. He sits in our meetings only as long as we need him. His report to us should concentrate on finances; they should always be in order, I think."

O'Toole reported that he met informally twice a month with the Administrator to

> "give him a pep talk once in a while and help maintain morale. He's 100% loyal. I also do this to more or less familiarize myself with the needs and problems of the hospital. Our relationship is one of mutual respect, I feel. Lately, expansion has been our main topic of discussion. I feel he's quite capable.
>
> As an employee of the Board, we call on him for information and advice. His overall report is good and contains a profit and loss sheet, an occupancy report, a progress report on projects undertaken, and a statement of needs such as equipment etc. He is a successful administrator, I think. He demonstrated a thorough knowledge of the problems and procedures of operations and has the ability to get along with people. He inspires and gets the most out of them. Edwards, before him, was even better at this, and he really helped us in setting up policies and making decisions.

> Edwards made us more aware about how various factors are tied in with general finances and what to look out for: the percent of occupancy, the income from various departments, collections and credit -- he showed us why we should have a credit supervisor.
>
> After a while, we left these detailed matters to the Administrator and his staff. Our basic policy is not to turn away anyone in need as this hospital is built on charity -- we have to maintain this attitude. The Administrator initiates and the Board approves major equipment purchases. All the rest is left to the Administrator."

Kingston said he saw the Administrator 2 or 3 times per month on an informal basis to discuss special emergencies and his opinions. He also was well disposed to him.

> "We are fortunate in having a very good administrator. He has more responsibilities than we do; we don't have enough of them, truthfully. The first one was excellent; this one is every bit as good. He can handle the help, patients, and public. We get along fine and I think he respects me.
>
> Although he isn't a Board member, he attends all the regular Board meetings, usually staying for the whole session. He brings in the Bookkeeper who answers our questions on funds and Blue Cross. Every Board member gets an operations review from Coachman each month, which contains some really vital information: the number of surgical operations performed per month, the financial statement, the number of patients admitted, the number of average patient days, the collections and past dues, the number of X-rays and lab tests -- these and other items are all reported.
>
> No, we don't really question him and the doctors about the deaths occurring in the hospital. Every death is hashed over by the Medical Staff. That's their business. We have no occasion to ask for it.
>
> The Administrator's report is well done. He goes over each item with us and even compares it with a year ago. He's learning fast; he's catching up on the medical end rapidly. He gets along with all the people in the hospital, which is a big thing given their differences; but he is not as good publicly -- in the community -- as the other man.

> We listen to him in his medical area, but he does not offer too many recommendations on finances or on collections and credits -- there the Board advises him.
>
> Major equipment purchase requests require him to present plans and these are checked with the doctors to see it is all he says it is; then the Board checks with outside parties and decides whether it should buy the item.
>
> Minor personnel problems, like discipline, he has delegated to his different supervisors to act on. He handles all others himself and keeps close tabs on the nurses, and their work. The other departments have given him some minor problems, but he's been able to handle them.
>
> Orderly procedures were established so well in so many areas by Edwards that few real problems crop up. As for the Medical Staff's performance, we have gone on Rhine's recommendations. We have real faith in him. Coachman did bring up the slight problem we had with a doctor here from nearby. It wasn't much really, but the doctors and he requested, and got, that doctor's privileges revoked."

Smith contacted the Administrator twice a month on the average, informally and by telephone usually. Of late, their topic of discussion has been accounts receivable.

> "I have guided and advised both administrators on these matters. His problem is to keep money coming in to meet the payroll.
>
> An Administrator to be successful should know one's job and be effective and efficient. He should have the ability to get along with people. In these respects both of our administrators have been good.
>
> Coachman gives us a picture of the day-to-day operations of the hospital and presents us with his problems, usually needing financial or legal advice. We leave the enactment of our policies to him. Coachman is following the procedures initiated and established by Edwards in his area of competence."

Rowlands and Evers do not meet regularly, or seldom, with the Administrator in any capacity. Both veiwed him and his contributions to the Board and hospital operation favorably. They had less detailed knowledge than the others as to his actual contributions to the latter, however.

Miss Evans met, informally and formally, with the Administrator most often of all the Board's members -- several times daily. She also met several times daily with the Superintendent of Nurses and the nurses and doctors in the surgery (in which she occasionally assists as scrub nurse); she visited patients; and acted as a go-between, carrying information to and from the doctors, the Board, and Administration. Because of her unique, personal, and official, Board position, her significant remarks on various facets of the hospital's and Board's operations were postponed for presentation here. She saw the hospital Board as motivated mainly by economics:

> "Money is our god; the hospital is not for brotherly love, as it should be. A lot of people felt the doctors didn't contribute enough money to the new hospital, but I feel they have -- most of them -- done a lot. I felt their offices should have been located in the hospital. I stood alone on the Board for this. Doctors contribute their valuable time and services freely; they're entitled to some reward.
>
> I was placed on the Finance Committee, but I don't know as I contribute anything to it. Finances are most important to this Board. Too much so. I don't know where you will find another hospital operating in the black. (Of course, the old hospital did, but it had to -- being a proprietary one.) This Board is not very interested in medical care aspects. They leave it to the Medical Staff. They are concerned, however, about patients' reactions to the hospital. (There've been many complaints about noise, but this is due to poor design features.) The Board has enough respect for the medical men's judgments in their medical area. They also are very much interested in the legal end -- legislation and such responsibilities.
>
> The Board was unhappy when I didn't take the administrative position they offered me in the planning stages. I knew we needed medical changes, however, in this town, so I refused. Also, the doctors would expect favors from me. The new hospital rulings make for better care and practice.
>
> Edwards set up this organization. He had a lot of finesse. (Coachman follows the procedural policies set by Edwards.)

> Edwards early got on the right side of the doctors and was even able to get Dr. Bert Roos to follow the procedures the Administrator himself had set for emergency operations. He had the guts to demand that the first super of nurses resign after 6 months. She was originally from Capital General Hospital -- a very large place and very formal by comparison -- and did not fit in this smaller, freer, and friendlier place. Her personality and relationships with many people were bad.
>
> Edwards put pressure on the doctors to keep up their medical records for accreditation purposes. (Coachman could set a firmer policy; I think it's needed -- the doctors are falling behind.) Edwards also demanded that certain orderly procedures be instituted in the nursing section.
>
> The Administrator keeps the Board informed on medical matters bearing on accreditation.
>
> Coachman is stronger on finances than was Edwards, but Edwards was better on interpersonal relations. Still, he's coming along. He is an excellent lab technician and is called upon frequently by the pathologist and lab men.
>
> I feel free to approach all of the various department heads and to tell them I don't feel some things are right. Edwards said to me, as he left, that I had helped him a lot both on the Board and because of my experience in the old hospital and with the doctors. I know a lot of the employees -- having been in the organization so long -- and the older ones look up to me."

Miss Evans felt strongly that both the Administrator and the Medical Staff representative to the Board should not be members "since their roles should be advisory only and to prevent conflicts of interest."

> "They are always invited and not often asked to leave. The advantages for having them present are that they can bring up things that should be in the hospital or in the Lab and X-ray Department, for example. They can better explain the reasons for getting qualified staff. They can give the medical approach to staffing and equipment.
>
> Still, the doctor has a selfish interest and should not be on the Board.

> My personal physician is Dr. Bert -- he is the senior. There is no ideal doctor as far as I'm concerned: all ours have shortcomings, but all have had good educations. Choosing a doctor is a matter of personalities and confidence.
>
> The younger ones -- Rhine and Sheridan -- are developing specialties but are G.P.s basically, as are the older ones. Rhine is our chief surgeon; Sheridan our anesthesiologist. They're good and improving.
>
> I have heard some grumbling in the hospital. The younger generation don't really want to work. If you paid them, they would stay home anyway; they want money without work. Some of the employees are loyal. It varies with age and the individual. The older workers and staff are better in this respect. The situation was better in the old hospital."

Warrington does not feel that the Medical Staff should have membership on the hospital's Board of Directors.

> "My expectations and only thoughts when getting on the Board were to get an economic pattern set for the hospital people to follow. If the doctors would have operated this hospital, or if they would now, it wouldn't last long, you can bet! Doctors are the poorest businessmen I know. I, and a number of solid citizens in this town, believe in a pay-as-you-go program. Most of these doctors are spendthrifts. They don't know the value of money.
>
> We have Rhine as an unofficial member of the Board. Through him we get their [Medical Staff's] problems to the Board and any suggestions they want to make. He has no vote. He serves us as a means of communication to the doctors. We can get their problems; they can get our reactions."

Warrington's personal physician is Bert Roos, of whom he thinks highly as a doctor.

> "He's the last of the old-fashioned doctors. He would come to watch your child all night if he's sick and you need him. The rest of them just think of you as cases. Sure, I talk to him informally about the hospital. He has some set ideas about it. He's a tough nut to crack.
>
> You know, I hope to enlarge the hospital to a minimum of 40 beds, but I don't think we can get

the support of the influential men in the community. Even some of the Board members are hesitant. They all want to know whether the doctors will contribute as they should.

You know, the doctors use the hospital to practice in -- its their workshop -- but they won't pay to improve the place they make their money in. They're all the same; they think they are good. I agree with the others (Smith, Kennedy and Kingston) about the doctors needing to contribute to expansion first. We would expect $15,000 per doctor. They got $4,000 a piece and that sum in two nearby towns. But, being on the bank board, I know they can't do it, especially the younger ones. Whey they're in debt for 30 or 40 years to come! They've plunged into debt buying new homes for $40,000 plus -- like Rhine. How can they pay $15,000 with their other debts? There has to be equality of sacrifice here. Otherwise, these influential people and myself would go ahead. We can't solicit it from the general public. They wouldn't go for it -- not the way they feel about the doctors' contributions. The doctors have recently put a bundle of money into their new clinic building which is extravagantly built and furnished. People see this.

O'Toole stated that it was policy that no doctors can be members of the Board.

"We feel this is out of their realm. We provide the facilities; they give service. We want to keep the hospital a community enterprise. With a doctor on the Board there would be a conflict of interest on his part with his individual practice.

Of course, Rhine is the staff representative and he sits in on nearly all Board meetings in that capacity, if it is mutually convenient. He presents the problems of the Medical Staff and advises. There have been no disadvantages to this arrangement as yet. It is a good way to tap the feelings and values of the doctors.

My personal physician is Dr. Bert, the Chief of Staff. He, especially -- but the other doctors too -- shows dedication to his work and patients. We have a unique situation here, I think. I believe the doctors show whole-hearted co-operation. With the exception of one outside doctor, the others on the consulting staff have been excellent. The concerned doctors automatically consult before any operation they do.

The other employees here seem to like the hospital. Turnover is relatively low. There is a lot of loyalty.

> The doctors and nurses influence the people on the lower levels in this way. We've only had to revoke one M.D.'s privileges for unprofessional conduct."

Kingston mistakenly thought that Dr. Rhine was a full-fledged member of the Board, with voting rights, and saw "nothing wrong with a doctor's being on the Board."

> "Through him the Board gets medical knowledge which only a doctor can explain to us. One disadvantage to this scheme is that it may be embarrassing to one doctor on the Board if something occurs with another doctor's patient to have to discuss his colleague's ability or mistake with us. So far, nothing like this has happened with a local doctor.
>
> My personal doctor is Herman Roos. I see him regularly and we often discuss the hospital situation. I can't say too much about Herman. He is well respected. He's not a pusher, though. Bert is an old fogey. We on the Board have had a lot of battles with him, but we still listen to him because he is their conservative with some sound ideas. He heads the doctors' group more by his experience and family position -- they're all related. Bert's due to retire pretty soon.
>
> My idea of an ideal doctor is one with the soundest medical knowledge plus the ability to get along with people. Rhine has the ability in his field and is the best informed of the bunch in that respect; but if he had Herman's, or even Bert's, personal interest in patients, he'd be ideal. But he's cold to people, not a mixer, not jolly.
>
> I think the personnel at the hospital really like it and are loyal. The nurses are really dedicated. They live that hospital. The doctors are less dedicated because of their clinic and practices but are still loyal, I would say.

Smith felt firmly that no medical staff member should be on the Board.

> "Actually, the doctors have their own representative on the Board in the person of Miss Evans who is there when a medical problem is presented. She, Rhine, and the Administrator can explain the hospital's needs from a medical viewpoint. There have been no disadvantages to this scheme. The doctors have ample decision-making and policy-making authority delegated to them in their right to approve staff appointments first. All their recommendations have been acted upon favorably.

> My personal doctor is Bert Roos, an old friend. He is a little too cautious, conservative, and reticent at times, but a good doctor. We have a pretty good staff. They're all a little different -- they have different personalities. The ideal doctor, I feel, is one of good repute, good habits, qualified in his line, and -- most importantly -- one who commands confidence. All our doctors measure up fairly closely in most respects to these qualities. No one is ideal.

Rowlands' comments left no doubt as to how he envisioned the role of the doctors vis-a-vis the Board.

> "No, I don't think they should be on the Board. We have Dr. Rhine sit in on our meetings to give us their opinions on certain matters they know more about. They also give us advice on things the Administrator wants to buy. Anything dealing with the medical angle we ask him because we don't know anything about medicine. Also, it's in our 'By-laws'. We want to keep it a community hospital. Some people want to make sure its kept that way I guess is why we have no doctors as voting members. [sic]
>
> My personal physician is Bert Roos. I don't think that I can rightly say what an ideal doctor is like. I do think we have a very good bunch of doctors, though.
>
> Yes, definitely, there's a real close spirit of harmony as far as I can see, in the hospital. Maybe there have been some minor problems you'd normally expect when people are together; nothing serious though."

Evans, Rowlands, and Evers were totally unaware of the availability of literature to help them perform their functions as hospital Board members. O'Toole, Kingston, and Warrington did some reading in the area: the first two the Blue Cross Quarterly and the monthly reports of Blue Cross/Blue Shield, and other hospitals; the latter only a hospital information sheet put out by a neighboring community's hospital. They were not particularly aware that such resources were available or had insufficient time to consult them -- as in O'Toole's case. Smith was the most widely read and cognizant of the Board's deficiency in this regard.

> "I get the Blue Cross/Blue Shield monthly and quarterly publications. Their information is prejudiced but still good. Once or twice a year, I pick up the hospital's magazines dealing with hospital problems, etc. -- Modern Hospitals, I think it's called. We have no policy of sending such publications around to the Board members. I think we should. Still, these are busy people. You can't force them to read the material, although they'd benefit surely, and so would the hospital."

Warrington restricted his informal social life and friendships to his family. He and his nephew, Kennedy, regularly attended family gatherings and the Kiwanis and other club meetings together. He was occasionally out socially with Smith, but they met more often informally on bank board business. Kingston was identified as the closest of his friends. "I have no very close friend. Kingston and I served on the city commission together. Once a year, Miss Evans has a shindig for the Board members and their families. Otherwise, there isn't much informal social interaction."

O'Toole stated that he had no close friends or associates in the hospital or on the Board. "Occasionally, I have dinner with Smith and Kingston on hospital business." Kingston, however, on his part saw O'Toole as "a quite close friend." He and Herman Roos were both Lions and associated together quite often with their families. He and the newest Board member, Carlyle, played golf together. Rarely, he associated socially with Rhine. Smith said that he saw only the Roos doctors socially. "We have a close social and church tie. Bert and I are both church administrators."

Rowlands, Evans, and Evers do not socialize with any of the hospital Board members or personnel.

In response to question B 17., Warrington asserted:

> "Financial bases determine all policy as far as I'm concerned. I want a pay-as-you-go, economically sound operation. You need them to stay in business. They should be used as they are established to be used.

> Rules and policies are the same thing, as I see it. Finances dictate all other operations. No one but the Board should develop policies. They can get suggestions from the Administrator and doctors and technicians. We let the M.D.s set up their own admittance to the hospital staff, but we check.
>
> We have no hospital budget; a budget is what you take in. We regulate ourselves in accordance with our income. We establish the various rates in accordance to income -- or we have so far. We have professional hospital auditors now come in and help us set up a rate structure.
>
> We purchase drug supplies from a local druggist. We can't anticipate these items. For all purchases you go where you can get the best price. At the start we were buying more from another druggist. He gives us the best price so we buy from him.
>
> Our credit and collection policy is a patient account is to be paid in full before he leaves the hospital. On a large account we ask for periodic payments. If there is a non-payment, we try to get it ourselves, then, if unsuccessful, we turn it over to a bill collector who calls on them. We've had no law suits yet. The Board established the collection and credit policy; the Administrator carries it out."

O'Toole was more specific about policy formation in the hospital than Warrington. For him policy referred to ...

> "establishing general rules governing the hospital's operations. The Board makes sure these rules ensure financial and legal responsibility. Their phrasing and interpretation on the detailed level require us to give leeway to the Administrator.
>
> The Board definitely has to establish basic policy in the areas of finance, building and equipment, and collections; it does so less in the area of medical care. Although it relies on the Administrator and Medical Staff there, it makes sure the legal end is covered.
>
> We work hand-in-hand with the Administrator. We have to delegate authority. The implementation and detailed carrying out of activities is the Administrator's responsibility. The most important factors in developing hospital policy, I feel, are financial.
>
> Really, the Board, Administrator, and department heads concerned or the Medical Staff must participate in both

> financial and purchasing policy. In the development of credit and collection policy, the Board, Administrator, and Comptroller are most concerned and knowledgeable. Maybe the Medical Staff. Others are not directly involved. Major equipment policy is the domain of the Board, but the Medical Staff and Administrator and concerned department heads are required as consultants. Personnel policy development is the business of the Board, the Administrator, and his department heads. He knows what qualifications and performances are needed. Maintenance policy is a Board and Administrator's concern -- maybe the Medical Staff as far as cleanliness, etc., are concerned. It depends on the specific problem. The Administrator has a committee of the department heads to handle details in this area."

The remarks of Kingston, Smith, and Rowlands in essential respects were similar to O'Toole's. Evans was not too informative, tending to see policy matters in terms of personalities and individual cases. Smith mentioned that "few of these policies are written down, but are rather understood." They are "clearly enunciated, if ever, only when an instance demands that they be."

> "The responsibility we have to charitable cases has been discussed more than anything else. It was finally decided that any emergency should be taken care of. 'Deadbeats' -- those who haven't paid 3 or 4 times -- would probably not be taken care of. The policy for them would be they would have to have quite an emergency. The hospital is always open to all, but where possible local people have been given preference."

The key board members responded variously to question(s) B 18. Warrington stated that the hospital receives the funds for its operations "from patients -- no other source." O'Toole and the others were more informative.

> "The patients are the main source of our income through the room and board rates they pay, X-ray and lab fees, and E.K.G. fees.

> The individuals and groups who contribute are Mills Springs Stamping, which contributes $1,000 a year -- it's worthwhile for that industry to do so; Smith has been most generous; and Warrington has been and will be when he wills the hospital 'a bundle'. The Lions and Kiwanis clubs have handled their end in the form of projects anytime they've been asked. No, they don't exert any significant pressure on how the hospital is run.
>
> I think if Old Age Prepayment goes in, this will create quite a problem for us since it will throw us into chronic and long-term treatment. We'll need more space and we'll have to give less intensive care and hospital service. It may mean lower costs. The Board will react as the community makes it possible. Going to more ward service can bring the per patient cost down, but at a price of quality. We have no wards now."

Kingston pointed out that "patient charges via Blue Cross are our main source of income." The Laboratory, X-ray Department, and pharmacy room "are real money-makers in this hospital -- they keep it in the black with $2-3,000 a month apiece." Daily room and board rates ...

> "bring in money, but the most of it comes from the other three sources. The auxiliary, industrial firms, and clubs have donated some money and equipment. I don't foresee any drastic changes in our income sources. We have few outside pressures -- none actually."

Smith was aware that patient charges brought in 99% of the hospital's income for operations,with Blue Cross-Blue Shield and other insurance plans instrumental in allowing payment.

> "Income from wills and legacies left the hospital are held for future expansion and don't go into our operating fund. The ladies' auxiliary and service clubs contribute in their way, as do some firms and industrialists.
>
> The Administrator, Bert Roos, and I have discussed building a geriatrics hospital near this one to handle our older patients. It's in the dream stage yet. We're thinking of federal funds because Blue Cross' allowance of cost only permits your reasonable improvement in equipment, not expansion. Federal Old Age

> Insurance will mean we will be getting more chronic cases to handle. There are few good nursing homes in the vicinity."

Rowlands added that "hardly any of our patients can afford hospitalization without some kind of prepaid insurance. I expect we'll get more of it. Also, if the federal government passes the Old Age bill, I think we'll have to gauge our charges to what they pay; but other than that, I don't know."

The answers of the various board members to questions B 20. and B 21., pertaining to determining the quality of medical and nursing care provided in their hospital, are enlightening.

Warrington gave a series of vague answers before finally admitting:

> "Board members have no means of evaluating medical or nursing care. Medical care is a function of the doctor-patient relationship. We have no control over the doctors whatsoever in medical care aspects, nor should we. We feel we're furnishing the best care that a patient can get. If he wants a private nurse, he has to pay for it ... If a professional person came in drunk, we'd throw him out."

O'Toole's responses, typically, showed acuter awareness than most board members.

> "The adequacy of facilities is one factor determining the quality of care provided in any hospital. The determination of the competence of the medical and nursing staff to give a high quality of care is, if anything, more important. We make every effort to supply the facilities. In a general way, the Board -- rather some of us on it -- check on or try to evaluate care. There are no specific checks or balances.
>
> The Administrator's report and the word-of-mouth reports you get from patients are good checks. The Medical Staff itself polices such activities. In one instance it denied the renewal of a doctor's privileges because of poor performance. He was removed. We can refuse to renew privileges and dismiss all personnel. There is a probationary period during which a doctor or others are scrutinized by the M.D.s, Administrator, and department heads."

Kingston relied heavily on patients' reports to determine the quality of medical and nursing care, "plus my own experience. I don't know what could be changed since everything seems to be ship-shape on that score."

Smith contacted or was contacted by patients informally on this score.

> "In addition to questioning Rhine at the Board meetings, I discuss the quality of medical care with Dr. Bert and Sheridan.
>
> Some of our Board members have had personal experience. Miss Evans is at the clinic. O'Toole is more conversant on this subject than I am. I question them all quite often.
>
> The Board can revoke and has revoked privileges. We also have a probationary period."

Rowlands felt he couldn't answer the question. "It's really out of my ken. We rely on the doctors."

Miss Evans commented: "As a Board member I can't do anything to better medical care; medical care is only as good as your doctors." She added ...

> "I can't tell the doctors what to do as a nurse. They should raise their own standards to attract other staff. They bring in and O.K. the other doctors on staff.
>
> It is good for all doctors to be watched so as not to get careless. It puts them on their toes. All the doctors are ready to tell one another what to do. They police themselves. Sheridan, the anesthetist, is a real 'eagle-eye' during surgery. They have a staff meeting every month in which they take a case and review and study it for improving their procedures."

It was interesting that Mrs. Evers mentioned the Administrator as one on whom the Board relied, as well as on the M.D.s, "to suggest factors needing tending" for the improvement of medical care.

> "They both give us a thorough discussion. Two doctors have been dropped who malpracticed. It was at the initiative of the Board to drop them. We got complaints from patients. I understand the cases weren't too serious and our insurance covered both clains. It was handled quietly. No publicity."

Regarding the liberal or strict interpretation of policies, question B 21., Warrington believed

> "the Board can consider each individual case of unusual aspects because of the small size of the community. We can have a deviation from the rules in a particular case in interpreting policies. After all, we have known most of these people for a very long time."

O'Toole felt all policies should be as strictly interpreted as possible.

> "The policies should be broad enough to cover all contingencies and to set limits. There is one qualification to that remark. Our policy on emergency cases is that they must be cared for immediately. Otherwise, our admission policy is firm. We are screening out non-payers. Many of them can go elsewhere and suffer no hardship."

Kingston -- like Warrington -- was for a particularistic application or interpretation of policies.

> "We have the admissions office investigate the merits of the individual case with problems. All emergencies are admitted and cared for. Others vary. We are liberal within reason."

Smith, too, revealed an inclination to a liberal interpretation and application of policy.

> "Our policies -- as any -- are rough guidelines. Policies have to be liberally interpreted on the merits of the case when a problem comes up. A policy can't possibly cover all contingencies. Ordinary cases are adequately or automatically cared for under the understood rules."

Rowlands, Evans, and Evers felt that some unusual cases would receive liberal treatment when necessary, while in other cases the rules should be strictly interpreted.

The responses of the Board members to the question(s) B 22., tapping their knowledge or awareness of extra-community structures -- legal or

otherwise -- on the operation of their hospital follow.

Warrington was very aware of state governmental laws:

> "The state laws we are obliged to comply with are perfectly reasonable with respect to reporting our finances and other things I've mentioned in passing. The Fire Marshal's laws, sanitary regulations, and regular equipment and safety inspections directly affect our hospital. I don't know of any kinds of legislation to be enacted immediately. We've steered clear of federal requirements."

O'Toole likewise pointed out that "our hospital does not come under a number of state and federal regulations other hospitals do because we don't receive aid from them." The State Department of Health, "of course, sets standards for hospitals ...

> "I'm not too familiar with them, but there are strict rules on how the operating room should be fitted out and run. I understand some minor changes in ours must be made. The usual complaint of the inspector is that there is no fault to find.
>
> Old age prepaid medical care will probably make demands of a different type on us. I suppose the A.M.A. accreditation requirements fit in this category too."

Kingston stressed that the county government had certain rules which the hospital had to follow in treating their welfare cases.

> "We've quite a few -- 1/6th to 1/5th of our patient load on the average. State laws are also affecting our operation. They are necessary to set minimum standards of health and safety. Federal aid for hospitals has brought some regulations. We're not much for federal aid for our hospital, so they don't affect us. We will still operate much as usual. I think federal aid should go to the individual. Many a 60 year old needs aid to pay for hospitalization. The federal government will be stung because there's a chance to make money. We need to watch this with Blue Cross. Federal old age insurance in this area of hospital care is sure to come and will bring some regulations, you can be sure.

Smith said:

> "The most important laws and regulations affecting our operation directly are those of the State Fire Marshal and State Health Department. County and federal rules are less important in our case. We store an auxiliary hospital unit in our basement in case of a national disaster. It's for the Department of Defense.
>
> Of course, the doctors are all under state and county legislation. In a way, but not mandatory, the accrediting hospital organization is having a direct impact on us. We are working toward accreditation. We need a medical library, and then we'll be in line for their examination and we can hope for approval."

Miss Evans responded by identifying state and national legislation.

> "I'm sort of fed up with some of this state legislation. In surgery you're not allowed to leave if gowned; someone else has to bring you the patient. Yet the inspectors wear no special clothing at all. There are just a lot of rules to be broken. Some rules are O.K., but some are too arbitrary; and they make a lot of unnecessary work for us as in the laundry, kitchen, and elsewhere."

Rowlands identified "county, state, and national sources of laws. Specifically--state safety, health, and fire laws directly affect us. I'm not too familiar with any other laws or regulations."

The unanimity of response, in terms of negative attitudes and values expressed by all the Board members toward unions, to question(s) B 23., was impressive. The most outspoken was Warrington.

> "Yes, I would strongly oppose any union. I don't want any unions in our hospital. They're a menace to society -- a regular menace. They do nothing but disrupt the orderly flow of things.
>
> I have no contacts with the professional organizations you mention. I don't know of any similarities.
>
> Hospital employees should not strike. A man has a right to work for whom he pleases, a man has a right to hire anyone. That applies to any vocation. Why should they burden the hospital with their demands for higher salaries?

> These would have to be absorbed in higher rates. The burden would be put on the patients. Yes, unions are a public menace. Those who do not like their pay can quit and go elsewhere."

O'Toole was calmer but not any less adamant against unionization of hospital workers.

> "I don't foresee any evidence for this becoming a problem here. I personally would oppose unionization. After all, the hospital performs a vital service to the public; it should not be disrupted by a selfishly motivated strike.
>
> We deal fairly with our employees on an individual basis. We have had few complaints about pay. The hospital can't be run like a shop. It doesn't have the regularity of other organizations -- it's not possible. In a small hospital we can -- and our Administrator does -- show more individual treatment of employees. Our wages compare pretty favorably with the average hospital employees' wages in this area. Of course, disaffected employees can quit, but we haven't had too many do so."

Kingston remarked that: "I am opposed to any unionization ...

> "...hospital employees have nothing to gain. A union has no business in a small organization. A small organization must be flexible. A union often doesn't allow for flexibility. A person who is not satisfied can always leave and get another job.
>
> We have no union here. We know the people and their families. Talk to them every day. With our informal atmosphere, we can reason in our small place. They pass you off in a large organization. Here they know the top man personally. There's more of a dedication in this kind of organization on all levels."

Smith preferred not to comment on unionization, stating simply, "I don't know what I would do. I don't think it is or will be a problem."

The other Board members were similarly against unions in the hospital, or anywhere for that matter, although they could see benefits in professional organizations. Rowlands stated: "I'm not for unions because I think they're too powerful. (I wish the farmers were as well organized.) Their aim is to get more money for less work." Both Rowlands and Evans stated: "There

are no similarities I can see between unions and those organizations you mentioned." Evans went on: "Those are professional more than anything, I think."

Rowlands felt that ...

> "...they [professional groups] are concerned with education, performance requirements, etc.
>
> No, workers in the hospital should not have the right to strike. The type of service is too necessary. If they feel they're not paid enough, they could get other jobs. I think our people are paid fairly well myself. I don't see any trouble in this regard."

BOARD OF TRUSTEES QUESTIONNAIRE -- REVISED

B1. Could you briefly describe your hospital's organization -- i.e., what are its different parts and how do they fit together?

(a) How does the board fit into the picture?

B2. What is the major goal, as you see it, of this hospital?

(a) What does the board contribute to the attainment of the hospital's major goal?
(b) What does the Administrator contribute to the attainment of the hospital's major goal?
(c) What does the medical staff contribute to the attainment of the hospital's major goal?
(d) What do nurses and other departments of which you are aware contribute to the attainment of the hospital's major goal?

B3. What are the responsibilities of the Board?

(a) Administrator?
(b) Medical Staff?
(c) Nurses or other departments which you are familiar with in the hospital?

B4. What committees do you serve on in your capacity of Board member?

(a) Are you a chairman? An officer?
(b) What duties do you perform as a chairman or officer?
(c) What is the function of each board committee?
(d) How does each committee contribute to the attainment of the Board's major goal?
(e) To the hospital's major goal?

B5. With respect to what kinds of things are Board members able to make decisions? What is their authority? (Examples)

(a) On what kinds of things can't board members make decisions? (Examples)
(b) Do you feel you have enough authority to do your job well?
(c) Where does the responsibility for disciplining action lie within the board?
(d) Under what circumstances do you believe a board member should act with prompt and vigorous decisiveness?
(e) Have there been any significant changes in power relationships on the board since you have served? What are they?

B6. What do you consider the important qualifications necessary to be a successful member of the board?

(a) What personal qualities do you feel this position calls for?
(b) If you were asked to appoint someone to perform your particular function, what abilities would you look for in that person?
(c) Do you feel you have these abilities?
(d) Do you consider yourself to be a person who is more capable of directing others, or do you feel that you are more capable of receiving direction from others (as a board member)? Explain.

B7. What significant changes have occurred in this hospital's organization since you've served on the board?

(a) What changes do you foresee in this hospital five years from now? Ten years from now?

B8. Which departments or segments of the hospital would you rank from most to least essential in attaining your hospital's major goal? Why?

B9. How did you get your present position?

(a) How long have you been a board member?
(b) Why did you come to this hospital to serve?
(c) What expectations did you have when you took this position on the board?
(d) Were they fulfilled? How?
(e) What hopes do you have for your board membership? In other words, what would you like to see your hospital accomplish while you are a member?
(f) What do you feel the chances are to accomplish this?
(g) Is your wife a help to you as a board member?

B10. Which of the people in the hospital who contribute significantly to its operation do you regularly contact in an official capacity as a board member?

(a) How regularly do you contact him? (Times/ month, week, day)
(b) Is your relationship with (each contact's name and position) formal or informal?
(c) Do you feel free to approach him?
(d) In what way do these meetings between you help you in doing your job as board member?
(e) How well do you think he understands your position as board member and its responsibilities?
(f) How do these meetings help (name of contact) in doing his job?
(g) How well do you understand his position and responsibilities?
(h) What do you think he thinks of you as a person?
(i) Do you feel this person has any major shortcomings, if any, preventing him from adequately performing his job?

B11. What do you feel the relationship of the board of trustees should be to the administrator?

(a) Should he be a member of the board of trustees? Should he have a vote or should he merely be called upon for information and advice?
(b) What constitutes a good, comprehensive monthly report of administrator to the board in your opinion?

B12. What do you consider the important qualifications necessary to be a successful hospital administrator?

(a) What personal abilities do you feel the job calls for?
(b) How should the administrator help you as a board member?
(c) What kinds of information does he present the board with to aid you in setting up policies or making decisions? For example, what in terms of general finances, collections and credit; major equipment purchases, supplies purchases; maintenance; dietary; personnel problems; medical staff performance, nursing care standards etc., does he present to the board?
(d) Are there any outstanding problems in those areas which he has had to bring to the board's attention?
(e) Do you feel his reports are adequate in these areas to permit the board to evaluate the hospital's operation as a whole?

B13. What do you believe the board of trustees' relationship to the medical staff should be?

(a) Do you think the medical staff should have membership on the hospital's board of directors?
(b) Why or why not?

(c) What are the advantages of having a medical staff representative report to the board?
(d) Are there any disadvantages?
(e) Who is your personal physician?
(f) What do you consider an ideal doctor should be like? How do your doctors compare?

B14. How do you think employees in the hospital feel about working conditions?

(a) Do you think they feel a loyalty to the hospital?
(b) Do you think the doctors and nurses have this loyalty?

B15. What literature is there available that you know of which might help you as a hospital board member?

(a) Which of these do you have time to regularly read?

B16. Some people who work together develop friendships which carry over into informal social relations away from the job. Do you do this?

(a) With which of the people from the hospital do you get together with? [Probe context]
(b) Do people in general in the hospital get together informally as friends to your knowledge?
(c) Of all the people you count as your very close friends, do any of them serve or work here? Who are they?

B17. What does the word "policy" mean to you when you think of it in relation to the hospital's operation?

(a) Over what areas of responsibility does the board establish policy?
(b) In what areas doesn't it?
(c) In your opinion, what are the most important factors to be considered in developing hospital policy?
(d) What individuals or groups in the hospital do you think should participate in the development of broad financial policy? Why? Which not? What is this policy?
(e) What individuals or groups in the hospital do you think should participate in the development of purchasing policy? Why? Which not? Why not? What is this policy?
(f) What individuals or groups in the hospital do you think should participate in the policy development as to which major equipment should be obtained? Why? Which not? Why not? What is this policy?
(g) What individuals or groups in the hospital do you think should participate in the development of credit and collection policy? Why? Which not? Why not? What is this policy?

(h) What individuals or groups in the hospital do you think should participate in the development of personnel policies? Why? Which not? Why not? What is this policy? (Who makes up the job description, hires, fires, etc.?)
(i) What individuals or groups in the hospital do you think should participate in the development of maintenance policy? Why? Which not? Why not? What is this policy?

B18. From what main sources does your hospital receive its funds for its operations?

(a) Are there any particular groups or individuals who contribute heavily or significantly? Who are they?
(b) Do they exercise significant pressure on how the hospital is run? How?
(c) What effect do you expect the changing pattern of financing hospital care (such as prepaid insurance) will have on the development and determination of your hospital's future policy?

B19. What procedures does the board follow in determining the privileges to be granted applicants for positions on the medical staff? Nursing staff?

(a) If the board doesn't establish a policy, who does?
(b) What check does the board have that competent men and women are recruited?

B20. What factors, of which you are aware, determine the quality of care provided in your hospital?

(a) By what means can a board member aid in the improvement of medical practice in his hospital?
(b) What standards do you as a board member use to evaluate medical care given in your hospital? Who determines the standards here?
(c) If the quality of medical care is not what it should be, how do you go about determining which physician or other personnel are at fault?
(d) How do you eliminate such physicians or personnel if necessary?
(e) Are there any alternatives to dismissal?

B21. Do you think the various policy documents (by-laws, etc.) which are prepared to give written authority and guidance to hospital operation should be strictly or liberally interpreted to meet changing conditions?

(a) Why or why not?
(b) Which should be liberally interpreted.
(c) Which strictly?

B22. What units of government are you aware of that enact legislation or quasi-legislation affecting hospital operation?

(a) What other bodies do you know of which either enact legislation or set standards for hospitals?
(b) Do you personally know of any legislation directly affecting your hospital's operations?
(c) What kinds of legislation do you think will be enacted in the future?

B23. Since other hospitals, large and small, are increasingly being faced by the specter of unionization of its employees, if your hospital employees expressed their desire to join a union, would you support or oppose such action?

(a) What do you believe are the most important motivating factors that might cause hospital employees to join a union?
(b) Do you see any similarities or differences between unions and hospital administrators' organizations, medical societies or nursing organizations?
(c) Do you believe hospital employees or union members should have the "right" to strike? Why or why not?
(d) What alternative do you think the employees would have otherwise -- i.e., if they are legally not permitted to strike?

APPENDIX B

MEDICAL STAFF QUESTIONNAIRE

MS1. Could you give me a brief description of your hospital's chart of organization? How does your position fit into the total picture?

(a) What responsibilities does the medical staff have?
(b) The administrator?
(c) The Board?
(d) Nursing?
(e) Other departments?

MS2. What committees do you serve on in your area of responsibility as a medical staff member? What are their major functions?

(a) What other committees are there in this area?
(b) What are their functions? How often do these various committees meet?
(c) Of which committees are you a chairman? Who are the chairmen of the other committees?
(d) Which committees or bodies outside of the medical staff area are you a member of? How often do they meet?
(e) Are you a voting member or not?
(f) How does each contribute to your fulfilling the responsibilities of your position?

MS3. What is the major goal of the hospital as you see it?

(a) What is the major goal of the medical staff?
(b) How do the other major subunits of the hospital -- administration and board -- and the various departments contribute to the attainment of the hospital's major goal?

MS4. With respect to what kinds of things are you able to make decisions in your job? In other words, what is your authority?

(a) On what kinds of things can't you make decisions?
(b) Over what areas do you have responsibility for disciplining action? Examples.
(c) Under what circumstances do you as a medical staff member act with prompt, vigorous, even autocratic decisiveness?
(d) Do you feel you have enough authority delegated to you by the board to do your job well?
(e) Do you feel you should have more authority in areas than you do? In what areas? Why don't you have the authority you feel you should?
(f) Have there been any significant changes in authority relationships in your area either before you took this post or after? What are they? How did they come about?
(g) Are there any people in the hospital you know of who resent your medical authority? Who are they?

MS5. If you had to, how would you rank the departments of the hospital from most to least essential in attaining the hospital's major goal. Why?

MS6. What significant changes have occurred in this hospital's organization since you've practiced here?

(a) What changes do you foresee in organizational structure of an acute general short term hospital like yours 5 years from now? 10 years from now? Why will they change?

MS7. Which of the people who contribute significantly to your hospital's operation do you contact regularly in an official capacity? How regularly? (Times/day,week, month).

(a) Is your relationship with (each contact's name and position) formal or informal?
(b) Do you feel free to approach him (her)?
(c) Of what importance are your contacts with this person in doing your job?
(d) How well do you think he (she) understands your job?
(e) Do these contacts hinder you in any way? How?
(f) How do these contacts help (name of contact) in doing his job?
(g) What do you think he thinks of you as a person?
(h) Does this person have any major shortcomings which prevent him from performing his job well? Which might limit you in doing your job?

MS8. How often would you say you contact your immediate superior?

(a) What do you talk about?
(b) If you were to describe your superior's leadership ability in one word or phrase, what would it be? (Ask for expansion).

MS9. How did you get your present staff membership?

(a) Why did you seek membership to this hospital's staff?
(b) Are you a staff member of any other hospital(s)?
(c) What expectations did you have when you accepted this appointment?
(d) Were they fulfilled? How?
(e) What aspirations or hopes do you have of your membership now?
(f) What are the chances for you to fulfill them on this particular appointment?
(g) How secure do you feel in your membership?
(h) In what ways is your wife a help to you in your professional activities?

MS10. What features of this hospital do you consider:

(a) Advantageous to you as a practicing physician?
(b) Disadvantageous to you as a practicing physician?
(c) Has your practice increased _____, decreased _____, or remained the same _____ since this hospital opened? Since you have had membership on this staff?
(d) Has your professional status been changed in your own eyes or those of your patients as a result of affiliation with this hospital? Explain.
(e) Have you lost any patients because of affiliation with this hospital? Explain.

MS11. What do you consider the important qualifications necessary to be a successful staff member?

(a) What personal abilities do you feel your job calls for?
(b) If you were asked to appoint someone to perform your particular job, what abilities would you look for in that person?
(c) Do you feel you have these abilities?

MS12. What do you feel the relationship of the medical staff to the Board of Trustees should be?

(a) Should he be a member of the Board?
(b) Should he have a vote or should he merely advise?
(c) What do you think constitutes a good, comprehensive monthly report to the Board?

MS13. What do you believe the medical staff's relationship to the administrator should be?

(a) What is your relationship to the administrator?
(b) What are the advantages of an administrator being a member of medical staff committees?
(c) Disadvantages?

MS14. How do you think the hospital employees in your area of responsibility feel about working conditions?

(a) What do you feel they like best about this hospital?
(b) Least?
(c) What do most people in this community think of your hospital, to the extent of your knowledge? How do you find out their sentiments?

MS15. What problems, if any, do you face today for which your original medical training never prepared you?

(a) What single activity, or whatever it is, causes you the biggest problem or pressure?

MS16. What pertinent literature do you regularly read to aid you in carrying out your functions as medical staff member?

MS17. Some people who work together develop friendships which carry over into informal social relations away from the job. Do you do this?

(a) Which of the people from the hospital do you get together with?
(b) Do people in general in your organization get together informally as friends?
(c) Do you believe it is good to have friends in the same organization as you? Why?
(d) Are there other people with whom you get together informally? Who are they?
(e) What do you do together?
(f) Of all the people you count as your very close friends in your life do any of them work here? Who are they?

MS18. What does the word "policy" mean to you?

(a) In your opinion, what are the most important factors to be considered in developing hospital policy?
(b) What individuals or groups in the hospital do you think should participate in the development of policy?
(c) What individuals or groups do participate? In what areas?
(d) Are all the people affected by a policy asked to participate in its development?

MS19. In what areas of policy development and to what extent should medical staff members try to influence the board in establishing policy?

(a) To what extent do you try?

MS20. To what extent does your board provide you with general or detailed and specific board policies?

(a) Do you feel the need for more of less provision of this nature from your board? Explain.

MS21. Do you think that the various documents (by-laws, etc.) which are prepared to give written authority and guidance to hospital operation should be strictly or liberally interpreted to meet changing conditions?

(a) Why or why not?
(b) Which should be liberally interpreted?
(c) Which strictly?

MS22. What bases and procedures do you follow in determining the privileges to be granted applicants for positions on the medical staff?

(a) Do such factors as the doctor's race, creed, or color affect such a decision involving selection and determination of a medical staff member's privileges?
(b) Why or why not?
(c) What other factors are considered?
(d) Do you feel the board of trustees should appoint to the medical staff only physicians nominated or approved by the hospital administrator?
(e) Why or why not?

MS23. How do you evaluate the qualifications of the members of your medical staff?

MS24. What factors, of which you are aware, determine the quality of medical or nursing care provided in your hospital?

(a) Who or what groups are most responsible for maintaining satisfactory control over each factor?
(b) By what means can an administrator aid in the improvement of medical practice in his hospital?
(c) What methods are used for controlling the quality of professional work performed by the medical staff of your hospital?
(d) Describe the medical staff's responsibility for controlling the quality of professional service its individual members provide for hospital patients?
(e) What information do you think should be interchanged between the medical staff and hospital administrator regarding staff professional performance as evaluated by established standards? What channels do you see?
(f) What do you think are the most important factors in the development and maintenance of good relations with the administration?
(g) What standards do you use to evaluate the operation of your hospital?
(h) How are the standards developed? By whom?
(i) What limits do you place on their application in your hospital?

MS25. If the quality of medical care does not meet the standards established by the hospital, what are the relative responsibilities of the administrator, board of trustees, medical staff and nurses for discovering and reporting why the quality of care is low?

(a) For determining which physicians or other personnel, if any, are at fault?
(b) For eliminating such physicians from the medical staff if necessary?
(c) For dismissing the personnel?
(d) What alternatives are there to suspension or revocation of staff privileges for such doctors?

MS26. What is the purpose of the medical record?

(a) What are its components?
(b) How should it be used?
(c) How do you evaluate the quality of a medical record?
(d) Its completeness?
(e) How do you assure yourself that a complete and adequate medical record is being prepared for each hospital patient?

MS27. What are the most essential and important ancillary services in your opinion? Why?

MS28. If hospital standards are to be developed by the state, who do you think should develop them?

(a) Who do you think will develop them?
(b) What organizations or groups do you think should participate in developing a piece of hospital legislation?
(c) What procedures would you like to see established to secure the group or individual participation you prefer in the development and evaluation of hospital legislation?

MS29. What are the units of government which enact legislation or quasi-legislation affecting hospital operation?

(a) What are the other bodies performing similar functions?
(b) What kinds of legislation have been enacted that you know of that directly affect your hospital?
(c) What kinds of legislation do you see enactable in the future?

MS30. Does the board of trustees always authorize the purchase of all equipment that the medical staff and administrator claim is absolutely necessary to provide good medical care? Why or why not?

(a) Do you personally investigate any unusual purchase request?
(b) When asking for purchase of equipment or supplies, do you allow price to be the determining factor or professionally determined standards and specifications?
(c) What resources are available to a hospital administrator when attempting to improve hospital operations by purchasing new equipment?
(d) What services are offered by equipment suppliers to aid purchases?

MS31. What patient or public relations and public information problems exist of which you are aware?

(a) What suggestions do you have for bringing about better patient and public understanding?

MS32. What similarities, if any, do you see between unions and hospital administrators' organizations? medical societies? nursing organizations?

(a) What differences do you see?
(b) What do you believe are the most important motivating factors that cause employees to join a union?
(c) Do you believe a hospital employee should have the "right" to strike? Why or why not?
(d) What alternative sanction do you think hospital employees should have if they are not legally permitted to strike?

MS33. What groups or individuals that are not an integral part of your hospital's professional or administrative organization are in a position to influence the hospital's policies?

(a) What is the basis of their influence?
(b) How do you anticipate the influence of these groups or individuals will vary 10 years from now?
(c) In what situations?
(d) Why?

MS34. What effect do you expect the changing pattern of financing hospital care will have on the development and determination of your hospital's future policy?

APPENDIX C

ADMINISTRATIVE RESPONSES AND QUESTIONNAIRE

Coachman meets informally several times daily with the Comptroller, the Director of Nurses, and the Surgical Supervisor (all women, the latter 2 R.N.s) on hospital business. He meets less often (2 or 3 times per week, or as required) with the Dietician and with the Chief Technicians of the X-ray and Clinical Laboratory Departments, and with the Head of Maintenance -- the first, a woman; all the rest, males.

> "I feel free to approach them at any time, as I am sure they feel free to contact me too.
>
> I am always interested in cash and billing. Mrs. Montgomery, the Comptroller, and I go over the books and discuss how we're operating. We talk about and I contact the indicated patients with regard to financial problems. I explain the bills and the manner of paying to the patients. This is necessary for the patients of below par mental capacity; also for the reluctant bill payers. Mrs. Montgomery refers the patients to me. Any administrator must keep abreast of his finances, but these must not outweigh his other interests.
>
> With Mrs. Kedzie, in Nursing Service, I discuss the patients area: their care, conditions, equipment needs -- really, anything to do directly with patient care. And then, of course, we discuss the nurses, their problems, equipment needs, etc.
>
> Mrs. Johnson, the Surgery Supervisor, and I go over the scheduling of her time and the new equipment she needs and the items which she uses. This is a big field. She's in charge of the O.R. and surgery [recovery] room. She makes sure the various surgical items are in good shape and that there are enough supplies. I encourage all the personnel to use common sense and to be aware of the money they're spending.
>
> Food is important to patients. There's nothing harder to do than to feed ill persons. The Dietician and I try to make the food more palatable. (We don't think some of the foods described in the Dietary Manual are good for hospital preparation.) Anyway, Mrs. Kimball and I have often discussed the employees and working conditions in the kitchen. The wages of our kitchen personnel were very low and the workers were unhappy about it. We just recently raised wages.

While I'm on the topic of personnel and their problems, let me say that I always consult with the department heads about them. I never hire, fire, or discipline employees without consulting the department heads involved. I review our wage scales with the department heads, which we discuss. Not all our problems are with wages, however. Well, there has been some personal bickering among the women in the kitchen and maintenance (housekeeping really.)

I told the Board that some of our employees were grossly underpaid and that immediate wage raises were needed. We could meet these increases by handling our unpaid bills more efficiently and effectively. We really need a full-time person in the business office to care for collections; too many bills are let slide. I plan on putting a bookkeeper-stenographer on this job with the aim of eventually setting up a Credit and Collections Department. Statements have to get out immediately and collections should be made within 30 days. It's better to get them [patients] while they're here. The outpatients really create a problem this way. We can do without them! I think the doctors should see them at their clinic. The collection of outpatient bills needs improvement badly. Before we can get better pay for our personnel, equipment, care, we have to collect from the outpatients. Inpatients are not as bad this way. The outpatients come to the hospital for X-rays, lab tests, suturing, casting, etc., by the doctors and it's done to keep costs down on these things. It is charged to the medical insurance plans. Ninety-five percent of those refusing to pay the hospital also refuse to pay the doctors. The doctors' charge-offs are even higher than here.

I see Barrett and Smith [the lab and X-ray technicians] 2 or 3 times per week -- sometimes more often -- on matters of equipment, supplies, and the communication of their test results to the doctors, basically. The matter of money taken in by them for services is also discussed.

Maintenance and cleanliness in the hospital is a constant problem, so I confer with Rupert several times daily about this.

I get along with all of the department heads, although I've had some run-ins with Smith in the past. He has some shortcomings revolving about his method of expressing himself. He is not too diplomatic." [A 10.]

Asked how often he contacted his immediate superior and what they talked about, Coachman identified four members of the Board as his superiors: Smith, Rowlands, Warrington, and O'Toole. He saw Smith and O'Toole in person about once or twice a month in informal meetings at the hospital; with Smith he mainly discussed "equipment and grounds business"; with O'Toole he "consulted on the history of the hospital mostly." He also kept these two men "posted on hospital developments or problems" he faced. Legal questions or problems were referred by Coachman to Warrington, whom he contacted by phone most often -- whenever he felt the need. (Warrington offered his legal services without charge.) He met least often with Rowlands, but in person, when he did so. Coachman said that he was advised by Edwards, and that he had found in his own experience, these four board members were "all good leaders and very progressive on hospital matters."

> "Smith has had the most and widest contacts with the supplies companies. He's a shrewd man, a good businessman. Warrington is a big man in many ways. He's powerful in this town. Rowlands is an understanding man and progressive. He and, especially, O'Toole are keenest on medical care matters." [A 11.]

Coachman thinks "the ability to get along with people" is the important qualification of a successful hospital administrator. "He must be able to because there are so many different kinds of people working together and he has to bring them together." The people "differ in terms of power and influence, knowledge and intelligence and so on."

> "You should have a pleasing personality. People should be made to feel they are on a par with you. You don't put yourself above these people. You talk and act on a level they're accustomed to. I try to get away from the personal pronoun 'I', be myself, not the almightly 'I'. I use 'we' a lot; this way you incorporate them in the job of administration.

> Yes, I feel I have these abilities, although I have to develop them. I do assert my authority when necessary, but I have not had to, too often. There were the cleaning situation and the kitchen squabbles. I spoke to the persons concerned after talking with their department heads. I threatened them with dismissal since it (the trouble) had come up too many times. In this job you have to both direct and receive some direction, especially from the Board." [A 12. and A 13.]

Coachman was satisfied with sitting in on the board meetings in an advisory or review capacity. He did not think that the administrator should be a member of the board.

> "A good, comprehensive, monthly report from the administrator to the board should present a complete balance sheet with income and expenditures by departments and collections by departments listed. Any changes or personnel and hospital physical improvements should be included. A list of statistics with which they should be acquainted are: occupancy rates, patient days, newborns, deaths, and numbers of outpatient procedures.
>
> I try to educate the Board with such a report so they know intelligently whether we are increasing our operation, and in cumulative terms these reports show, I feel, that we need definitely to expand facilities and services. I keep a running chart on occupancy and on the number of X-ray and lab procedures done per month. I developed this with Edwards." [A 14.]

Coachman saw his relationship to the Medical Staff to be one of "a general helper and to push for better medical care."

> "Accreditation is in most people's minds. The Medical Staff and we in administration, and the other services, work together on this. Patient care is paramount in all this. The doctor should not be taxed with little details. As the administrator, I can keep the doctors abreast of new equipment, drugs, policies, procedures, etc., they have little time to spend on.
>
> Policies, such as admitting patients and the preparation procedures, we get their approval for. For example, we found we needed to admit surgical patients to the hospital between 12 and 2 P.M., if we were to properly prepare them for surgery the next day. (We want tonsillectomies in overnight before they are performed.

> [sic] Not because of the money -- because we don't charge for that day -- it's for the better handling of the kids. It helps keep them quiet.)
>
> I get the doctors to communicate with the nurses and the nurses' communications to the doctors. Some doctors never specified the oxygen flow into the tent. Now a doctor must write where the flow meter is to be set. Unless the doctor writes it down, he doesn't have the right to criticize where the nurse sets it. He has to write the flow and times. It has helped.
>
> The state of our medical records is the biggest problem the Medical Staff and we in administration face, since the doctors are so busy. Medical records are important from a legal and medical reference point of view. Last year, 45% of our patients were readmitted. With complete medical records, we can pull out their old charts and save time and effort. Of course, it has to be complete to be good. The doctors are 2 years in arrears, confidentially. This has held us back from accreditation more than anything else."

Coachman displayed a concise knowledge of the required contents of a properly completed medical record.

> "The weakest feature of the improperly completed medical records has to do with consultations -- there are many, many, oral consultations which the doctors won't even dictate, let alone write down. The average doctor sees 40 patients a day. Sure, they have a fairly efficient office (about 10 people work there in the office, which makes for 2 people per doctor.) Still, the records are incomplete. We have discussed this problem many times. 'If we have to dictate our records or sacrifice seeing patients, we'll sacrifice records', say the doctors to me. I see their point. In the long run, I feel, the doctors will have to slow down. They're talking of taking on still another new doctor at the clinic.
>
> If they don't increase their money intake, they'll be at a stalemate. They didn't know in the past how much money was owed them. They only became aware of it in the last few months. Their pressure for payment helps the hospital in pressure for collection too. They can stop spreading themselves thinner. Surely, they can shear off the non-payers."

Coachman sat in on almost all the medical staff committees at the pleasure of the doctors. Although he admitted there were real advantages

to doing his job as administrator in being an invited member of these committees, he, nevertheless, was not happy with some of the committees nor with his restricted participation in them generally, which he saw as disadvantages to doing his job properly.

> "The Sterilization Committee and the Medical Records Committee are the poorest; not because of their heads, but because the other men are not co-operating. They make a ruling or rulings and then proceed to break them. The sterilization of females is a problem here. Most of them are low mentality people who are dependent and yet keep having children. (The doctors suggest it -- sterilization.) There are rules set, however: the woman must be of a certain age; she must have had so many pregnancies; she must make an application which is reviewed by the committee; and so on. But some of the doctors throw these rules out the window. I try to control the matter, but how can I if the doctors can't get together?
>
> They can't police their own work alone. They try to have a mutual understanding. They're free to discuss medical practice problems themselves. They consult each other, but their own practices come first. I would like to see more organization for malpractice suits protection and so on, on their part. I get more from the doctors singly and alone. As a group, they take things too lightly. They don't get into their own practice policy. They don't care to open that 'can of worms', and they certainly don't welcome my inquiries into these matters. Edwards had the same problem. Has he told you so? [He had.]
>
> So far we haven't had any bad repercussions from the active staff's practice. Rhine, Sheridan, and the new man, Hardt, are the leaders in standards. I'd rank Bert Roos and Herman next in that order. The doctors handle the cases they are competent in.
>
> No, I don't think the doctors should have any formal place on the Board. Rhine already influences the Board as the Staff's Joint Conference representative. Then, too, Bert Roos influences his board patients, Smith and Warrington, to an extent." [A 15]

If anything, Coachman felt that he had established a more informal flow of information to come to him and to flow from him throughout the organization. The departmental heads were encouraged to channel all

suggestions, preferably written, to him from their departmental personnel.

> "I see no disadvantages to communication. The more we get people to say, the better we can operate. I have had the example of Edwards before me and my military experience to draw on in this regard. He had more experience than I have had." [A 16.]

Coachman thought that the job of the administrator (both as regards the estimation of the position's importance and its performance by Edwards and himself) was viewed favorably by the Board, Medical Staff, nurses, and all the departmental heads -- with the possible exception of Smith in X-ray. "The job carries a certain prestige here, in the hospital and the community. I like to think that Edwards and I have helped create that positive image." Both Coachman and Edwards stated that they had received direct, as well as indirect, confirmation of this collective assessment from the various parties in the organization just mentioned, and from the public outside of it. [A 17.]

Both Coachman and Edwards commented on the esprit de corps and the close, informal relations existing among most of the employees and sections of the hospital. They felt that this was one of the basic reasons why so few of the members of the hospital have left the organization. Turnover appeared to be low. "The thing they like least -- especially the people on the lower levels and in nursing," Coachman asserted, "is the low pay. Also, the nurses (R.N.s) don't like to do their administrative chores, although we all understand they are necessary if distasteful tasks for professionals like them." The Administrator remarked that "we also send along to our patients a brief form-questionnaire asking for their critical comments on the hospital services. Overwhelmingly, they are constructive -- so we seem to be satisfying the public. We've acted on several of their suggestions." [A 18.]

Coachman felt that, other than the problem of expansion, he had not encountered any serious problem for which he was totally unprepared. As for his training, he claimed: "Working as closely as I did with Edwards was a very valuable experience. Working on the job helps you get the hang of it. I try to read as much as I can in the area of hospital administration and I attend as many conferences, lectures, and the like as I can." The list of journals and magazines he consulted regularly included: Hospital Topics, Catholic Hospital Magazine, Business Week, American Hospital Association publications, Hospital Progress, Hospital Management, The Modern Hospital, and Hospitals. [A 19 and A 20.]

Coachman stated that he had developed "fairly friendly relationships" with Edwards, Rhine, and Sheridan, of those persons working in the hospital. Rhine is a neighbor of Coachman's and they occasionally dig and plant trees or do landscaping on their yards together. With Sheridan he sometimes goes fishing. They all three drink beer together, now and then, and discuss hospital matters and current events. His close friends with whom he socializes regularly, however, are a few young businessmen and semi-professional people in the community.

Of the various sections of the hospital, Coachman believed that the "nurses constitute a real in-group. The members of the other sections are not as friendly among themselves as are the nurses. A number of them socialize off the job with their families." Although he did not look with disfavor upon good friends working in the same place or office together, Coachman felt "that it results in a more business-like operation if some distance is maintained -- friendly but not 'buddy-buddy'. I have no very close friend working here." [A 21.]

Coachman then proceeded to rate or evaluate his departmental heads:

> "Al, the Lab Head, is improving with age and responsibility. He still shows room for improvement, but I'm generally happy with results.
>
> Our Comptroller, Mrs. Montgomery, is indispensable, although not as broad-minded as she should be in this kind of setting.
>
> The Dietician, I'll replace.
>
> Our top nurse, Mrs. Kedzie, has very definite and very good ideas. She is quick to judge and able to size up and talk about many situations.
>
> X-ray is an efficiently run department. Jay is very efficient and his department is a smooth operation. He leaves a lot to be desired personality-wise. We will have to live with it. He doesn't get on with the other employees. I've had to get tough with him because he tongue-lashed the head of another department.
>
> Maintenance has quite a job in caring for the whole hospital. Rupert is very competent." [A 31.]

Edwards and Coachman were both opposed to the unionization of hospital personnel. Coachman stated that,

> "I am definitely opposed to unionization of hospitals in general, and ours in particular. I don't foresee this as a problem here.
>
> I was a union member myself. I know its advantages and disadvantages. A more intelligent group, even in a large hospital, can accomplish the same things as a union. I would not encourage it. I would try to keep the personnel's wages or salaries equal to or above other hospitals to prevent it from happening. Working conditions in hospitals are quite good generally.
>
> There are and there aren't similarities between unions and the organizations you named. But professional status is the big difference. It means such people can bargain individually and to good effect due to their knowledge and importance to a hospital's operation.
>
> Too many unions are too powerful. Some are good. The big drawback is that they can ruin a small outfit with their excessive demands. A small place simply doesn't

> have the resources to meet them. Costs will rise too steeply, and they'll have to be passed on to the patients. We'd be in trouble.
>
> If every hospital collected every penny of their accounts receivable, salaries could be upped. Socialized medicine is not the answer; just look at England. Not only that, money and wages would still be problems.
>
> No, the workers in hospitals should not have the right to strike; it's too vital a service. They could resign, if they didn't like the situation. Not many here will, because they're too dedicated. I'm sure that it won't happen here." [A 33.]

Coachman cited the local County Board of Health, the State Board of Health, the State Fire Marshall, and other state inspectors (of engineers and the like) as those units of government which he knew enacted and enforced legislation affecting the operation of his hospital.

> "The Michigan Hospital Association and other hospital groups, accrediting agencies and the like, enact and enforce, if that's the right word, quasi-legislation. The state malpractice laws, workmen's compensation laws, and insurance regulations all directly affect our institution. I don't know what kinds of legislation might be enacted and enforced in the future." [A 34.]

Coachman had previously responded partially and in other contexts to a series of questions presented at the close of the interviews. These answers to questions A 35.- A 42., therefore, will be abbreviated.

The current hospital budget was worked out by Coachman and the Comptroller in consultation with the heads of the other departments and the Medical Staff and with the approval of the Board. He and Edwards admitted that the lack of a budget in the early years of operation had resulted in "haphazard financial scrapes on occasion." Out of necessity, Edwards and Rhine had drafted a "working budget" without the full sanction of the Board.

Coachman's remarks supported Edwards', that the main source of the hospital's operating funds came from Blue Cross/Blue Shield and other insurance plans, plus "some donations" by prominent citizens.

> "The donations made by Warrington and Smith, on the Board, and others have been substantial. It's rumored that Warrington has willed half of his estate to the hospital.
>
> Warrington was instrumental in getting construction under way and supervised it. He's still important. He is powerful but not tight-fisted. He, O'Toole, and Smith are good leaders. The Board has loosened up and delegated more authority than it had at first. They control, if that's the word, hospital policy or operation through finances. There are limits to what the community can do for us and these people see themselves as responsible to it.
>
> Warrington and the others on the Board, I feel, should participate in determining the capital funds to be raised, not only for construction, but expansion. They are better informed than I or others in the hospital are on this. We have hunches only, they know. They can withhold money and put pressure on us, that way keeping control. But we don't feel that much pressure.
>
> When it comes down to it, the Board and I (although I nominally) establish purchasing policies. We have to judiciously satisfy the needs of the Medical Staff and the department heads.
>
> Warrington, Smith and others on the Board have business and personal connections and they try to get the lowest bidder to supply us, often succeeding. I don't favor, nor do they, the awarding of contracts only to local suppliers. We actually don't have too much local suppliers of our needs; the community is too small. We have transferred purchases of our drugs out because we can buy more cheaply outside. We have no real [hospital]pharmacy -- no need for it yet.
>
> Earlier, the Board was much more involved in purchases of major equipment and in general purchasing. They are still important in the first, but they exercise less control now.

> I personally investigate any unusual purchase request, yes. No, I don't allow the price to be the sole criterion. Both professionally determined standards and specifications have to balance out the advantages and disadvantages of various supplies or equipment.
>
> I rely in part on suppliers to provide information on products. I also have consultations with medical staff people and other experts. The journals really help. In short, our personnel are specialists and work with equipment and supplies, in effect testing them. The suppliers give quite a bit of aid in purchasing.

Coachman was not too informative in discussing the basic principles or underlying concepts used in developing credit and collection policies and practices. He merely repeated the position he had taken previously. It was evident that he fully shared the main values of the Board (and to an extent of the Medical Staff and Comptroller) in this regard.

The Administrator saw the effect of payment from insurance companies or governmental agencies on the amount of the hospital's rate structure, and its relationship to costs of service, as "balancing out so far; it has been adequate support by-and-large. However, we may need a new system." He saw a problem coming with Blue Cross/Blue Shield payments insufficient to cover costs of service and to allow reasonable room rates. "So far state or federal government payments have not made much of an impact. We have been able to stay in the black (just barely at times) because we run a check on the percentage of costs. We pull in our belts." He continued, ...

> "Our financial situation appears to be sound. Our present rate policy enables us to make a small profit, but it is easily threatened. Rates will have to go higher shortly, I'm afraid, for a greater margin of safety.
>
> The programs for financing are limited. We will need donations to expand. The Board -- at least most of it -- is suspicious of governmental help, although

> the hospital has accepted grants, (I'm not sure where I stand on government aid.)
>
> We use the knowledge of the Board of the community, the knowledge of the Medical Staff and other personnel of the practices of other hospitals -- which they get through meetings, seminars -- to help us in determining rates for rooms and services. We are able to economize and charge somewhat less due to our lower costs and cheaper labor at several levels. We try to get a fair return plus money for modest increases in salaries and wages.
>
> Warrington, the Comptroller and myself, Rhine and Miss Evans have been directly involved in setting up the various rates. We've had the most experience in these matters. The places where policy of this sort has been hammered out are the Board meetings, Joint Conference Committee, as well as informal discussions.
>
> Blue Cross is not fulfilling expectations. Actuarially sound government insurance may be the answer. Costs will go up in hospitals in any event, you can be sure of that. We have tended to follow the trends set in the area, as well as feeling a pinch, before changing the rate structure." [A 40.]

Coachman viewed public relations as quite important to the hospital. He reiterated the remarks he had made previously in other contexts and identified the Board and himself, the Medical Staff "to a certain degree", as those most responsible for public relations. Controls on release of information on patients was described as "tight" and "legally correct". He referred to and produced a copy of policy on this matter. He felt that the hospital has to "definitely sell the public on expansion. We are suffering from overcrowding. We will have to call for the community's financial support."

His priority list for future hospital plans or programs consists of expansion in the form of the establishment of a geriatrics division, a new kitchen, and a new operating room. "Yes, I feel they will come to fruition. The money will come from Warrington and others. It has to." [A 41. and A 42.]

ADMINISTRATIVE QUESTIONNAIRE

A1. Give me a brief description of your hospital's organizational set-up or chart of organization? How does your position fit into the total picture?

(a) What responsibilities do you have as administrator?
(b) What responsibilities does the Board have?
(c) What responsibilities does the Medical Staff have?
(d) Nursing?
(e) Other departments?

A2. What committees do you serve on in your area of responsibility as an administrator? How often do they meet?

(a) Which committees are you chairman of?
(b) Which committees outside of the administrative area are you a member of? How often do they meet?
(c) Are you a voting member or not?
(d) What is the function of each committee?
(e) How does each contribute to your fulfilling the responsibilities of your position?

A3. What is the major goal of the hospital as you see it?

(a) What is the major goal of administration?
(b) What does administration contribute to the attainment of the hospital's major goal?
(c) The Board?
(d) The Medical Staff?
(e) Nursing?
(f) Other departments?

A4. With respect to what kinds of things are you able to make decisions in your job? In other words, what is your authority?

(a) On what kinds of things can't you make decisions?
(b) Over what areas do you have responsibility for disciplining action? Examples.
(c) Under what circumstances do you as a hospital administrator act with prompt, vigorous, even autocratic decisiveness?
(d) Do you feel you have enough authority delegated to you by the Board to do your job well?
(e) Do you feel you should have more authority in some areas than you do? If so, in what areas? Why don't you have the authority you feel you should?
(f) Have there been any significant changes in authority relationships in your area either before you took this post or after? What are they?
(g) How did they come about?
(h) Are there any people in the hospital you know of who resent your administrative authority? Who are they?

A5. If you were to, how would you rank the departments or segments of the hospital from most to least essential in attaining the hospital's major goal? Why?

A6. What significant changes have occurred in this hospital's organization since you've worked here?

(a) Do you know of any significant changes that occurred before you came here?
(b) From what sources did you learn about them?
(c) What changes do you foresee in organizational structure of an acute, general, short-term hospital like yours 5 years from now? 10 years from now? Why will they change?

A7. How did you get your present job?

(a) Why did you come to this hospital to work?
(b) What expectations did you have when you took this job?
(c) Were they fulfilled? How?
(d) What aspirations or hopes do you have of your job now?
(e) What are the chances for you to fulfill them on this particular job?
(f) Is your wife a help to you in your job? In what ways?

A8. If you had a job which you considered ideal, what would it be like? [Probe for responsibility, authority, peer relationships]

(a) What parts of your job are furthest from your ideal?
(b) What do you think your chances are of moving into such a job as you outlined?
(c) What job, if any?
(d) How soon?

A9. What do you like about your job?

(a) Dislike?
(b) What would you like to see changed about your job?

A10. Which of the people who contribute significantly to your hospital's operation do you contact regularly in an official capacity? How regularly? (Times/day, week, month).

(a) Is your relationship with (each contact's name and position) formal or informal?
(b) Do you feel free to approach him? (Her understood)
(c) Of what importance are your contacts with him in doing your job?
(d) How well do you think he understands your job?
(e) Do these contacts hinder you in any way? How?
(f) How do these contacts help (name of contact) in doing his job?
(g) What do you think he thinks of you as a person?
(h) Does this person have any major shortcomings which prevent him from performing his job well? Which might limit you in doing your job?

A11. How often would you say you contact your immediate superior?

(a) What do you talk about?
(b) If you were to describe your superior's leadership ability in one word or phrase, what would it be? (Ask for expansion.)

A12. What do you consider the important qualifications necessary to be a successful hospital administrator?

(a) What personal abilities do you feel your job calls for?
(b) If you were asked to appoint someone to perform your particular job, what abilities would you look for in that person?
(c) Do you feel you have these abilities?

A13. Do you consider yourself to be a person who is more capable of directing others, or do you feel that you are a person who is more capable of doing a job and receiving direction from others? Explain.

A14. What do you feel the relationship of the administrator to the Board of Trustees should be?

(a) Should he be a member of the Board?
(b) Should he have a vote or should he merely advise?
(c) What do you think constitutes a good, comprehensive monthly report to the Board?

A15. What do you believe your relationship should be to the Medical Staff?

(a) What are the advantages of an administrator being a member of Medical Staff committees?
(b) Are you a member of any Medical Staff committees?
(c) What are the disadvantages?
(d) Do you think the Medical Staff should have membership on the hospital's Board of Directors? Why or why not?

A16. What channels have you established as an administrator to permit or stimulate flow of information to come to you from throughout your organization?

(a) To flow out to your organization?
(b) What disadvantages do you see in communication?
(c) How does your activity in this area differ from that of your predecessor?

A17. How do you think the administrator's job rates around here?

(a) In the eyes of the Board?
(b) Medical Staff?
(c) Nurses?
(d) Other department heads?
(e) On what basis do you make this rating?

A18. How do you think the employees in your area of responsibility feel about working conditions?

(a) What do you feel they like best about this hospital?
(b) Least?
(c) What do most people in this community think of your hospital, to the extent of your knowledge? How do you find out their sentiments?

A19. What problems, if any, do you face as an administrator for which your training never prepared you?

(a) What single activity, or what it is, causes you the biggest problem or pressure?

A20. What pertinent literature do you regularly read to aid you in carrying out your functions as hospital administrator?

A21. Some people who work together develop friendships which carry over into informal social relations away from the job. Do you do this?

(a) Which of the people from the hospital do you get together with? [Probe context]
(b) Do people in general in your organization get together informally as friends?
(c) Do you believe it is good to have friends in the same office as you? Why?
(d) Are there other people with whom you get together informally? Who are they?
(e) What do you do together?
(f) Of all the people you count as your very close friends in your life, do any of them work here? Who are they?

A22. What does the word "policy" mean to you?

(a) In your opinion, what are the most important factors to be considered in developing hospital policy?
(b) What individuals or groups in the hospital do you think should participate in the development of policy?
(c) What individuals or groups do participate? In what areas?
(d) Are all the people affected by a policy asked to participate in its development?

A23. In what areas of policy development should an administrator try to influence the Board in establishing policy?

(a) To what extent do you try?
(b) Have you succeeded in any area?

A24. In what areas does your Board provide the hospital or you with detailed and specific policies?

(a) In what areas do they provide general policies?

(b) Do you feel the need for more or less specific provision of this nature from your Board? In what areas?

A25. Does the Medical Staff or any other segment of the hospital develop policies?

(a) What are they?
(b) How well informed is the Board of these policies?

A26. Do you think that the various documents (by-laws, etc.) which are prepared to give written authority and guidance to hospital operation should be strictly or liberally interpreted to meet changing conditions?

(a) Why or why not?
(b) Which should be liberally interpreted?
(c) Which strictly?

A27. Who determines the privileges to be accorded applicants for positions on the medical staff?

(a) Do you feel the Board should appoint to the Medical Staff only physicians nominated or approved by the Medical Staff? Why or why not?
(b) Do you as a hospital administrator feel you should take part in this process? Why or why not?
(c) Do such factors as the doctor's race, creed or color affect such a decision involving selection and determination of staff privileges?
(d) What other factors are considered? Should be considered?

A28. What factors, of which you are aware, determine the quality of medical and/or nursing care provided in your hospital?

(a) Who or what groups are more responsible for maintaining satisfactory control over each factor?
(b) By what means can an administrator aid in the improvement of medical practice in his hospital?
(c) What methods do you use for controlling the quality of professional work performed by the medical staff of your hospital?
(d) Are there other methods you would prefer to use? What are they? Why don't you?
(e) What justifications, if any, do you and board of trustees have for exercising controls over the quality of medical care?
(f) Describe the medical staff's responsibility for controlling the quality of professional services its individual members provide for hospital patients?
(g) What information do you think should be exchanged between a hospital administrator and medical staff regarding staff professional performance as evaluated by established standards? What channels do you use?

(h) What do you think are the most important factors in the development and maintenance of good relations with a medical staff?
(i) What standards do you use to evaluate the operations of your hospital?
(j) How are the standards developed? By whom?

A29. If the quality of medical care does not meet the standards established by the hospital, what are the relative responsibilities for discovering and reporting why the quality of care is low?

(a) For determining which physicians or other personnel, if any, are at fault?
(b) For eliminating such physicians from the medical staff if necessary?
(c) For dismissing the personnel?
(d) What alternatives are there to suspension or revocation of staff privileges for such doctors?

A30. How important is the keeping of the medical records in this hospital?

(a) Would you like to see its importance increased? Why or why not?
(b) How should it be used?
(c) How do you evaluate the quality of medical records? Their completeness?
(d) How do you assure yourself that a complete and adequate medical record is being prepared and filed for each hospital patient?

A31. How do you evaluate the qualifications of the members of your administrative staff?

(a) Which personnel do you recruit?
(b) How do you do so?
(c) How do you determine how much each should be paid?
(d) What personal characteristics do you require of a subordinate before delegating authority to him?

A32. What do you consider "control" of personnel relations means?

(a) How do you attempt to secure and maintain such controls?
(b) What channels of communication do you use in handling delicate interdepartmental personnel matters?
(c) What grievance procedures do your employees follow?
(d) Do these procedures vary for different departmental employees? Why?
(e) At what point, if any, do grievances reach the executive offices?

A33. If your employees expressed their desire to join a union, what would you do?

(a) What similarities, if any, do you see between unions and hospital administrators' organizations, medical societies, state and national nursing organizations?
(b) What differences do you see?

(c) Do you believe a hospital employee should have the "right" to strike? Why or why not?
(d) What can they do if they are not legally permitted to strike?
(e) What would this mean to your hospital?

A34. What are the units of government you know of which enact legislation or quasi-legislation affecting hospital operation?

(a) What are the other bodies performing similar functions?
(b) What kinds of legislation have been enacted that you know of that directly affect your hospital?
(c) What kinds of legislation do you foresee enactable in the future?

A35. Do you have a hospital budget?

(a) How is it determined?
(b) How do you operate without one?

A36. From what main source does your hospital receive its funds for its operation?

(a) Are there any particular groups or individuals who contribute heavily or significantly? Who are they?
(b) To what degree do the individuals or groups who finance hospital operation or construction control hospital policy? Hospital administration?
(c) By what means do groups or individuals who finance hospital operation exercise control of hospital policy or operation?
(d) What individuals or groups do you feel should participate in determining the amount of capital funds to be raised for hospital construction within the community?
(e) What pressures are they able to apply to secure compliance with control measures they wish to have established?

A37. Who establishes purchasing policies? How are purchasing policies established?

(a) Does the board of trustees always award or supply orders to the lowest bidder regardless of location? Examples.
(b) Should the hospital administrator favor local firms in awarding hospital contracts even though they may increase hospital expense? Explain.

A38. Does the board of trustees always authorize the purchase of all major equipment that the medical staff and the administrator claim is absolutely necessary to provide good medical care? Why or why not?

(a) Do you personally investigate any unusual purchase request?
(b) When purchasing equipment or supplies, do you allow price to be the determining factor or professionally determined standards and specifications?

(c) What resources are available to a hospital administrator when attempting to improve hospital operations by purchasing new equipment?
(d) What services are offered by equipment suppliers to aid purchases?

A39. What basic principles or concepts do you think should be considered when developing credit and collection policies and practices? What principles are considered? By whom?

(a) What control do you think administration should exercise over implementation of collection policies?
(b) How should it exercise such control?
(c) How do you believe a collection policy should be developed?

A40. What effect does payment from insurance companies or governmental agencies have on the amount of your hospital rates and their relationship to costs of services?

(a) What effect does your hospital's financial situation have on its rate policies? Its standards? Its programs?
(b) What objectives are you attempting to achieve when establishing the amount of the hospital rate? The rate system? How do you determine what an equitable rate should be?
(c) What individuals or groups participate, or should, in the establishment or revision of a rate system? Why?
(d) What means of communication do you use to gather the comments of those who will be assisting in the establishment of a hospital rate?
(e) What factors do you consider when deciding hospital rate revisions are in order?
(f) What are the most important factors to consider in hospital-Blue Cross contractual arrangements from the hospital's poing of view? From the Blue Cross'?
(g) What effect do you expect the changing pattern of financing hospital care will have on the development and determination of your hospital's future policy?

A41. What is your public relations program in this hospital?

(a) Who determines the specific needs of your hospital in this area?
(b) What controls do you have on the release of information on patients?
(c) What ideas do you think your hospital should sell?

A42. What priority have you established for future hospital plans or programs?

(a) What changes do you plan?
(b) Do you feel they will come to fruition?
(c) Why or why not?

APPENDIX D

RESPONSES OF THE DEPARTMENTAL HEADS AND QUESTIONNAIRE

Director of Nurses and Surgical Supervisor

The Director of Nurses was recruited by Edwards. He had gone to the V.F.W. Home, where she was working, to take delivery on an X-ray machine they had donated to the hospital. While there, he talked to her about her background and informed her that the position of Nursing Director would be available soon and asked her whether she would be interested in taking it.

> "The other supervisor could not adjust to either the community or the hospital. She was too exacting, highly educated, and used to a rigidly operated hospital."

Since she knew all the doctors in town, she asked them if they wanted her and they said they did. "I said I'd come over if they would help me set up the department. The hours were better (weekends off). I was, in any case, assured of re-employment at the V.F.W. if things did not pan out. It was a real challenge. Could I do it?" At first it was difficult for her to direct, but since she knew a number of the nurses from before, and she had worked with Miss Evans for a number of years, she readily gained the confidence and support of her colleagues. "I really like it now", she stated.

She would like to see "a recovery room set up, an expansion of the pediatrics unit, and more emphasis on intensive care. We really need more doctors on the Active Staff and more trained nurses. An improvement in the economic status of the nurses and other personnel is overdue. We need more in-service education."

Mrs. Kedzie was especially proud of the new O.B. policy she had recommended. "A father can go into the delivery room with his wife, if he so chooses. People come to have their children here because of it. It's unique in this area."

She felt that in the long-run the improvements and changes she envisioned and desired "might come through, if we get the money. It depends on Warrington and the doctors, then certain others will contribute. The problem is with the doctors, I think."

Mrs. Johnson had begun her work in the hospital in O.B., a type of nursing which she still likes very much. She was asked by Edwards to become a surgical nurse, upon the recommendations of Rhine and Miss Evans. It was Evans who encouraged her to try it "because I could get ahead by extra work. I was offered this job when I evidently demonstrated my willingness and ability to learn. They also sent me to train in New York." She appeared to be quite satisfied with her job. "It's responsible and interesting. I like Rhine as a surgeon and doctor." She had only one dislike: "There are too many callbacks. My life is not my own." Another "surgery and another R.N. and aide to staff it" are her hopes. She felt that the possibility of this happening is good. Rhine has talked to her about it and in any expansion it would have priority.

Mrs. Kedzie contacted the Administrator about particular patients and on other business unofficially and informally on the average of once a day, sometimes more often. All the nurses were informally contacted at least once a day about patients and their problems. She personally saw the nurses on the day shift and those nurses on the afternoon shifts, she either saw or left notes. The night shift was left notes.

She discussed the patients and their care with the doctors "...just about everyday, when I can track them down." She readily admitted to a troubled relationship with the Medical Staff.

> "I think we need to change this situation of hit-and-miss communication. The doctors and nurses should have a roundtable discussion as to how to

> best serve patients. I think the nurses and I should be permitted to attend the Medical Records Committee meetings of the staff, at least. After all, the visiting Medical Librarian does, and isn't as well qualified as we. Who is most concerned with a patient's case?
>
> We do talk about charts and cases, but if we are to have better medical and patient care, communication will have to improve. Contributing to accreditation is a nurse's job too. Medical records contain nursing notes. All physical recordings are necessary. A meeting of the minds and meshing of these functions of doctor and nurse are important.
>
> Don't get me wrong, I don't think the Medical Records Librarian from Detroit should not attend the meetings, but to enable we nurses to even co-operate more fully with her, we should be at those meetings. Coachman is sympathetic but he can't help us much himself. We'll probably have to go to the Board through Evans."

Mrs. Kedzie saw the Surgical Supervisor whenever the latter wished to discuss her section's problems or needs. "Otherwise, the Surgery Supervisor rules surgery, as far as I am concerned. I trust her implicitly. I don't interfere." She contacted the recovery room nurse whenever major surgery was scheduled in order to discuss the precautions to be taken on the case.

With all of these people, the Director of Nurses had informal relationships and felt she was free to approach them and vice versa. The contacts were all important to her doing her job, she thought. "With the exception of the doctors, perhaps, I think all these people understand my job. We all have mutual respect for one another. The doctors are probably too busy to realize they are taking some shortcuts which are endangering our nursing-medical staff relationships and unnecessarily jeopardizing patient care."

The number of people regularly contacted by the Surgical Supervisor was smaller than for the Nursing Director. The doctors Rhine and Sheridan --

sometimes Herman Roos -- were usually contacted daily on business connected with surgery such as schedules, equipment, etc. "I see and talk to Dr. Rhine just in surgery or in O.B.; I check with Sheridan on anesthetics; Mrs. Kedzie and I confer on scheduling, supplies, etc.; Della, the recovery nurse, and I go over the particulars of the case of any patient she cares for; and, finally, Coachman and I usually have coffee together at break time and talk over my needs for O.R. and, of late, for a new surgery." With all of these people, she felt "very comfortable. I am informal with all of them." Her contacts with the 2 doctors, Mrs. Kedzie, and the recovery nurse were seen to be very important to the proper accomplishment of her job. "They all understand my position quite well. The Administrator makes sure we get what we need. Of course, what I do on my job is very important to the surgical team of which I am a part. We respect and like each other."

Mrs. Johnson considered the Director of Nurses and Dr. Rhine to be her immediate supervisors, although she recognized the Administrator to be superordinate to her too.

> "He doesn't direct us in nursing much. As a matter of fact, neither does Mrs. Kedzie bother us in surgery. I would rather have it that way -- people doing their jobs and not having to be directed. But, of course, I find that directing and being directed somewhat is necessary for co-ordination. My job rates pretty highly in any hospital, so I don't suffer from over-supervision."

The Nursing Director consulted with the heads of the Lab, X-ray, Maintenance, and Dietary departments on the average of once a week on the business of proper patient care, as it was affected by the operations of those units. She found most of these people easy to get along with. "I have had some problems with Smith in X-ray and with the dietetics people.

The kitchen will have to be reorganized. Smith is too brash and arrogant with people; its especially bad to be that way with patients. He does his job well, however." She saw Coachman "about technical and personnel problems, co-ordination of activities of nursing with other departments, and scheduling of my nursing personnel." She felt he was competent and "coming along. Edwards was really tops."

With regard to directing or receiving directions, she stated she, as anyone, had to do both, but that in her position she did much more directing. "I have to initiate and supervise many of the activities of my department. The Administrator has the big job of co-ordinating the whole hospital. So we all have to work as a team but do our own jobs first. My job is fairly important in the scheme of things."

Both women stated that the nursing employees seemed to be satisfied with their working conditions. Both, however, called attention to the fact that low wages being paid nursing and other personnel created considerable dissatisfaction. "This is our biggest problem," the Director of Nursing stated. The Surgical Supervisor listed other complaints of her staff: "shortage of room, need for another surgery, and more help." Both women reported that the community "appeared to be well satisfied with the hospital and proud of it." The patients and others had told them so. They were aware of the favorable comments in the questionnaire the hospital mailed out to ex-patients.

Of the two, Mrs. Kedzie read more widely and regularly in the literature pertinent to hospitals and nursing. She felt that her reading measurably helped her to carry out her functions. Mrs. Johnson admitted that she would like to do more reading in the area but could not, given the demanding nature of her job and family obligations. Still, she regularly read Modern Hospitals.

In addition to it, Mrs. Kedzie read The Registered Nurse, The Michigan Nurse, The American Journal of Nursing, American Hospital, and Hospitals.

Neither woman was much of a socializer with other hospital personnel off the job. Both claimed that the younger nurses did so socialize. Mrs. Kedzie associated with friends outside the hospital of her own age group, went to occasional parties, and "to shows." She was of the opinion that ..."It's better to avoid talking shop or seeing too much of one another. Besides, I'm older than most of the R.N.s and am their boss. One doesn't 'chum around' with one's boss, does one?" Mrs. Johnson's family was most important to her and family outings took up the bulk of her social life. "Rarely, I'll go shopping or go out with some of the older nurses. I fit in a narrow cirlce here."

Both women identified the practice of using the combination of percentage of death rate and percentage of detectable infection among the patient population as the proper gauge for measuring quality of medical and nursing care provided by a hospital. Both felt that their hospital had a very good record, measured by this standard. "Doctors and nurses both have to co-operate closely as they are the most responsible of the groups in the hospital for maintaining control over these factors," said the Director of Nurses. She cited "the doctors, nurses, and Administrator, and, of course, our pathologist and radiologist" as those persons and/or groups who are responsible for discovering and reporting why quality of care is low. "In part we are self-policing and in part we have checks on our work coming from the Lab, X-ray, and the pathologist and radiologist." Both stated that any signs of slipshod work or care -- whether by doctors, nurses, or whomsoever -- were reported.

Medical records were in arrears, the two women realized, and the Director of Nurses complained mildly about the situation, but both she and the Surgical Supervisor commended the doctors on the "intensive and high quality of the reports." The hospital had received written commendation from the U. of M. audit on the high quality of records submitted at random to them. The consulting Medical Records Librarian also was impressed by the quality of the records.

Mrs. Kedzie referred to the Michigan State Nurses Association's commendation of her R.N. nursing staff (the result of an investigation which rated the nursing staffs of all community hospitals in the state.) It was she herself, essentially, who evaluated the qualifications of the nursing staff. "I look at their experience, credentials, and I can recognize their merit by seeing how they do on the job during the probationary period." The Board, Administrator, and she determine how much each person should be paid.

> "We investigate the pay scales in other hospitals and in other places in our community and area. We demand that a R.N. know her job and be able to get along with people. I recruit all the R.N.s. The Administrator hires the L.P.N.s and aides in consultation with me. Mrs. Johnson sometimes makes suggestions and recommendations. All our girls are local or area persons."

Mrs. Johnson expanded on the above statements by indicating that aides were selected on the basis of their "reputation in the community." After training, they are kept on only if they are efficient and knowledgeable about their jobs. They also have to keep their mouths shut about patients.

> "If they can handle a job once shown how to do it, they're rated O.K. I recommended the aide working in surgery on the basis of her performance in training. Aides have to exercise initiative and have their wits always about them in this kind of setting. The bulk of them are satisfactory."

Grievance procedures to be followed by nursing personnel were not formally spelled out. Any complaints were addressed personally to Mrs. Kedzie,

sometimes to both her and Coachman.

> "There haven't been too many occasions for this since there aren't many real grievances. One nurse has complained a lot, but that's how she is. She happens to be married to a partner in one of the local small plants and evidently feels she's superior or more important than the others. She feels, I guess, that she should get preferential treatment which we won't give."

Neither woman thought that the employees or nurses would join a union in their hospital. Mrs. Kedzie was outspokenly for unions and confidentially expressed the opinion that the personnel in the lower echelons would benefit from organization.

> "However, I feel they won't organize because they're not in a position to do so. They passively accept the anti-unionism of this town. Many of them have not worked outside the community, as I have. These people, by-and-large, are ones who can't get another job. They're too old, uneducated, or both."

The Nursing Department had no set budget by which to gauge its operation.

> "We try very hard to keep within our limits set by the Administrator (and Comptroller.) He keeps a running check on our financial needs and tells us how we're doing. We spend in relation to the state of the other needs of the hospital. We haven't run short because he juggles things pretty well. We will have to move in the direction of setting a firm budget as we get bigger. The Administrator presently establishes priorities and he establishes our department's purchasing policies basically. We suggest the materials to be bought. The Board empowers him to do so."

Neither woman felt she was knowledgeable enough to answer the questions dealing with credit and collection policies and practices or the effect payment from insurance companies or other sources had on hospital rates or costs of services. Mrs. Kedzie was aware, however, that the bulk of hospital income derived from the insurance plans and patients' donations.

Both women preferred that more R.N.s be added to the hospital's nursing staff complement. Mrs. Kedzie pointed out...

> "that more, rather than fewer, R.N.s are needed in hospitals whose operations are becoming more complex and technical with each passing day. We tend in too many hospitals -- ours included -- to give too much responsibility to P.N.s and aides. We're in for a rude awakening. Errors and suits can be costly and damaging in many ways."

Mrs. Johnson added that money problems are preventing

> "our hospital from hiring as many R.N.s as we need or would like. But if expansion takes place, we will need not only more surgical R.N.s but others. We can't indefinitely place R.N.s in administration and leave technical nursing tasks to untrained personnel. Although necessary to a degree, our R.N.s don't care for administrative or supervisory duties."

Mrs. Kedzie likened the plight of the R.N.s and L.P.N.s -- in terms of the latter taking on more patient care functions of the former -- to the abrasive situation which has existed between M.D.s and osteopathic physicians. In addition to being willing to countenance secretarial, administrative aides on wards, she saw the answer in restricting intensive patient care and supervision of routine care to R.N.s. Mrs. Johnson felt the hospital was fortunate in having reliable part-time help of married R.N.s settled in the community and area. Most of the L.P.N.s were described as dependable.

Chief Technicians of X-ray and Medical Lab

Smith had been hired by Edwards whom he had dropped by to see on an impluse while on a fishing trip in Mills Springs, some 3 months before the hospital was to open. Later, he was contacted and Edwards made an offer which, after some dickering over salary, was accepted by Smith.

> "At that particular time the job was exactly what I was looking for -- a department head in a small town. This had been a good learning experience and beneficial to my career. I'm an ambitious person, so I would move any time for advancement to a job like this in either of the large capital hospitals. I'd prefer administration better."

Smith expressed disenchantment with some aspects of the hospital.

> "I had a feeling this hospital would grow. My doctor friends back home highly recommended these doctors. I was also interested in Edwards. He's a very unusual individual. For an administrator, he knows when to listen and when to speak. I've often sought his advice because I respect his views and judgement.
>
> I wanted to be in a small but growing hospital. However, I did not expect the community situation which I found. I had been led to expect an addition to the hospital 2 years before now, with a doubling in personnel and more output.
>
> Finances seem to be the problem here. The powers that be -- Warrington and others -- are holding back the expansion. I don't know why they won't kick in. The hospital is self-sustaining, so it wouldn't be a drain on the community. Maybe it has something to do with the school issue (3 bond issues were voted down.) They're probably hesitant to ask the community for hospital aid again. Perhaps they are right.
>
> Certainly, expansion would benefit me and the hospital. I'd say the other personnel feel as I do.
>
> We sorely need a new X-ray department. Our present location next to the nursing station is bad. It can't help being noisy. From a selfish angle, I could use more than the little cubbyhole I've got. As it is, my office is cluttered. The files have to be kept inconveniently in a separate room. There's only one dressing room, and to get to the bathroom, one has to go through it. Another undesirable thing is that the darkroom is part of the X-ray room proper.
>
> The whole staff feels the building is ill-designed."

Smith's hobby is cabinetry. He was proud of the fact that he and Edwards had designed the basement rooms together. He had made all the doors as well as the cabinets and cupboards in the pharmacy room. He was obviously peeved that he had not received wider recognition for his contributions.

> "Who you know and not what you know. Edwards did recognize the fact and patted me on the back. The Board didn't give thanks at all.

> As a matter of fact, when I went up for the job of administrator, Warrington didn't even know my name, although I'd spent the greater part of a morning X-raying him a short time before."

Smith's resentment became more open as the interview progressed. His ambition, he felt, was being "stunted" where he was.

> "Personally, and realistically, I feel most qualified to be a chief technician in charge at a 200-300 bed hospital. I have the background and interest in it. I plan to pick up the necessary college work at State. I have my assistant on night coverage now, so I can do it. The money and prestige are in the administration end of it. A selling point is that I have had 4 years of teaching experience. With my assistant passing her board exams, this will reflect on me. She is an excellent student and knows as much or more than a lot of them coming out of the formal schools. She's been tutored, and that makes a big difference."

Smith interacted with a number of different departmental representatives. He was in constant contact, of course, with his assistant, working as closely with her as he did. He was the liaison of the department with others, however, being in touch several times daily with two of the women in the front office -- "the girls in admitting" -- and he also saw the day floor nurses, about both outpatients and patients in the hospital.

> "I see them in both an official and unofficial capacity, depending upon the occasion. Predominantly, we are informal. I'm known to most as 'Jay'. (Of course, we're paged by our last names -- it's more professional.)
>
> Yes, I feel free to approach them all. All of these contacts are equally important in handling the cases of patients. We exchange information on bills, etc. with the front office. The nurses pass on personal information about the patients and how or when to move them. We try to co-ordinate the activities of our various departments so that we usually work together smoothly.
>
> Certain nurses are less willing to co-operate or are slower to, than other nurses are. It's due to individual personalities and training. I had no trouble elsewhere. I got along with all the nurses. Here I've had difficulties with 2 nurses on personality. I now avoid the one and get along most of the time with the other."

Smith sees Coachman daily but usually not on official business. "Officially, we discuss ordering of supplies once or twice a week. As a general rule", Smith felt that he was not hindered in the performance of his duties by anyone.

> "One contact was out of order -- starting with the nurse I've mentioned. She tends to raise her voice and bark orders. Rhine gave her certain orders and in transmitting them to me the scheduling was changed from normal procedure. Being puzzled, I checked it and refused to follow it. She called Coachman and he reprimanded me in front of my assistant and that nurse. I kept my mouth shut at the time, but it wasn't my fault and I told Coachman so later."

Smith continued in expressing his shock and dismay ...

> "It is difficult for me to adjust to the situation of the ex-lab technician now being the Administrator. I spoke to both Short and the Chief of Staff about it. Short was shocked and surprised. The Chief of Staff and the Nursing Supervisor should clear up scheduling. I don't know what Rhine felt, but he thanked me for telling him.
>
> I don't know what the rest of the hospital people feel about me. I like to feel most know and like me. I tend to be outspoken, but I see that as a virtue.
>
> I hate to be a judge of what Coachman feels of me as a person. I'd rather not say what I think of him. There are areas I feel I could have done better and handle differently, including administration."

Smith considered Dr. Short to be his immediate supervisor whom he consulted in person twice a week. When necessary, he contacted him or East by telephone about patient procedures ... "ninety percent of the time, the other ten about administrative details". Their relationship was described as excellent. "I've never met a radiologist like him. He will listen to all problems and has a real fund of knowledge". Smith then amended some remarks he had made earlier about Coachman, his other supervisor. "He is

doing a good job with some reservations. I haven't known him long enough to judge him fairly or thoroughly".

Smith viewed himself as more capable in directing others than in taking directions. "I have worked to this end". He rated his position "on an equal level with other supervisory positions".

As for his relationship with his assistant, Smith claimed that ...

> "She's never complained; she is not one to do so. Occasionally, I'll ask her for her suggestions for improvement in the areas she's been working in mostly, and she has offered some good suggestions. Improvements are better if they're made together.
>
> She helped in the modification of our coding and cross-indexing of the files. (I'd started such a program at the other hospital.) With this simplified cross-indexing, we really shortened search time and preparation of files."

Smith did not know how his assistant "actually feels about the hospital or myself. She seems to be very satisfied, wants to take her exams, and work here. I don't know what she likes best or least."

Smith said he read thoroughly the journal The X-ray Technician, and that he kept up on the hospital literature available in the medical library. He found the lectures delivered at radiological meetings especially informative. Short courses he took in supervision and management of departments were described as "a great help to me. I've found the regional survey of patients done some time ago valuable."

Smith socializes very little with the other people working in the hospital. His best friends are located in the capital where he often goes to visit them and his parents or relatives.

Barrett stated that he preferred not to exercise much authority. "I don't care for authority that much. I have enough responsibility in the lab. My training is in the lab."

"Coachman sets the salary figures and he checks our tests too. I have showed my male assistant how to do procedures and have set up procedures with Coachman's advice.

I order the equipment and reagents. Big purchases go to Coachman. Still, I have a free hand with the money.

I don't want to repeat the situation I've gotten into. I brought a buddy into the lab from Bad Axe. He liked this place and got a better deal financially than he had. But his wife doesn't like the town and wants to be back near her mother. As a result, they are leaving, which puts me on the spot. The next assistant will not be a friend. He will have to be a stable, coming person -- preferably married and with children -- one will stay on. He should be civically-minded.

Another problem with Fogarty was that I couldn't bring myself to show my authority over him in the lab. There was trouble over when he was to be on call, vacation scheduling, and times he was to come to work. I'll never do it again."

Barrett got his job through the placement bureau at his school. About it, he commented:

"I was fortunate in getting this job. The salary is high for starting out. Starting salaries in this field are improving every year. We're in great demand since lab work is increasingly important -- one of the most important units in modern hospitals. Tests developments are still coming. I took this place because it is near a college for further training. I liked the lab equipment -- all new. Coachman and Edwards came across well.

I'm very satisfied here, even with calls. I see them as necessary.

One gripe is that patient 'freeloaders' are preventing a wage increase for all personnel."

Barrett attended the pathologist at the autopsies performed 2 or 3 times a month. He personally reported the results to the local doctors, in addition to the written reports of the pathologist. "They appreciate this."

All internal hospital relationships between departments and personnel were described by Barrett as "friendly and informal; outside relationships are formal." The persons he saw most often on lab business, and pertaining to cases of patients or with regard to doctors' orders, were the Floor and Surgery Nurses, the X-ray Technician, and Coachman. "I see them on the average of once or twice a day. Much of our business is done over coffee."

Barrett's reading was restricted to the medical technicians' journal Laboratory World and to manuals, such as The American Medical Technician's Manual. "On my own time, I read anything having to do with the medical field in The Readers' Digest. I find it stimulates discussion."

Barrett socialized off the job with Coachman and their families, "often, but not too often. We have a good friendship. My old buddy and his wife and we don't interact as much as we used to. We've cooled off some. There's too much interaction in the lab as it is." Rarely, Barrett and his family visited with Smith's; more often, but occasionally, with that of a young nurse on staff." Really, there is not an awful lot of social interaction among hospital people. They are pretty busy. Friendship can be double-edged."

Business Office, Dietetics, and Maintenance Heads

Mrs. Montgomery was hired by Edwards on the recommendation of the physicians, Bert Roos and Rhine. "I had worked for Dr. Bert half days for a period, then moved to the old hospital. I came to work here because I liked the doctors and knew some of the other people." However, Mrs. Montgomery felt "I got more than I bargained for. There is more work and responsibility here than I thought there would be. With more beds in expansion it will mean help hired and more work for us." Still, she found her job satisfying.

The only thing she disliked about her job was that "we need more planning in advance than we do. Too often, problems accumulate. Equipment and procedures are cases in point. The Administrator is a harried man; in this kind of place any man would be."

Mrs. Montgomery saw Coachman first thing every morning, during which time they checked the mail and invoices together. She described herself as his business advisor. She saw him several times later on in the day "as he needs me". She accompanied Coachman to all the Board meetings "to answer any questions about the financial report which I do for Coachman." The only other people she saw regularly (usually daily) on hospital business were the Nursing Supervisor and the Dietician -- the former about invoices and personnel time schedules, the latter about payroll and time schedules. (Both of these departments had a large number of part-time employees.) Occasionally, she discussed vacation scheduling and revised work schedules with other departmental heads.

Mrs. Montgomery described Coachman as

> "a very good and just administrator. (Edwards was excellent.) Coachman is calm and diplomatic, not easily upset. I'd rather have people work with me than under me. Coachman has helped me to handle a slight problem we had with the receptionist on admissions. She was snippy with one doctor's patients."

Employees in her section were described as being pleased overall with their working conditions. "They have pleasant working conditions and work with nice patients. Occasionally, the girls get static from the patients and doctors during times of stress and bills. The girls are proud of the hospital. Most community people I've met like it."

Mrs. Montgomery read extensively any material contained in Hospitals, The Modern Hospital, Medical News, The Michigan Hospital Association Bulletin, and Hospital Accounting dealing with business procedures. She found

the last "really a help on my job." She also read

> "all I can on hospital legislation. I hope for a lot of legislation to be passed in this area as it affects finances. We need a good lien law. Auto accident cases present a problem in this state in that hospitals have no assurance they will get their money from them. The M.H.A. has had committees working with legislators on this problem."

She pointed out that the hospital was not affiliated with the state program on Crippled and Afflicted Children because it was not large enough.

Mrs. Montgomery did not socialize with any of the hospital personnel on or off the job. "It's not wise to be socially close to anyone with whom you work. A cool but cordial relationship is better. It eliminates bias on the job and people get fairer treatment that way."

Mrs. Kimball was working at the township school with a friend of hers, a cook, at the time when Edwards invited them to apply for positions in the hospital. "Mr. Edwards gave me the privilege of trying out the job. I found it pleasant and stayed. The pay was better." However, Mrs. Kimball admitted a feeling of inadequacy in the position.

> "I thought a real dietician and a nurse would be working with me. This was all a new experience to me. I had to study books and consult the doctors to bone up. I'm too old to carry on at the pace this job requires. I'm going to retire as soon as they get someone else."

The person she contacted most often with reference to doing her job was Coachman. The Director of Nursing and the Comptroller, toward whom she felt very friendly, were the two others of the "key people" she saw regularly. Coachman was seen several times daily, Mrs. Montgomery usually twice a day, and Mrs. Kedzie about once a day. The Food Service Supervisor was seen several times per day, but fleetingly. "We try to stay out of each other's way. She does her work; I do mine." Personnel problems and budgetary problems,

diets, and purchasing and budgetary problems were informally discussed with Coachman, Kedzie, and Montgomery, respectively. Mrs. Kimball got along "well", "good", and "very well" with these three people -- in that order. "I need to see Mr. Coachman so we can feed the patients the right foods. He helps me with the finances. I help him in his overall planning. Lately, we've talked about additional space for the kitchen."

Mrs. Kimball expressed an implicit preference for Edwards as an administrator. "Mr. Edwards was a wonderful person -- capable and considerate of everyone. Mr. Coachman is doing very good. I expect he will eventually be equally as good. Mr. Edwards and I set up the hospital kitchen together, being as I came here at the beginning." She considered herself to be more capable of doing her job and receiving direction from others, and related the information that this was more possible under Edwards than under Coachman.

Mrs. Kimball hesitated in commenting upon the feelings of her staff with regard to their working conditions. "They are not completely satisfied. Things are not so convenient. The kitchen helper does not like to wash the dishes without a dishwasher, and I don't blame her. Washing by machine is more sanitary." Since she was instrumental in getting all the workers a little raise (up to minimum standards at the four levels), "the women are more satisfied than before." Community people and patients have commented to her "about what a wonderful hospital we have."

Aside from a food service manual and popular magazines, Mrs. Kimball did very little reading. "Once in awhile, I'll read the hospital magazines on dietetics in the library here, but much of it is over my head." She went on to discuss her position in this connection. "This hospital needs a real dietician and a R.N. trained in this area; it really needs more emphasis

than it gets from us. As it is, my job is not the most important of supervisory jobs."

Mrs. Kimball socialized, both on and off the job, quite often with one of the cooks in the department, her life-long friend. "Sometimes I think the Head Cook resents our being friends. Jane and I go back a long ways."

Rupert was painting houses at the time when he learned that the hospital was in need of a janitor. Preferring an inside job, he accepted the offer made by Edwards.

> "He knew my background, but was still willing to hire me. I worked hard for him; when he asked me to fix something, I did it immediately. I installed the lights for a third less than a company bidding lowest would have. My advancement was rapid and I became head of maintenance. When the purchasing agent left, Edwards tried to handle it, but it was too much for him. He asked me to handle it, knowing about my army experience in purchasing. I only expected to be a janitor and return to painting. My expectations were more than fulfilled."

Rupert planned on staying on with the hospital for the remainder of his working career. He envisioned the possibility of being appointed the assistant to the Administrator and the elevation of his son to head of maintenance. "I believe I'd be qualified for it. Coachman and I have discussed this possibility. If expansion goes through, he will need an assistant."

Rupert was highly critical of the physical layout of the hospital.

> "We definitely need more bed space. I've had to set up beds in the sun-room on occasions when we were rushed. The kitchen has to be moved as it's in the wrong place and adversely affects everybody -- the patients and staff. Because of limited space, there is no good dining area and it smells up the hospital. The business office was to be the kitchen, so the dumbwaiter is in there. The women and I have to lug supplies up and down stairs."

Rupert placed the blame on the Board for not foreseeing the expansion that has occurred and for not making adequate provision for storage space.

"With the present physical layout, the set-up we have is as good as it can be, short of an addition to the building."

Rupert saw a large number of people daily. The Administrator was seen 2 or more times per day, and their business varied -- ranging as it did over the whole series of responsibilities Rupert had. Once a day, he met with the Supervisor of Nursing and they discussed housekeeping or maintenance services needed by her department. He also met daily with the Surgical Supervisor in Central Supply about surgical equipment supplies -- to make sure they were delivered there, sealed and sterile. As needed -- but usually each morning -- he saw the station nurses to deliver supplies demanded, such as I-V solutions, cups, and the like. He met with Mrs. Kimball and Montgomery 2 or 3 times per week: the former with regard to kitchen equipment and supplies (there were some areas of overlap in purchasing of soap and scouring powder); the latter with regard to processing of purchase orders and certification of shipments received, as well as maintaining the perpetual inventory of some 360 items. "I regularly see my people to check on how things are going -- several times a day."

Rupert described Coachman as a very good administrator. "He's an excellent leader. He's done a very fine job in a short time. He will listen to your side of the story. If he doesn't agree, he has a thought-out counter-proposal." Mrs. Kedzie was described as

> "doing a very fine job with the problems she has. In addition to a larger staff than all the other departments, she has to keep happy women who are a lot more independent than other workers. Ninety percent of the nurses are married and don't have to work if they didn't want to. They are underpaid and understaffed in nursing. There's no inducement here for young R.N. grads: no young men, no recreational life (only bowling alleys and taverns) -- they can demand and get better work. We're lucky our younger married nurses live here and are dedicated."

Rupert characterized the other people with whom he associated as "good workers from what I see of them." He thought his job rated "about average in responsibility and importance." He preferred to think of himself as more capable of supervision and initiating activities than of "always being told what to do."

Rupert described the dissatisfactions of his department's employees with hospital working conditions as involving "the hospital's physical limitations and inadequate pay. All my employees realize the limitations; they have to work harder to do their jobs because no serious thought was given to housekeeping or maintenance activities. I try to get them more money, but I'm limited in what I can squeeze out for them." Rupert stressed how important the service aspect of hospital work was to himself, his and other employees. "My people are doing their share in helping the community to better health, at a considerable sacrifice. Of course, most of my people are older, but a few of them (the younger ones) could get better paying jobs. These people, like people in the community, really are proud of their hospital."

Rupert regularly read The Modern Hospital, Hospital Topics, and Hospitals. "I read articles not directly pertinent to my particular job but which do aid me in seeing the hospital operation as a whole. I read the ads to get information about the mechanics of hospital equipment. I'm designing a distilling plant to handle our scraps more efficiently in disposal." Other reading included perusal of manuals on laundry operation and other tasks.

Rupert did not socialize with any of the hospital personnel, with the exception of his son. "It's better to separate work and social life."

1. Give me a brief description of your department's organizational set-up. How does your position fit into the total picture?

    (a) What responsibilities do you have as department head?
    (b) What functions does your department perform?

2. What committees do you serve on in your area of responsibility? How often do they meet?

    (a) Which committees are you chairman of?
    (b) How does each contribute to your fulfilling the responsibilities of your position?

3. What is the major goal of the hospital as you see it?

    (a) What is the major goal of your department?
    (b) How does your department contribute to the attainment of the hospital's overall goal?

4. With respect to what kinds of things are you able to make decision in your job? In other words, what is your authority?

    (a) On what kinds of things can't you make decisions?
    (b) Over what areas do you have responsibility for disciplining action?
    (c) Do you feel you should have more authority in some areas than you do? If so, in what areas? Why don't you have the authority you feel you should?
    (d) Have there been any significant changes in authority relationships in your area either before you took this post or after? What are they? How did they come about?
    (e) Are there any people in the hospital you know of who resent your administrative authority? Who are they?

5. How did you get your present job?

    (a) Why did you come to this hospital to work?
    (b) What expectations did you have when you took this job?
    (c) Were they fulfilled? How?
    (d) What aspirations or hopes do you have of your job now?
    (e) What are the chances for you to fulfill them on this particular job? In what days?

6. If you had a job which you considered ideal, what would it be like? (Probe for responsibility, authority, peer relationships.)

    (a) What parts of your job are furthest from your ideal?
    (b) What do you think your chances are of moving into such a job as you outlined?
    (c) What job, if any?
    (d) How soon?

7. What do you like about your job?

    (a) Dislike?
    (b) What would you like to see changed about your job?

8. Which of the people who work in the hospital do you contact regularly in an official capacity? How regularly? (Times per day, week, month).

    (a) Is your relationship formal or informal?
    (b) Do you feel free to approach him?
    (c) Of what importance are your contacts with him in doing your job?
    (d) How well do you think he understands your job?
    (e) Do these contacts hinder you in any way? How?
    (f) How do these contacts help him in doing his job?
    (g) What do you think he thinks of you as a person?
    (h) Does this person have any major shortcomings which prevent him from performing his job well? Which might limit you in doing your job?

9. How often would you say you contact your immediate supervisor?

    (a) What do you talk about?
    (b) If you were to describe your superior's leadership ability in one word or phrase, what would it be?

10. Do you consider yourself to be a person who is more capable of directing others, or who is more capable of doing a job and receiving direction from others?

11. How do you think your job rates around here?

12. How do you think the employees in your area of responsibility feel about working conditions?

    (a) What do you feel they like best about this hospital?
    (b) Least?
    (c) What do most people in this community think of your hospital, to the extent of your knowledge? How do you find out their sentiments?

13. What pertinent literature do you regularly read to aid you in carrying out your hospital functions?

14. Some people who work together develop friendships which carry over into informal social relations away from the job. Do you do this?

    (a) Which of the people from the hospital do you get together with?
    (b) Do people in general in your organization get together informally as friends?
    (c) Do you believe it is good to have friends in the same office as you? Why?
    (d) Are there other people with whom you get together informally? Who are they?

(e) What do you do together?
(f) Of all the people you count as your very close friends, do any of them work here? Who are they?

15. What does the word "policy" mean to you?

(a) In your opinion, what are the most important factors to be considered in developing hospital policy?
(b) What individuals or groups in the hospital do you think should participate in the development of policy?
(c) What individuals or groups do participate in your area? Are all the people affected by a policy asked to take part in developing it?
(d) What policies have they developed?

16. In what areas do you feel you should try to influence policy development? Why?

(a) To what extent have you tried?
(b) Have you succeeded in any area?

17. Do the Board, Administrator, or Medical Staff provide your department with detailed and specific policies? What are they?

(a) In what areas do they provide general policies?
(b) Do you feel the need for more or less specific policies from these sources? In what areas? Why?

18. What factors, of which you are aware, determine the quality of medical and/or nursing care provided in your hospital?

(a) Who or what groups are most responsible for maintaining satisfactory control over each factor?

19. If the quality of medical care does not meet the standards established by the hospital, what are the relative responsibilities for discovering and reporting why the quality of care is low?

20. How important is the keeping of medical records in this hospital?

21. How do you evaluate the qualifications of the members of your department?

(a) How do you determine (or who does) how much each should be paid?
(b) What personal characteristics do you require of a subordinate before delegating authority to him?
(c) Which personnel do you recruit?
(d) How do you do so?

22. What grievance procedures do your employees follow?

23. If your employees expressed their desire to join a union, what would you do?

24. Do you have a departmental budget?

    (a) How is it determined?

25. Who establishes purchasing policies for your department? How are purchasing policies established?

26. From what main source does your hospital receive its funds for its operation?

27. What basic principles do you think should be considered when developing credit and collection policies and practices? What principles are considered? By whom?

28. What effect does payment from insurance companies or governmental agencies have on the amount of your hospital rates and their relationship to costs of services?

29. What do you think of the recent trend in bringing non-professional people in to help the nurse on the floor?

30. How would you describe the nursing turnover at this hospital? In your opinion what makes it the way it is?

APPENDIX E

QUESTIONNAIRE ON ISSUES

Now I should like to discuss how issues get resolved in your hospital. I'm not primarily interested in how you stand for or against a particular hospital issue or project. However, what, in your opinion, are some of the major issues before _____ hospital -- either recent or current, say within the last 3 years? (Get history of an issue as it involves the respondent and his appraisal of his unit's role in resolving the issue. Also, obtain pattern of opposition and probable resolution.)

Examples of such issues are:
Hospital drive and expansion;
Pathologist or other ancillary service problems;
Unionization and personnel;
Major equipment purchase;
Others.

63. Which one of these issues, if any, involve all of the major subunits of the hospital -- i.e., the administration, board of trustees, medical staff, nurses?

(a) _____

(b) Why?

(c) Have you been contacted on this issue?

_____ Yes

_____ No

(d) (IF YES) How were you contacted?

Personal call _____ Informal chance meeting _____
Private luncheon _____ Other (specify) _____
Committee meeting _____ _____

(e) Who contacted you? (organization referent)

(f) Did you contact others?

_____ Yes

_____ No

(g) (IF YES) Whom did you contact?

(h) What did you decide to do?

(i) Did you do it? (Explain)

(j) Who else did you involve?

(k) Why? (Follow action, involvement, etc.)

(l) What persons and subunits in the hospital have worked for this issue?

Organizational Subunits _____ Persons _____

(m) What persons and hospital subunits will work against this issue?

Organizational Subunits _____ Persons _____

(n) What persons or organizations outside the hospital will work for this issue?

Outside Organizations _____ Persons _____

(o) What persons or organizations outside the hospital will work against this issue?

Outside Organizations _____ Persons _____

(p) How will this issue be resolved in your opinion?

(q) Why do you feel this way?

(r) Whose influence will count most?

Names of persons _____ Names of organizations _____

(s) How will they put it across or get their way? (Control, activity devices)

64. Would hospital representatives of other groups generally agree or disagree that these are the most important issues?

_____Agree

_____Disagree

_____Other (IF NO or other specify)

(a) What are the most important issues for them?

(b) In your judgement, do you feel that big hospital decisions in your organization are made by the same small "crowd" of people working together, or do these people change according to the issue confronting the hospital?

_____Small group

_____Group changes

_____Other (Explain)

(c) Who are these people?

(d) Do the people who make important hospital decisions do this pretty much on their own, or do they have to get approval for their actions from organizations to which they belong?

_____On their own

_____Approval needed

_____Other (Explain)

(e) Concerning the people who are primarily involved in making the big decisions in the hospital, do you feelthey have a broad sense of hospital responsibility or are they more concerned with protecting or furthering their own particular interests?

_____Broad hospital responsibility

_____Further particular interests

_____Other(Explain)

(f) Are the important hospital issues usually quietly solved without the whole hospital knowing what they are, or are they usually brought out in the open?

_____Solved quietly

_____Brought out in the open

_____Other (Explain)

(g) What subunits in this hospital do you feel have most weight in getting things done, or in preventing some things from getting done?

APPENDIX F

DEPARTMENTAL ORGANIZATIONAL CHARTS

RADIOLOGY

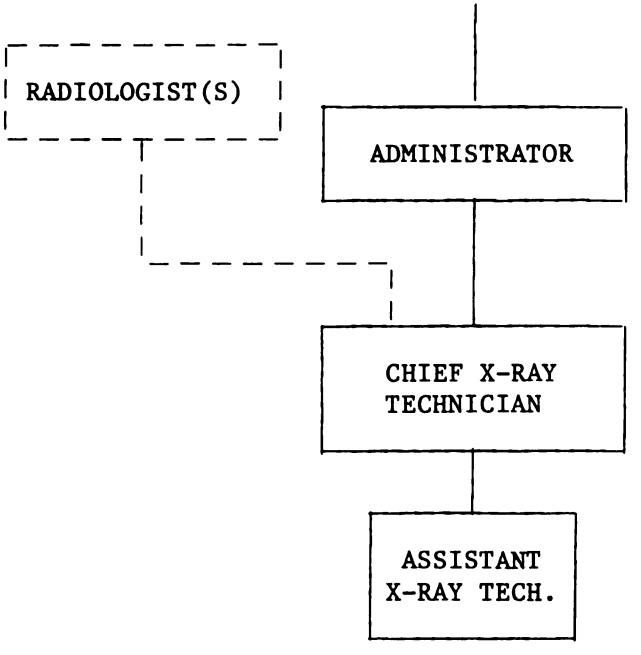


Figure 2

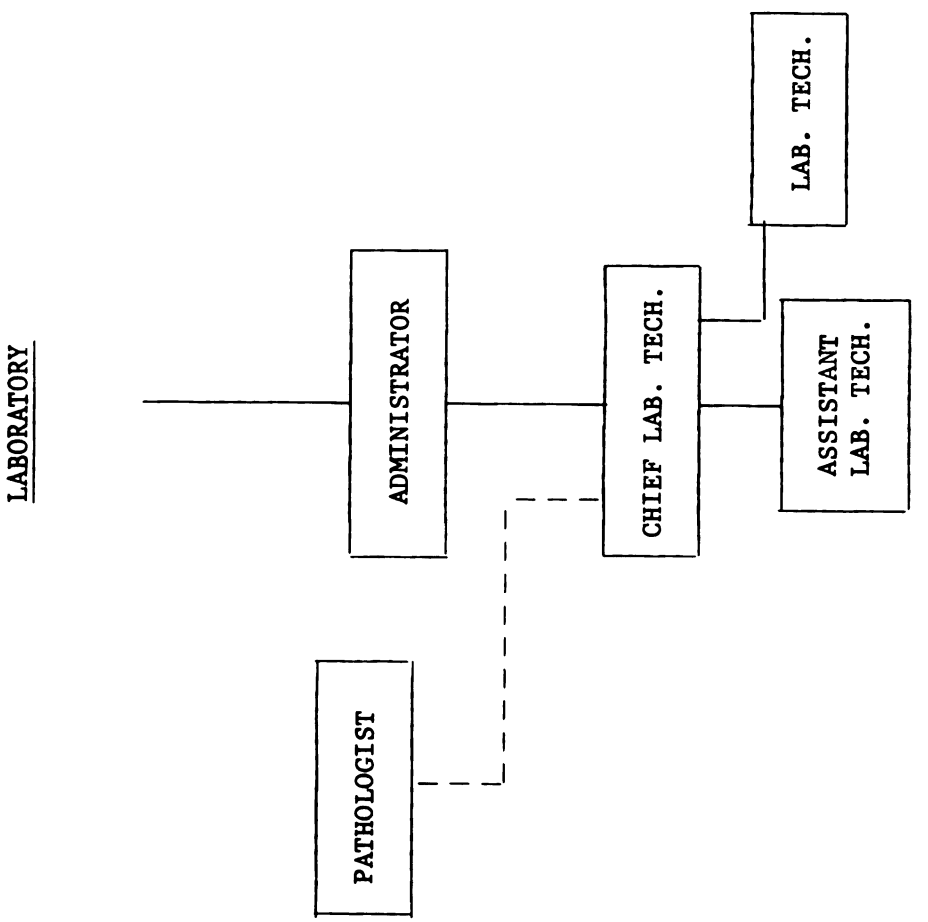

LABORATORY
ADMINISTRATOR
CHIEF LAB. TECH.
LAB. TECH.
ASSISTANT LAB. TECH.
PATHOLOGIST

Figure 3

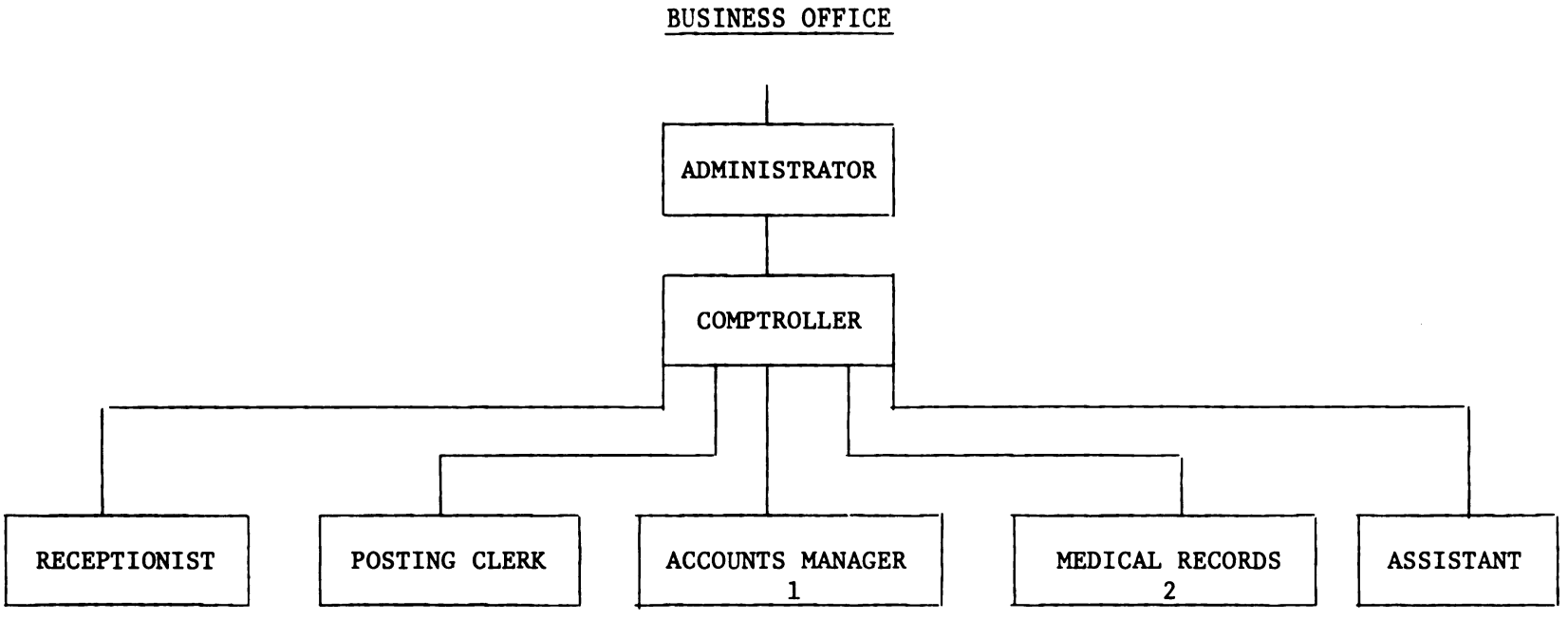

BUSINESS OFFICE
ADMINISTRATOR
COMPTROLLER
RECEPTIONIST
POSTING CLERK
ACCOUNTS MANAGER
1
MEDICAL RECORDS
2
ASSISTANT

Figure 4

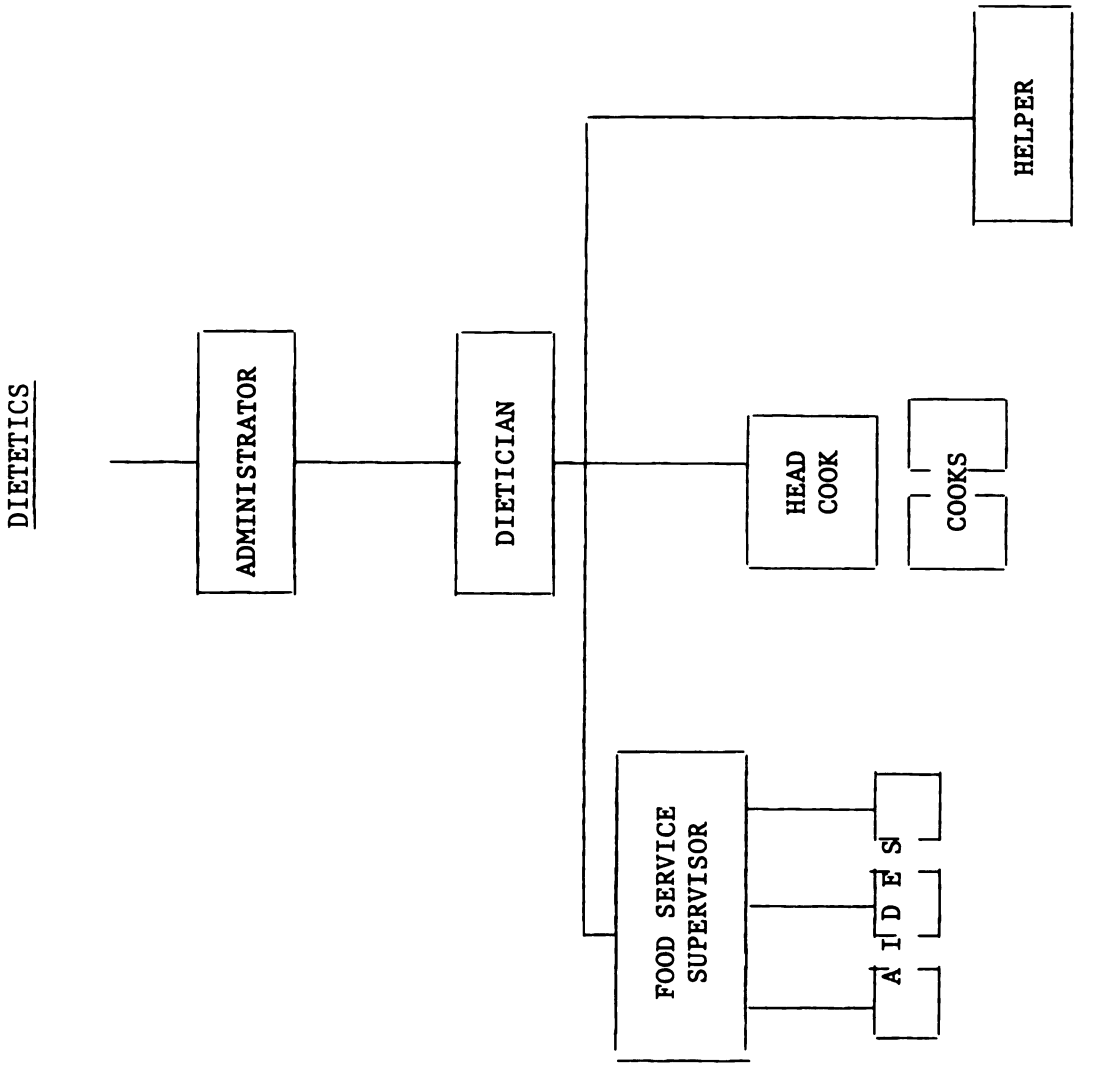

DIETETICS
ADMINISTRATOR
DIETICIAN
HELPER
HEAD COOK
COOKS
FOOD SERVICE SUPERVISOR
AIDES

Figure 5

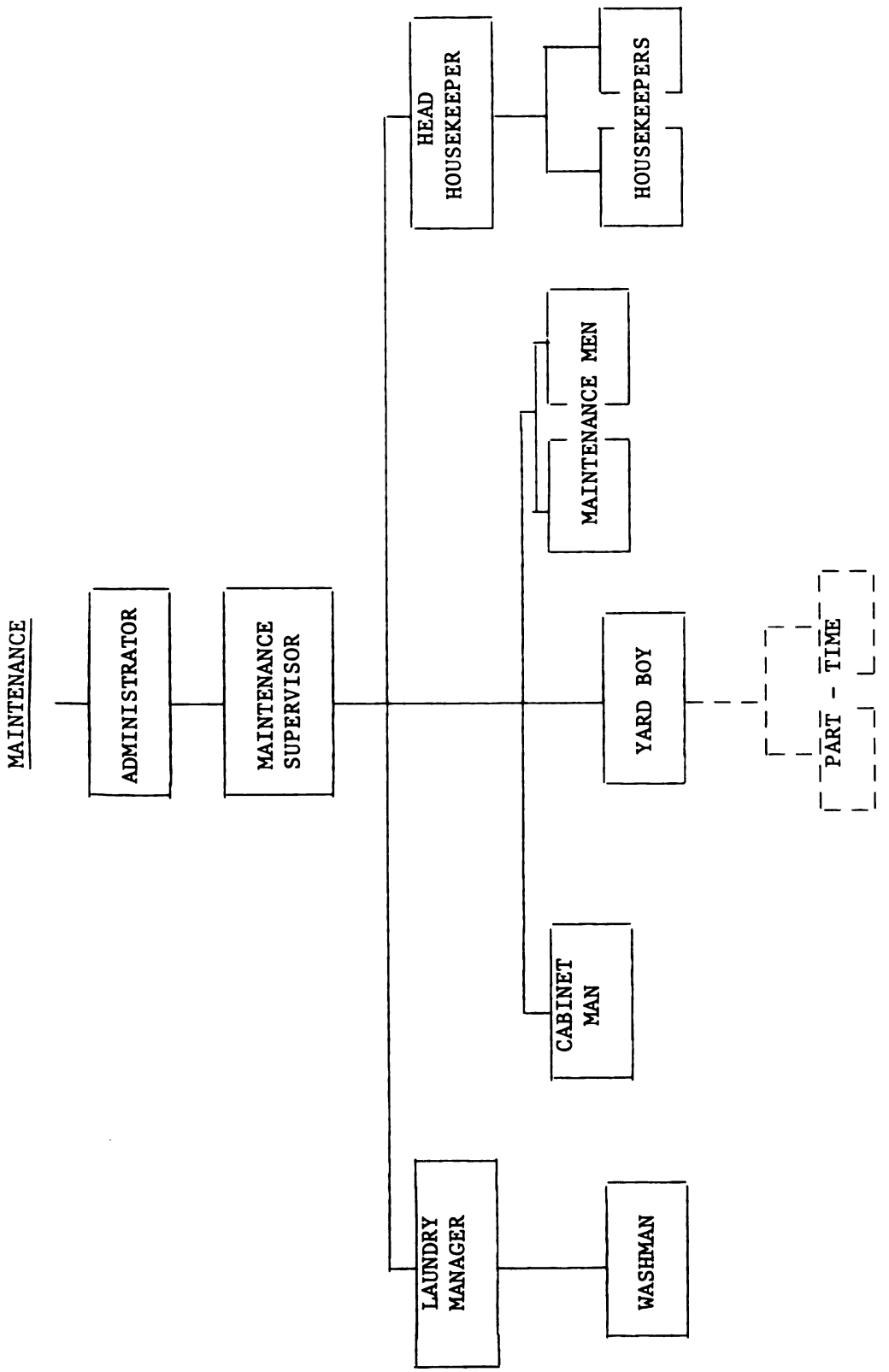

MAINTENANCE
ADMINISTRATOR
MAINTENANCE SUPERVISOR
HEAD HOUSEKEEPER
HOUSEKEEPERS
MAINTENANCE MEN
YARD BOY
PART - TIME
CABINET MAN
LAUNDRY MANAGER
WASHMAN

Figure 6

APPENDIX G

PERSONAL BACKGROUND QUESTIONNAIRE

Background Data Sheets

Name _____ Date _____

1. What is your age? _____

2. Where were you born? _____

3. Which one of the following categories describes the place where you spent most of your childhood?

   (a) _____On a farm
   (b) _____Open country but not on a farm
   (c) _____Village under 2,500 population (not a suburb)
   (d) _____Town of 2,500-10,000 population
   (e) _____City of 10,000-100,000 population (or in nearby suburb)
   (f) _____City of over 100,000 population (or in nearby suburb)

4. Where do you live in the _____ area?

   (a) Address _____

   (b) Section _____

   (c) Inside city _____
   Outside city _____

5. Do you like the _____ area?

   (a) What are its advantages to you?
   (b) What are its disadvantages?
   (c) How well integrated in the community are you?
   (d) Do you contemplate any move?

6. How long have you lived in the _____ area?
   _____years, months

7. Are you married at the present time?
   (1) _____Yes
   (2) _____No

8. How many children do you have and what are their ages?

   _____

   _____

9. What was (or is) your father's main occupation or type of work?

   _____

10. How much formal education did you receive?

(a) _____Grade school
(b) _____Some high school
(c) _____High school diploma
(d) _____Some college
(e) _____College degree
(f) _____College post-graduate
(g) _____Other; please specify: _____

11. If you have (a) degree(s) from college or university:

Degree	University or College	Major subject or specialty
Degree	University or College	Major subject or specialty

12. What has been your military experience?

Rank	Branch	Duty

13. What type of business or profession are you in?

_____

14. What is the full name or title of your position?

_____

15. How long have you held this position? _____ years, months

16. How long have you been with this organization? _____ years, months

17. What is the approximate annual income that you derive from your job?

$ _____

18. Do you have any other sources of income?

(1) _____Yes
(2) _____No

19. What have been your significant previous occupational and work experiences? Start with the position you had prior to this one and work backwards.

Description of position	Company or Organization	City	State	Dates (Years

I would like to know what organizations you are a member of and what your activities in these organizations are. To help you recall them, these organizations have been classified into several areas below. I shall give you examples as we proceed of the kinds of organizations.

20. (a) Do you belong to any local business associations such as the Chamber of Commerce, the Downtown Businessmen's Association, the Board of Realtors, Management or similar associations?

Name of Organization	Are you now an officer? (Name of office)	Are you a committee head or member? (Name of committee) (H-Head; M-Member)	Do you attend regularly or not? (Check:) (Reg. Irreg.)

(List all committees under each organization)

Have you been an officer in any of these organizations in the past?

_____ Yes (If yes, what were the organizations and what offices did you hold?)
_____ No

Organizations	Offices

Do you have any comments to offer about the significance of these activities, and your part in them, of these organizations?

(Probes: Why did you join this organization? Do you still belong for these reasons? Who are other members of the group. -- social class, age, occupation, etc.)

20. (b) Do you belong to any professional associations? (Local, state, national)

Name of organization	Are you now an officer? (Name of office)	Are you a committee head or member? (Name of committee) (H-Head; M-Member)	Do you attend regularly or not. (Check:) (Reg. Irreg.)

(List all committees under each organization.)

Have you been an officer in any of these organizations in the past?

_____ Yes (If yes, what were these organizations and what offices did you hold?)
_____ No

Organizations	Offices

Do you have any comments to offer about the significance of the activities, and your part in them, of these organizations?

---

20. (c) Do you belong to any service clubs, such as Rotary, Kiwanis, Lions, or Junior Chamber of Commerce?

Name of organization	Are you now an officer? (Name of office)	Are you a committee head or member? (Name of committee) (H-Head; M-Member)	Do you attend regularly or not? (Check:) (Reg. Irreg.)

(List all committees under each organization.)

Have you been an officer in any of these organizations in the past?

_____ Yes (If yes, what were the organizations and what offices did you hold?)
_____ No

Organizations Offices

Do you have any comments to offer about the significance of the activities, and your part in them, of these organizations?

---

20. (d) Are you presently associated with any civic or welfare organizations such as the Community Chest, Y.M.C.A. boards, P.T.A., Boy Scouts?

Name of organization	Are you now an officer: (Name of office)	Are you a committee head or member? (Name of committee) (H-Head; M-Member)	Do you attend regularly or not? (Check:) (Reg. Irreg.)

(List all committees under each organization)

Have you been an officer in any of these organizations in the past?

_____ Yes (If yes, what were the organizations and what offices did you hold?)

_____ No

Organizations Offices

Do you have any comments to offer about the activities of significance, and your part in them, of these organizations?

20. (e) Are you associated with any governmental or political activity such as City Council, Board of Education, Mayor's commissions, Planning Boards, Republican or Democratic party committees, or similar activities?

Name of Organization	Are you now an officer? (Name of office)	Are you a committee head or member? (Name of committee) (H-Head; M-Member)	Do you attend regularly or not? (Check:) (Reg. Irreg.)

Have you been an officer in any of these organizations in the past?

_____ Yes (If yes, what were the organizations and what offices did you hold?)
_____ No

Organizations _____ Offices _____

Do you have any comments to offer about the activities of significance, and your part in them, of these organizations?

20. (f) Do you belong to any fraternal, social, or religious organizations such as the Masons, Country or City Club, Veteran organizations, churches, or other organizations?

Name of organizations	Are you now an officer? (Name of office)	Are you a committee head or member? (Name of committee) (H-Head; M-Member)	Do you attend regularly or not? (Check:) (Reg. Irreg.)

(List all committees under each organization)

Have you been an officer in any of these organizations in the past?

_____ Yes (If yes, what were the organizations and what offices did you hold?)
_____ No

Organizations _____ Offices _____

Do you have any comments to offer about the significant activities, and your part in them, of these organizations?

21. In any of the organizations you have mentioned, do you sometimes think of yourself as representing a group such as business, profession, or government?

_____ No (go to question 22 directly)

_____ Other _____

_____ Yes (If yes)

21. (a) What organizations?

(1)
(2)
(3)
(4)
(5)

Why is _____ representation important?
(occupational group)

21. (b) In the community organization in which you have represented _____, do you feel that your participation made a real difference in the organization's general policies or not?

_____ No. Why not?

_____ Yes. Which organizations?

(1)
(2)
(3)
(4)
(5)

_____ Other. Explain.

21. (c) Are there other organizations you would like to belong to?

Why?

22. Do you think it is important or not for _____ to participate
(occupational group)
in as many community organizations as possible?

_____ Important. Why?

_____ Unimportant. Why?

_____ Other. Explain.

23. Are there any organizations or activities in the community in which you feel that the participation of _____ is more important
(occupational group)
than in others?

_____ No. Why do you feel this way?

_____ Other. Why do you feel this way?

_____ Yes. What are they?

Organizations _____ Why are they more important?

APPENDIX H

M.S.C.H. PATIENT OPINION QUESTIONNAIRE

WANTED! PATIENT OPINION!

This opinionaire will take very little of your time, and it will be very helpful to those responsible for administration and patient care at Mills Springs Community Hospital. We at Mills Springs spend much time, effort, and money to assure you, our patient, of the finest possible care, and we are anxious to know your reaction to our efforts.

Please tell us exactly what you think. We will appreciate it.

Room No. _____

	YES	NO
1. Were you interviewed in a courteous and efficient manner in the Admitting Office? Have you any comments about this service?	___	___
2. Were you satisfied with your room and with the house-keeping services?	___	___
3. Was the nursing care of high quality?	___	___
4. Did you feel that the nurses were interested in you as a person?	___	___
5. Did you receive prompt service when you rang for the nurses? If not, was there a reasonable explanation for the delay?	___	___
6. Did nurses, technicians, and other hospital personnel explain the nature of the services they were giving you? Was this explanation presented in a thorough and friendly fashion?	___	___
7. Within the restrictions of diet ordered by your physician, did you enjoy your food?	___	___
8. Were the portions adequate?	___	___
9. Was it attractively served?	___	___
10. Was it served hot?	___	___
11. How was the coffee? (Write opinion here)	___	___
12. Did you find Business Office courteous and understanding about financial arrangements for the payment of your bill?	___	___
13. Can you better understand the reasons for the high cost of hospital care?	___	___
14. Would you recommend this hospital to others?	___	___

COMMENTS:

_____

_____

_____
Sign here if you wish

APPENDIX I

M.S.C.H. BY-LAWS

BY-LAWS

ARTICLE I

Section 1.
CORPORATE NAME: The name of this Corporation shall be --

MILLS SPRINGS COMMUNITY HOSPITAL INC.

ARTICLE II

Section 1.
PURPOSE OF THE CORPORATION:

A. To raise money through solicitation from the general public of funds or other property for the construction of a new hospital within the City of Mills Springs, Mills County, Michigan, for use by Doctors of Medicine qualified to practice under the laws of the State of Michigan, and for general use of the community and surrounding rural areas for hospital service.

B. Acquiring of title to real estate necessary to and which might in the future be convenient for the construction and/or expansion of such hospital facilities.

C. Entering into contracts for the construction and equipping of such hospital facilities and the operation thereof.

ARTICLE III

Section 1.
MEMBERSHIP:

Any person over eighteen (18) years of age who has made a non-delinquent pledge to the Corporation covering the years of 1954, 1955 and 1956 shall be a member of this Corporation; provided that such pledge is maintained after the year of 1956 by the contribution of one dollar ($1.00), or more, per year. Husband and wife pledges shall be considered as joint pledges and as separate memberships and which shall entitle each to vote at any regular or special meeting of the membership hereof. After 1956, membership may be acquired by making an initial contribution and may be maintained thereafter by payment of the annual membership contribution of one dollar ($1.00), or more, per year.

ARTICLE IV

Section 1.
PLACE OF MEMBERSHIP MEETINGS:

Membership meetings shall be held in the City of Mills Springs, Mills County, Michigan, except upon due notice being given of a Special Meeting to be held at some designated place in Mills County, or in an emergency, in an adjoining county.

Section 2.
ANNUAL MEMBERSHIP MEETING:

The annual meeting of the Membership of the Mills Springs Community Hospital Inc. shall be held during the month of October each year beginning

with the year 1955. Members shall receive thirty (30) days notice of such meeting in writing, mailed to their last known address and such notice shall state the time and place of such annual meeting. The time and place of such meeting shall be set by the Board of Directors prior to the month specified. Said Notice of annual meeting shall include: a list of the nominations for the current election to the Board of Directors, Copy of the Annual Report, if any, copy of any proposed changes or amendments to the Charter or By-Laws, and a brief outline of any special problems then known to the Directors to come before the Membership.

Section 3. SPECIAL MEMBERSHIP MEETINGS.

Special membership meetings shall be called as necessary, on proper resolution of the Board of Directors, at which time such notice shall be mailed at least ten (10) days prior to the date of such special meeting. Said notice shall state the purpose of such special meeting and shall designate the time and place thereof. No business not mentioned in said Notice shall be transacted at such special meeting.

Section 4. SPECIAL MEMBERSHIP MEETINGS shall be called on petition of 20% of the registered membership, on presentation of such petition therefor to the secretary of this corporation who shall present said petition to the Board of Directors at the next regular meeting of said Board. Such petition shall state the purpose for which the Special Meeting is requested and shall bear the individual signatures, date and address of the signers thereto.

Section 5. QUORUM OF THE MEMBERSHIP.

A quorum of the membership at any regular or special meeting of the membership shall consist of twenty-five (25) or more qualified members being present at such meeting.

Section 6. PROXY.

No member may vote by proxy at any regular or special meeting of the membership.

Section 7. VOTING.

Voting at any regular or special meeting of the membership shall be by voice vote except when there is a question of majority at which time the President shall call for a show of hands. Provided, however, that voting for members of the Board of Directors shall be by ballot and such ballots shall be collected and counted by the Tellers of the election who shall make proper returns of such election to the members present. Tellers of the election shall be appointed by the president.

ARTICLE V

Section 1. THE GOVERNING BODY OF THIS CORPORATION shall consist of the Board of Directors thereof. The President, Vice President, Secretary, and Treasurer of this Corporation shall be elected by said Board of Directors from the members of the Board of Directors and shall be the executive officers of the Corporation.

Section 1. (B) Member(s) of the Board of Directors must be elected from the voting membership of the Corporation and must be a resident of Mills County or an adjoining County; physicians, surgeons, and other healers may not be members of the Board of Directors.

Section 2. (A) ELECTION OF THE BOARD OF DIRECTORS.

The members of the Board of Directors shall be elected annually at the Regular Annual Meeting of the Membership and shall consist of nine (9) members whose terms of office shall run for three (3) years; provided, however, that at the first annual election, the three members receiving the highest number of votes shall hold office for three (3)years; the three members receiving the next highest number of votes, below the first three mentioned above, shall hold office for two years and the three members receiving the next highest number of votes below those specified above shall hold office for one year. In case of ties in the first election, the result shall be decided by lot among the tied candidates. Three members of the Board of Directors shall be elected annually hereafter for full terms of three years each.

Section 2. (B) ANNUAL MEETING OF THE BOARD OF DIRECTORS.

The Board of Directors shall meet annually not more than ten (10) days after the Annual Meeting of the Membership, at which time they shall proceed to elect from their members a President, a Vice President, a Secretary and a Treasurer and such other officers or department heads as they may require. Such officers to-wit, the President, Vice President, Secretary and Treasurer shall hold office until the close of the next annual meeting of the Board of Directors and may be re-elected to any office at the discretion of the Board of Directors.

Section 2. (C) REGULAR MEETING OF THE BOARD OF DIRECTORS shall be held in the City of Mills Springs at least once each month at such time and place as a majority of the Board of Directors shall determine in advance. No notice of meeting shall be necessary for the call of any regular meeting when set a month or more in advance by the Board of Directors.

Section 2. (D) SPECIAL MEETINGS OF THE BOARD OF DIRECTORS shall be held at such time and place within the City of Mills Springs as shall be determined by any two of the regular officers of the corporation. Each member shall receive a notice of such special meeting at least three days prior to such meeting; provided that an emergency may be called by personal contact or by telephone at which meeting being called with less than three days notice, each member shall sign a waiver of due notice of such meeting.

Section 3. QUORUM OF THE BOARD OF DIRECTORS.

Six members of the Board of Directors shall constitute a quorum for the transaction of business at any regular or special Board meeting; provided, that at any regular or special meeting of the Board of Directors not having a quorum present, the members present shall proceed to adjourn such regular or special meeting to a future date, not less than three (3) days nor more than seven (7) days from and including the date of the current meeting. All Directors not present shall receive specific notice of such adjourned meeting prior to the time and date thereof.

Section 4. (A) VACANCIES.

The office of Director shall be declared vacant when such Director has died or does not reside in Mills County or an adjoining County, or has failed to attend at least four (4) consecutive regular Board meetings, without specific waiver of such attendance by the Board of Directors, or after proper hearing has been found guilty of misfeasence or malfeasence of office.

Section 4. (B) Any vacancy on the Board of Directors shall be filled by the members of the said Board of Directors until the next annual meeting of the Membership who shall then elect another Director to fill the unexpired term thereof.

Section 5. AUTHORITY AND DUTIES OF THE BOARD OF DIRECTORS.

The property and lawful business of this Corporation shall be managed by the Board of Directors whose duties it shall be to make recommendations to the membership and to act on the orders thereof; to act as the governing body and as an emergency body in the proper conduct of the affairs of the Corporation; to supervise the collection of all funds due the Corporation; to authorize and supervise the expenditures of the Corporation and to do all things necessary in their judgment to the proper conduct and management of the affairs of the Corporation to the best interests of the members thereof. The Board of Directors shall, through its officers, provide the membership with an annual report of the affairs and operation of the Corporation and shall provide a report compiled by a Michigan Certified Public Accountant, showing the financial condition of the income and disbursements of the Corporation for the year to date.

Section 6. EXECUTIVE COMMITTEES:

The Board of Directors may by resolution, designate any two or more of its members to act with the President of the Corporation to constitute an executive or other committee, who, to the extent provided in the resolution, shall possess and exercise the authority of the Board of Directors in the management of the affairs of the Corporation between meetings of the Board of Directors.

Section 7. REMUNERATION.

Directors shall serve in their capacity as director without salary or other financial remuneration or favor.

ARTICLE VI

Section 1. THE PRESIDENT shall be the Chief Executive Officer of the Corporation, and subject to the control of the Board of Directors, shall have general charge of its affairs. He shall preside at all meetings of the Corporation Membership and of the Board of Directors, and shall have such other powers and duties as are incident to his office and not inconsistent with these by-laws, or as shall be assigned to him at any time by the Board of Directors.

Section 2. THE VICE PRESIDENT shall assist the President in the performance of his duties when called upon to do so by the President or the Board of

Directors. In the event of the disability of the President or his absence from any place in which the business at hand is to be done, the Vice President shall have all the powers and perform all the duties of the President. He shall have such other powers and duties as may at any time be assigned to him by the Board of Directors.

Section 3. THE SECRETARY shall supervise the recording of all proceedings of the meetings of the corporate membership and of the Board of Directors and shall keep accurate permanent records of all the proceedings and business transactions of the corporation. He shall keep a permanent file of the names and addresses of all members of the Corporation, the amount of their pledges and the dates and amounts of all contributions by the members of the Corporation and shall perform such other duties as shall be prescribed from time to time by the Board of Directors.

Section 4. THE TREASURER shall keep full and accurate account of all receipts and disbursements and shall deposit all money, checks and other obligations, to the credit of the Corporation in such depository or depositories as may be designated by the Board of Directors. He shall disburse the funds of the Corporation only in accordance with due authorization of the Board of Directors and with the exception of Payroll Checks, such disbursements shall be in the form of voucher checks, prepared in triplicate by the Secretary who shall retain one copy thereof. Such voucher checks shall be signed by the Treasurer and countersigned by the President or Vice President of the Corporation. One copy of such voucher check shall be retained by the Treasurer for his files in the place of a check stub. Payroll checks shall be prepared by the Secretary on approved Payroll Check forms from a payroll prepared in duplicate by the Secretary. Such payroll checks shall require only the signature of the Treasurer and shall be cashed from a separate Payroll bank account. The payroll shall be approved by the President and the usual voucher check shall be payable to the Treasurer's payroll account and shall be deposited therein.

The Treasurer shall furnish security in an amount fixed by the Board of Directors and which said security shall be approved by said Board of Directors.

The books and records of the Treasurer shall be audited annually and at such other times as the Board may direct by a Certified Public Accountant, selected by the Board of Directors, who shall file his report with the Board of Directors of the Corporation.

ARTICLE VII

Section 1. BORROWING POWER.

The Board of Directors may, whenever the general interests of the Corporation may require, and with the approval of the membership, borrow money and issue its promissory notes or bonds for the repayment thereof with interest and may in like case mortgage its property as security for its debts or other lawful engagements.

ARTICLE VIII

Section 1. PARLIAMENTARY GUIDE.

The Robert's Rules of Order shall govern the Corporation in all cases to which they are applicable and in which they are not inconsistent with the By-laws.

ARTICLE IX

Section 1. AMENDMENTS.

These By-Laws may be amended at any annual or special meeting of the membership of this Corporation by an affirmative vote to two thirds of the members present and voting at said membership meeting. Such amendments may be proposed by either the members or the Board of Directors. All proposed amendments shall be referred to the Board of Directors and their legal council, for study and preparation, at least sixty (60) days prior to such meeting and such amendment in the form approved, shall be submitted in detail to the membership of this Corporation, together with the notice of such meeting, not less than thirty (30) days prior to the date of such meeting. Such amendment as proposed may be altered and adjusted at the date of such meeting, prior to the vote thereon, in accordance with Robert's Rules of Order.

ARTICLE X

Section 1. NOMINATIONS FOR THE BOARD OF DIRECTORS.

The President shall annually, and not less than sixty (60) days prior to the Annual Membership Meeting, appoint a nominating committee of five (5) persons, two (2) of whom shall be members of the Board of Directors, with terms expiring on different dates other than the date of the election in question, and three (3) shall be appointed from the membership in general, who shall reside in Mills County, and not more than one (1) of whom may reside in an adjoining county. Said nominating committee shall prepare a list of at least two names for each regular director to be elected and for each director to be elected to fill a vacancy. Nominations for any of the positions to be filled, may be made from the floor at the time of the Annual Membership meeting.

APPENDIX J

BY-LAWS, RULES AND REGULATIONS OF THE MEDICAL STAFF OF M.S.C.H.

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital governing board, and that the best interests of the patient are protected by concerted efforts, the physicians practicing in the Mills Springs Community Hospital hereby organize themselves in conformity with the by-laws, rules, and regulations, hereinafter stated. For the purpose of these by-laws the term "Medical Staff" shall be interpreted to include all physicians who are privileged to attend patients in the Mills Springs Community Hospital.

ARTICLE I

Name

The name of this organization shall be the Medical Staff of the Mills Springs Community Hospital.

ARTICLE II

Purpose

The purpose of this organization shall be: 1. To insure that all patients admitted to the hospital or treated in the outpatient department receive the best possible care. 2. To provide a means whereby problems of medico-administrative nature may be discussed by medical staff with the governing board and the administration. 3. To initiate and maintain self-government. 4. To provide education and maintain educational standards.

ARTICLE III

Membership

Section 1. QUALIFICATIONS.

The applicant for membership on the medical staff shall be a graduate of an approved medical school, legally licensed to practice in the State of Michigan, qualified for membership in the local medical society, and practicing in the community or within a reasonable distance of the hospital.

Section 2. ETHICS AND ETHICAL RELATIONSHIPS.

The Code of Ethics as adopted by the American Medical Association and The American College of Surgery shall govern the professional conduct of the members of the medical staff. Specifically, all members of the Medical Staff shall pledge themselves that they will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services.

Section 3. TERM OF APPOINTMENT.

Subsection 1. Appointment shall be made by the governing body of the hospital and shall be for the period of one year. At the end of this year

the governing body of the hospital may reappoint all members of the medical staff for a further period of one year, provided the medical staff has not recommended that any specific appointment shall not be renewed. In such case all other reappointments may be made.

Subsection 2. In no case shall the governing body take action on an application, refuse to renew an appointment, or cancel an appointment previously made without conference with the medical staff.

Subsection 3. Appointment to the medical staff shall confer on the appointee only such privileges as may hereinafter be provided for.

Section 4. PROCEDURE FOR APPOINTMENT.

Subsection 1. Application for membership on the medical staff shall be presented in writing, on the prescribed form, which shall state the qualifications and references of the applicant and shall also signify his agreement to abide by the by-laws, rules and regulations of the hospital medical staff. The application for membership on the medical staff shall be presented to the Administrator of the Hospital, who shall transmit it to the secretary of the medical staff.

Subsection 2. At the first regular meeting thereafter the Secretary shall present the application to the Medical Staff, at which time it shall be either recommended for rejection or referred to the Medical Staff as a whole which shall constitute the Credentials Committee.

Subsection 3. The Medical Staff as a whole shall investigate the character, qualifications, and standing of the applicant and shall submit a report of their findings at the next regular meeting of the Medical Staff, or as soon thereafter, recommending that the application be accepted, deferred, or rejected. In no case shall this report be delayed for more than three months.

Subsection 4. When determining qualifications, the Credentials Committee shall also assign privileges as provided for in Article 6 of these by-laws.

Subsection 5. The recommendation of the medical staff shall be transmitted to the governing body of the hospital through the Administrator.

Subsection 6. The governing body shall either accept the recommendation of the medical staff or shall refer it back for further consideration, stating the reason for such notice.

Subsection 7. When final action has been taken by the governing body, the Administrator of the hospital shall be authorized to transmit this decision to the candidate for membership and, if he is accepted, to secure his agreement to be governed by these by-laws, rules and regulations.

Section 5. EMERGENCY AND TEMPORARY PRIVILEGES.

Subsection 1. In case of emergency the physician attending the patient shall be expected to do all in his power to save the life of the patient, including the calling of such consultation as may be advisable. For the

purpose of this section an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

Subsection 2. The administrator of the hospital, after conference with the Medical Director, or Chief of Staff, shall have the authority to grant temporary privileges to a physician who is not a member of the medical staff. The chief of staff or the Medical Director shall give an authoritative opinion as to the competence and ethical standing of the physician who desires such temporary privileges, and in the exercise of such privileges he shall be under direct supervision of the Chief of Staff, or the Medical Director. Temporary privileges may not be granted to attend more than four patients in any one year, after which the physician to whom temporary privileges have been granted shall be required to become a member of the medical staff before being allowed to attend additional patients.

ARTICLE IV

Divisions of the Medical Staff

Section 1. THE MEDICAL STAFF

The medical staff shall be divided into honorary, consulting, active, and courtesy groups.

Section 2. THE HONORARY MEDICAL STAFF

The honorary medical staff shall consist of physicians who are not active in the hospital and who are honored by emeritus positions. These may be (a) physicians who have retired from active hospital service; or (b) physicians of outstanding reputation not necessarily resident in the county.

The honorary medical staff shall have no assigned duties.

Section 3. THE CONSULTING MEDICAL STAFF

Subsection 1. The consulting medical staff shall consist of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment.

Subsection 2. The duties of the members of the consulting medical staff shall be to give their services in the care of patients on request of any member of the active medical staff.

Section 4. THE ACTIVE MEDICAL STAFF

Subsection 1. The active medical staff shall consist of physicians resident in the community and surrounding area who have been selected to transact all business of the medical staff and to attend free patients in the hospital. Only members of the active medical staff are eligible to vote and hold office.

Subsection 2. Members of the active medical staff shall be required to attend medical staff meetings, as provided for in Article VIII of these by-laws.

Section 5. THE COURTESY MEDICAL STAFF

The courtesy medical staff shall consist of those members of the medical profession eligible as herein provided for staff membership, who wish to attend private patients in the hospital but who do not wish to become active staff members or who, by reason of residence, are not eligible for appointment.

ARTICLE V

Clinical Departments

Section 1. DEPARTMENTS

Departments of the medical staff shall be as follows: (1) General Medicine and General Surgery, (2) Radiology, (3) Pathology.

Assignment to departments shall be made at the first meeting of the active medical staff. The head of each department shall be the member best qualified by training, experience and demonstrated ability for the position.

The department of General Medicine and General Surgery shall be under the direct supervision of the Chief of Staff, while the Department of Radiology and Pathology shall be supervised by heads appointed by the medical staff.

The administrative head of all departments shall be the Medical Director of the Hospital, appointed by the Board of Directors, annually.

ARTICLE VI

Determination of Qualifications & Privileges

Section 1. CLASSIFICATION OF PRIVILEGES

Privileges granted to physicians who have been appointed to the medical staff shall be recommended by the Credentials Committee.

Section 2. DETERMINATION OF PRIVILEGES

Subsection 1. Determination of initial privileges shall be based upon an applicant's training, experience, and demonstrated competence.

Subsection 2. Determination of extension of further privileges shall be based upon an applicant's training, experience and demonstrated competence which shall be evaluated by review of the applicant's credentials, direct observation by the staff, and review of reports of the medical record and tissue committees, as provided for in Article VII, Section 2, of these by-laws.

ARTICLE VII

Officers and Committees

Section 1. The officers of the medical staff shall be the president, the vice-president, and the secretary-treasurer. These shall be elected at the annual meeting of the medical staff and shall hold office until the next annual meeting or until a successor is elected.

The president shall call and preside at all meetings, and shall be a member ex officio of any and all committees. He shall also be the chief of staff.

The vice-president, in the absence of the president shall assume all of his duties and have all of his authority.

The secretary-treasurer shall keep accurate and complete minutes of all meetings, call meetings on the order of the president, attend to all correspondence, and perform such other duties as may pertain to his office, he shall be accountable for all funds entrusted to him.

Section 2. COMMITTEES

The Executive Committee shall be composed of the Medical Director, the Chief of Staff, and the third member which shall be elected by the staff. The duties of the executive committee shall be to coordinate the activities and general policies of the departments, to act for the staff as a whole under such limitations as may be imposed by the staff, and to receive and act upon the reports of the medical record, tissue and such other committees as the medical staff may delegate. This committee shall meet at least once a month and maintain a permanent record of its proceedings and actions. This committee shall also be responsible for preparation and presentation of the programs of all meetings or the delegation of this responsibility.

The Credentials Committee shall consist of one member of the consulting staff, and one member of the active staff, appointed by the Chief of Staff and shall investigate the credentials of all applicants for membership and make recommendations in conformity with Article III, Section 4, Subsections 3 and 4, of these by-laws. This committee shall investigate any breach of ethics that may be reported, review any records that may be referred by the other committees and come to a decision regarding the performance of the staff member, or refer the case to the full staff if this is considered desirable. The committee shall review all information available regarding the competence of staff members, and as a result of such review, make recommendations for the granting of privileges, reappointments, and any assignments which may be called for under Article V and VI of these by-laws.

The Joint Conference Committee shall consist of the Medical Director and one other member of the active medical staff, appointed by the Chief of Staff, and will represent the medical staff in meetings with the governing body of the hospital. This committee shall be a medico-administrative liaison committee and the official point of contact among the medical staff, the governing body, and the Administrator.

The Medical Record Committee, the Tissue Committee, and any Special Committees shall consist of the staff (active) as a whole, and shall perform the following duties:

(a) Supervision and appraisal of medical records, to insure their maintenance at the required standard. The Committee shall meet at least once monthly at which time a report shall be made in writing and recorded in the staff minute book.
(b) The tissue committee shall study and report to the staff on the agreement or disagreement among the preoperative, postoperative,

and pathological diagnoses and on whether the surgical procedures undertaken in the hospital were justified or not. This study will also include those procedures in which there was no tissue removed. The report of the committee shall be in writing, and incorporated into the staff minute book, upon acceptance.

(c) Any special committee shall confine its work to the specific purpose for which it was appointed and any reports which the committee shall submit will be recorded in the staff minute book, upon acceptance.

ARTICLE VIII

Meetings

Section 1. THE ANNUAL MEETING

The annual meeting of the staff shall be on the first Tuesday of each month of June. At this meeting the retiring officers and committees shall make such reports as may be desirable, officers for the ensuing year shall be elected, and recommendations for appointments shall be made.

Section 2. REGULAR MEETINGS

The sole objective of staff meetings is improvement in the care and treatment of patients in the hospital. Monthly meetings of the staff, not less than 12 in each calendar year will be held. In addition to matters of organization, the programs of these meetings shall include a report of the executive committee and minutes of the tissue committee, medical records committee and any special committee constituted by the staff as a whole. Also incorporated must be a report of the Joint Conference Committee. In addition, these committee meetings shall be devoted to the review of current or recent cases in the hospital. Scientific programs not associated with the work of the hospital do not meet this requirement. Attendance is required, as provided for under Article VIII, Section 4, of these by-laws.

Section 3. SPECIAL MEETINGS

Special meetings of the staff may be called at any time by the president and shall be called at the request of the governing body, the executive committee, or any 3 members of the active medical staff. At any special meeting no business shall be transacted except that stated in the notice calling the meeting.

Section 4. ATTENDANCE AT MEETINGS

Active staff meeting attendance shall average at least 75% of the active staff who are not excused by the executive committee for exceptional conditions. Absence from one-fourth of the meetings, or three consecutive meetings shall constitute resignation from the staff, unless excused by the executive committee for exceptional conditions such as sickness or absence from the community.

Reinstatement of members of the active staff to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of the original appointment.

Members of the honorary, consulting and courtesy staffs shall not be required to attend meetings, but it is expected that they will attend and participate in these meetings unless unavoidably prevented from doing so.

Subsection 1. Quorum. Fifty percent of the total membership of the active staff shall constitute a quorum.

Section 5. AGENDA

The agenda of the regular meetings shall be:

Business

1. Call to order
2. Reading of the minutes of the last regular meeting and any special meetings
3. Unfinished business
4. Communications
5. Reports of standing and special business committees
6. New Business

Medical

7. Review and analysis of the clinical work of the hospital
8. Reports of standing and special medical committees
9. Discussion and recommendations for improvement of the professional work of the hospital
10. Adjournment

ARTICLE IX

Rules and Regulations

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these by-laws; except that they may be amended at any regular meeting without previous notice by a two-thirds vote of the total membership of the active medical staff. Such amendments shall become effective when approved by the governing body.

ARTICLE X

Amendments

These by-laws may be amended after notice given at any regular meeting of the medical staff. Such notice shall be referred to a special committee which shall report at the next regular meeting and shall require a two-thirds majority of those present for adoption. Amendments so made shall be effective when approved by the governing body.

ARTICLE XI

Adoption

These by-laws, together with the appended rules and regulations, shall be adopted at any regular meeting of the active medical staff, shall replace

any previous by-laws, rules, and regulations, and shall become effective when approved by the governing body of the hospital. They shall, when adopted and approved, be equally binding on the governing body and the medical staff.

Adopted by the Active Medical Staff of MILLS SPRINGS COMMUNITY HOSPITAL INC.

_____
President of the Medical Staff

Date _____ _____
Secretary of the Medical Staff

Approved by the Governing Board of the MILLS SPRINGS COMMUNTIY HOSPITAL INC.

Date _____ _____
Secretary of the Governing Board

RULES AND REGULATIONS

1. The meetings of the medical staff shall be held as provided for in Article VIII of the by-laws.

2. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the administrator secured. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

3. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

4. Standing orders shall be formulated by conference between the medical staff and the administrator. They may be changed only by the administrator after conference with the medical staff. These orders shall be signed by the attending physician.

5. All orders for treatment shall be in writing. Verbal orders shall not be accepted or carried out. An order shall be considered to be in writing if dictated to a Senior nurse, supervisor, or licensed practical nurse, or any other authorized person, and signed by the physician. Orders dictated over the telephone shall be signed by the person to whom dictated, with the name of the physician per his or her own name. At his next visit the attending physician shall sign such orders.

6. The attending physician shall be held responsible for the preparation of a complete medical record of each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports, such as consultation, clinical laboratory, x-ray, and other reports; provisional diagnosis; condition on discharge; follow-up; and autopsy report when available. No medical record shall be filed until it is complete, except on order of the medical record committee.

7. A complete history and physical examination shall in all cases be written within 24 hours after admission of the patient.

8. When such history and physical examination are not recorded before the time stated for operation, the operation shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

9. All records are the property of the hospital and shall not be taken away without permission of the Administrator. In case of readmission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient be free or pay and whether he be attended by the same physician or another.

10. Except in cases of emergency, patients for operation shall be admitted not later than 2 o'clock the day previous to operation. A surgical operation shall be performed only on consent of the patient or his legal representative, except in emergencies.

11. All operations performed shall be fully described by the operating surgeon. All tissues removed at operation shall be sent to the hospital pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis, and he shall sign his report.

12. When a patient is admitted in a condition of abortion, she or her representative shall sign a statement certifying that neither any employee of the hospital nor the attending physician was directly or indirectly responsible for its production.

13. Except in emergency, consultation with another qualified physician shall be required in all first caesarean sections, and in all curettages or other procedures by which a known or suspected pregnancy may be interrupted. The same requirement shall apply to operations performed for the sole purpose of sterilization on both male and female patients. In major surgical cases in which the patient is not a good risk and in all cases in which the diagnosis is obscure or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital medical staff through its Chief of Staff and its Executive Committee to see that members of the staff do not fail in the matter of calling consultants as needed. The consultant should include in his consultation an examination of the patient, and the record, and a written opinion signed by the consultant which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation.

14. Patients shall be discharged only on written order of the attending physician. At the time of discharge the attending physician shall see that the record is complete, state his final diagnosis, and sign the record.

15. The medical staff discussions at meetings held as provided for under Number 1 of these rules and regulations shall constitute a thorough review and analysis of the clinical work done in the hospital, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis, and results of treatment from among selected cases in the hospital at the time of the meeting and selected cases discharged since the last meeting, and an analysis of clinical reports from the departments and of reports of committees of the active staff.

16. Each member of the medical staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall

be performed by the hospital pathologist or by a physician to whom he may delegate the duty.

17. The hospital shall admit patients suffering from all types of disease except the following: (a) Active Tuberculosis, (b) Severe Mental Disorders.

18. Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff.

19. All patients admitted to the hospital shall have a routine chest X-ray, and Laboratory Studies, to include, WBC, Differential, Hemoglobin, and Hematocrit. Such reports of studies must be attached to the patient's chart before any major or minor surgery is attempted. Except, in the case of extreme emergency, as noted by the physician over the patient's chart.

Adopted at a regular meeting of the Active Medical Staff

_____
President of the Medical Staff

Date _____

_____
Secretary of the Medical Staff

Approved by the Governing Body:

Date

Guidelines Used by M.S.C.H. Medical Staff

"A guide in selecting the medical staff, as a safeguard for preventing the appointment of those who are not desirable, should be adopted and rigidly enforced."

HOSPITAL ORGANIZATION & MANAGEMENT
MacEachern

For the appointment to the medical staff of a reputable, ethical hospital, a physician must have the following qualifications.

(a) He must be a graduate of a recognized school of medicine with a degree of Doctor of Medicine.

(b) He must be legally licensed to practice medicine in the state or province in which the hospital is situated.

(c) He must have served an internship of at least one year in a hospital approved for internship by the American Medical Association (or by the Canadian Medical Association if the hospital is situated in Canada).

(d) He must enjoy the reputation of being a conscientious physician, as well as an ethical one.

(e) He must participate in the activities of organized medicine as demonstrated by membership in local, state and national medical societies.

(f) He should be of a temperament and disposition that will enable him to work in harmony with his colleagues on the medical staff, with the professional, technical, and other personnel in the hospital, and with the administration, accepting criticism without resentment and offering it in a spirit and manner that is constructive and devoid of offence or malice. If he accepts the status of specialist, he should possess the necessary qualifications based on such study, training, and experience as would warrant recognition by the national society or examining board representing his specialty, and he should present proof of such qualifications. Every qualified, ethical, and licensed physician in the community should be eligible to receive a hospital appointment and to be granted privileges in the hospital consistent with his demonstrated qualifications. A general practitioner may be granted limited privileges in a specialist's department according to his abilities. It should be left to the discretion of the medical staff should such necessity arise.

APPOINTMENT TO THE MEDICAL STAFF

(1) Initial staff appointments:

(a) Every physician desiring the use of the facilities of the hospital for the professional care of his patients should make application in writing. (This application is usually presented to the administrator and transmitted to the secretary of the medical staff, but it may be made to the secretary of the board or direct to the medical staff.)

(b) When application has been received by the secretary of the governing board, the administrator, or the secretary of the medical staff, it is referred by him to the medical staff for recommendation.

(c) The medical staff should review the qualifications of the applicant and after making its decision, transmit its decision to the secretary of the governing board for action.

(d) The governing board then acts on the application and instructs its secretary, or the administrator of the hospital, to notify the applicant as to the action taken.

Should the decision to reject the application be made, the governing board is not obligated to give a reason. It has the right to grant or withold the privileges of the hospital as may be dictated by consideration of the best interests of the institution, and it is better to confine the notice to a simple statement of the action without giving any reason.

The governing board represents the owners of the hospital, whether these be the community, or some other organization. The governing board therefore is held legally liable for the professional acts of incompetent physicians if it knows, or should know of their incompetence. There is thus a duty as well as a right to select physicians for appointment to the medical staff in order both to protect the patients in the hospital, and to absolve the hospital from liability.

PLEASE DO NOT REMOVE FROM THE ATTACHED CHART
Mills Springs Community Hospital, Inc.
Mills Springs, Michigan

RECORD CHECK SHEET

Diagnosis
- Admission
- Final

History
- Present Complaint
- Present Illness
- System Inventory
- Family History
- Past History

Physical Examination
- Physical Examination

Physicians
- Orders
- Discharge Orders
- Progress Notes
- Condition on Discharge

Special Reports
- Anesthesia
- Autopsy
- Consultation
- Electrocardiogram

Signatures
- Countersign TO & VO
- X-ray Reports
- Summary Sheet
- Labor Record
- Surgical Report
- Physical Examination
- Anesthesia Record

Consultation Record
- First Caesarean Section
- Dilatation & Currettage
- Sterilization
- Other

Authorization for
- Med/Surg Treatment
- Release of Information
- Release from Responsibility for Discharge
- Release for Responsibility for Abortion
- Autopsy Permit
- Bone Marrow Biopsy

Obstetrical
- Prenatal
- Labor
- Delivery
- Physical Exam

Miscellaneous
- Pathology Report
- Special Reports

Nurses Bedside Rec.
Admission:
- Date
- Time
- Manner

Discharge
- Date
- Time
- Manner

Nurses Sig. on above information

RECORD-TISSUE COMMITTEE REPORT

CHART NOT REVIEWED BECAUSE _____

Hospital Service Patient
(1) Satisfactory
(2) Lab not Satisfactory
(3) X-ray Not Satisfactory
(4) Nursing Not Satisfactory
(5) Pt and Family not Cooperative [ ]

Consultations [ ]
(1) Not Necessary
(2) Desirable and not Recorded
(3) Desirable and Recorded
(4) Required by Staff Rules & Recorded
(5) Required by Staff Rules & Not Recorded

Investigation by Physician:
(1) Adequate
(2) Inadequate
(3) Excessive
(4) Inappropriate

Pertinent History [ ]
Menstral History [ ]

Substantiating Physical Findings [ ]
Blood Pressure [ ]

Heart [ ]
Lungs [ ]
Rectal [ ]

Pelvic [ ]
Reasonable Progress Notes [ ]

Operation

(1) Was fully described?
(2) Was the correct procedure done? ☐
(3) Was the operation justified?
(4) Was surgery improperly withheld by physician?
(5) Was operation refused?

Hospitalization

(1) Adequate
(2) Insufficient ☐
(3) Excessive
(4) Inappropriate
(5) Delayed

Gen'l. Magt. of Patient

(1) Exceptional
(2) Adequate
(3) Fair ☐

Drugs

0. Properly withheld
1. Properly Given
2. Improperly Withheld
3. Too Much Given
4. Too little given
5. Given Inappropriately
6. Given when contraindicated

antibiotics	narcotics	sedatives	cardiac regulators	anti-coagulents	whole blood
☐	☐	☐	☐	☐	☐

fluids & electrolytes	anti-bacterial chemother	O_2
☐	☐	☐

Tissue

(1) Tissue report justifies operation
(2) Normal tissue removed, which contraindicates operation
(3) No tissue removed--operation justified ☐
(4) No tissue removed-- operation unjustified

Deaths

(1) Operative--Surgical
(2) Operative--Anesthesia
(3) Post Operative--Surgical
(4) Post Operative--Anesthesia
(5) Maternal
(6) Adverse reaction to drug therapy
(7) Other ☐

Evaluation

(1) Justified--Autopsy
(2) Justified--No Autopsy
(3) Probably Justified--Autopsy
(4) Probably Justified--No Autopsy
(5) Probably Not Justified--Autopsy
(6) Probably Not Justified--No Autopsy
(7) Not Justified--Autopsy
(8) Not Justified--No Autopsy ☐

REMARKS

Criteria for request for Sterilization to Special Sterilization Committee*

(a) As pertains to parity ____

Any woman having her 6th living child, or

Any woman over 30 years of age having 5 living children, or

Any woman over 35 years of age having 4 living children.

(b) As pertains to Caesarean Section _____

Any woman having her third Caesarean section

(c) As pertains to physical condition _____

Any woman, who in the opinion of her physician will endanger her own life by becoming pregnant or by delivery of her child.

(d) All other requests will be carefully reviewed by the committee.

* The Sterilization Committee shall be composed of three physicians appointed by the chief of staff, and the committee shall enter on the patients chart their approval or disapproval before any sterilization operation is permitted.

APPENDIX K

SUPERVISORY MANUAL, WARD BOOKS TOPICS,
AIDE'S INDIVIDUAL RECORD, EMPLOYEES' HANDBOOK, AND
RULES FOR HANDLING NEWS ABOUT PATIENTS

SUPERVISORY MANUAL

MILLS SPRINGS COMMUNITY HOSPITAL

JULY 7, 1958

Regardless of size, all hospitals must function as a well co-ordinated, cooperative institution. The multiplicity of various procedures, jobs, and activities require the utmost utilization of every employee, in order to successfully carry out the tasks which are set before us.

There is no institution or type of business in which the stakes are higher. A mistake in any department can be drastic. With the inter-woven necessity of each department relying on other departments for a smooth-running performance, there must be those whose primary job it is to see that the various departments function as efficiently and as easily as possible.

No one individual can completely oversee the management of a hospital. Whether the institution be 10 beds or 100 beds. There are too many jobs, and not enough time, for this to be accomplished.

Knowing these things, and hoping to always maintain a good hospital, which serves its patients well, this supervisory manual is prepared for each employee of the hospital to read. Through this manual it is hoped that each person can conceive of what is to be done, and how to do it. All procedures must be varied, depending upon the circumstances, but with a basic outline, the problems which present themselves, can be channeled to the right individual, with a minimum of confusion.

This booklet is not presented as a cure-all. Rather, it is hoped that it will serve to better define the jobs in this institution, and to give individuals who are qualified the latitude they need in maintaining a good hospital department.

It is written for the Mills Springs Community Hospital, and perhaps could find no application in other institutions. Regardless of its adaptability to other situations, we feel that it will serve the purpose for which it is intended.

THE LEVELS OF SUPERVISION

The Mills Springs Community Hospital is organized and managed through a nine-man Board of Directors. These directors are elected for the purpose of establishing over-all policy. Each member is a citizen of the community and as such has his or her own business to oversee. But pooling their individual resources, each attends a Board of Directors meeting, once per month to review the operation of the hospital, and to establish a basic operating policy.

Through this Board of Directors, the Administrator is employed as the executive head of this institution. The Board of Directors invests him with the power to organize, and manage this institution. Through him the intended functions of the hospital are carried forth.

Understanding the basic organization thus far, the remainder of this bulletin shall be devoted to the specific breakdown of supervision, and the duties and responsibilities carried forth by these individuals.

NURSING SERVICE

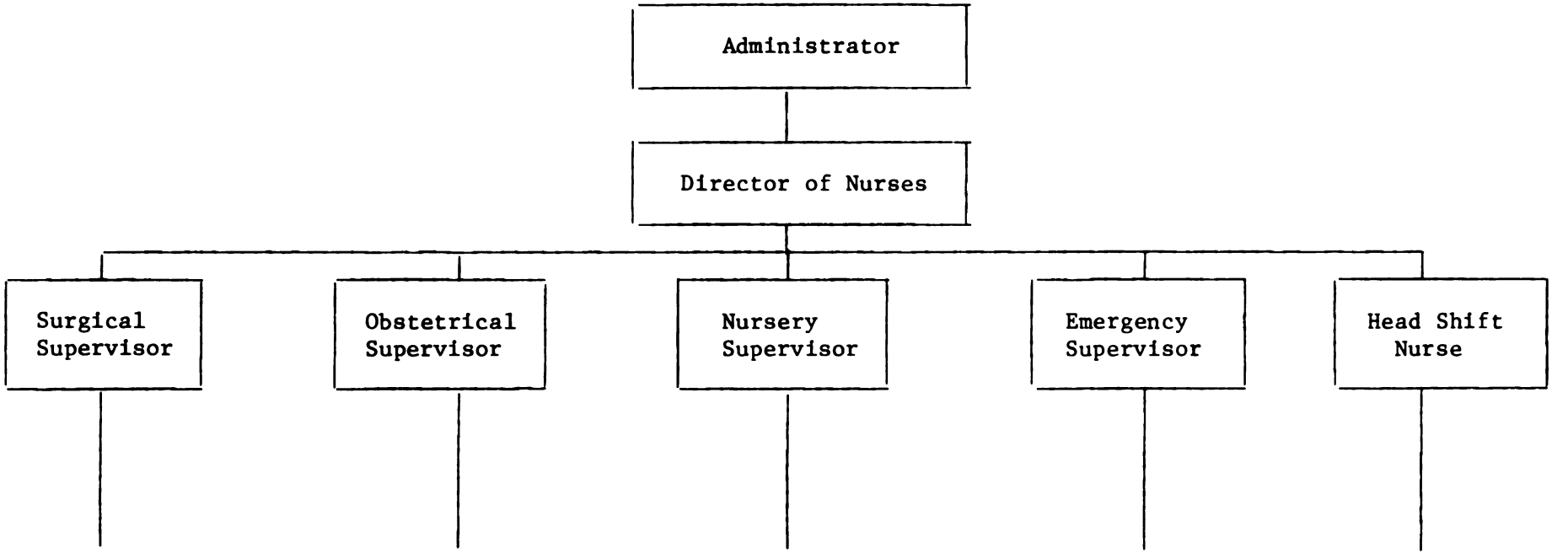


Figure 7

NURSING SERVICE

The largest, single staff of any hospital is always that of the nursing service. It is interesting to note that over 60% of the entire expense of operating a hospital is paid out to personnel and of this percentage over 40% is devoted to the nursing service. With its size, also goes the greatest single responsibility, for it is the members of the nursing staff who are directly concerned with the minute by minute care of the patient.

DIRECTOR OF NURSING

The director of the nursing service is the individual who is directly responsible for each part of the care rendered to the patient. Her duties are wide in scope, and comprehensive in nature. Her classification is in that of management. Again, there are far too many duties for her to oversee personally, and yet, she is the responsible party, the one to whom people turn when the functions of the service are not up to expected quality. Naturally, she must delegate her responsibility.

Directly: the Director of Nurses has the following duties:

(1) All personnel management of the nursing service. The interviewing of prospective employees. The termination of employment. The establishment of working duties.

(2) The arrangement of work schedules, so as to provide the necessary personnel, on duty, at all times, as needed.

(3) A daily visitation to each and every patient in the hospital to ascertain their needs, hear their criticisms, and help in any way to improve the service which each patient receives.

(4) The teaching of ancillary personnel on the nursing service, to better enable them to perform their duties.

(5) Coordinator of the nursing supervisors, to hold monthly meetings with the supervisors, and work out any problems which might be brought before her.

(6) To hold regular monthly meetings with Nurses Aides to better establish their role in the hospital team, and to listen and guide.

(7) To inform the Administrator of all accidents, emergencies, and unusual happenings on the nursing service. To report on the quality of care being rendered, and to maintain close liaison between the Nursing Staff and the Administration.

(8) To speak for the employees, under her supervision, in all matters which Administrative policy might affect.

(9) To constantly study new and varied techniques, which will enhance the care being rendered in this institution.

SUPERVISOR

A supervisor is one who "oversees" a project or a job. The term has the same applicability in the hospital that it has in any business. Most generally the work is tedious, for many problems present themselves which must be slowly dissected before a solution can be arrived at. Likewise, it is usually thankless, since any decision which must be made usually pleases some and dissatisfies others.

A supervisor is appointed to a specific duty because of capability. When one has demonstrated an ability to handle problems, a proficiency in a particular field, and the ability to work with others, he or she has the basic qualities of supervision. This does not mean that others are not just as capable, nor equally proficient, but it does mean that in a composite way they should make good supervisors. Such is the policy with this institution.

A supervisor is only as good as the cooperation received from her co-workers.

OBSTETRICAL SUPERVISOR:

It is the policy of this hospital to use only Registered Nurses to assist physicians in the Delivery Room. However, each nurse has had

different training, and each hospital operates differently, so that even the fact that a Registered Nurse is in attendance does not guarantee conformity to the procedure of a particular hospital. It is with this that the Obstetrical Supervisor must first concern herself.

Her specific duties being:

(1) The establishment of a written procedure to be followed by all personnel in the Delivery room.

(2) The dissemination of new techniques and procedures to all personnel who concern themselves with such procedures.

(3) To work with the physicians in rendering changes which are beneficial to the patient and the hospital.

(4) The instruction of prospective parents concerning pre-natal care, labor, and the delivery.

(5) The instruction of the post-partum patient as to her personal hygiene, and body care after leaving the hospital.

(6) The requisitioning of supplies and equipment for the labor and delivery rooms.

NURSERY SUPERVISOR:

The nursery supervisor is the appointed head of this department. As such she is responsible for the following duties:

(1) The establishment of techniques used in care of the newborn.

(2) The training of personnel who are assigned to work in this department. (all).

(3) The supervision of charts and records which are maintained on each newborn patient.

(4) The supervision of formula preparation.

(5) To see that cultures of all bottles and nipples are made each 30 day period, and to retain duplicates of these reports for inspection at all times by the State Health Department.

(6) To place all new methods and techniques in a suitable written form for the reference of all duty personnel, and Charge Nurses, in event that the Nursery Supervisor is absent.

(7) To confer with staff physicians and see that standing orders are reviewed periodically to ascertain any changes in infant care which the physician might desire.

(8) To requisition supplies for the nursery, and review new literature concerning new equipment -- to maintain the best facilities possible.

(9) To consult with the Director of Nurses on all personnel changes in the nursery, and to see that all nursery personnel is examined every six months by a physician in addition to the regular Kahn, and Chest X-Ray.

(10) To instruct the mothers in the hospital regarding care of their babies, and post-natal care of themselves.

EMERGENCY ROOM SUPERVISOR:

(1) The Emergency room supervisor will be in charge of ordering, and maintaining all equipment and supplies necessary for the Emergency room.

This will be accomplished through orders to the Medical Supply room, as per the usual methods.

(2) The supervisor will take it upon herself to instruct nurses aides and auxillary personnel in the procedures to be followed, and to instruct each individual so that they are capable of assisting a doctor in the performance of his duties, without any other personnel being present.

(3) The supervisor will see that all charges for services are posted, and kept up to date, so that any individual working in that room can ascertain the charges for the patient without reference to any other department.

(4) The supervisor will consult with the Nursing Director on any and all necessary changes in this department.

SURGICAL SUPERVISOR:

(1) It is the duty of the surgical supervisor to take complete charge and control of Central Supply and Surgery.

(2) The supervisor is responsible for all procedures carried out in the Surgery, and is responsible for the training of auxillary personnel employed by this department.

(3) The supervisor is responsible for the automatic culturing of all hospital autoclaves, no later than once every 30 days, such reports to be kept on file by her.

(4) The supervisor is responsible for the scheduling of all surgery.

(5) The supervisor is responsible for maintenance of the Operating Room Ledger, and to see that it is kept up to date at all times.

(6) The supervisor is responsible for the requisitioning of all supplies necessary to maintain the central supply and surgical suite.

(7) The supervisor is to post, at least once monthly, a schedule of the personnel on call for the operating room, and provide adequate information as to how this personnel can be reached immediately.

(8) The supervisor is responsible for all sterilization procedures throughout the hospital, and is to check these periodically, to see that proper techniques are being carried out.

FLOOR NURSING SUPERVISOR:

(1) The floor supervisor is responsible for the ordering of all medication for patients and for floor stock. This will be accomplished daily, and a minimum of a 24 hours supply will be stocked.

(2) The supervisor is responsible for assigning personnel to patients, by name and room number. To be accomplished either weekly, monthly, or daily, depending on the feasibility.

(3) The supervisor is responsible to check and ascertain that all routine Laboratory and X-Ray examinations have been ordered, and then carried out on all newly admitted patients.

(4) The supervisor is to record and check after each shift, the narcotic register.

(5) The supervisor is to make it a part of her duty to instruct aides in the routine performance of duties, to see that uniform procedures are in use.

(6) The supervisor is to make all amendments to the diet order sheet, which is transmitted to the Dietician, daily.

(7) The supervisor is to visit each paitent, personally, at least one time during her tour of duty, and to note the condition of this patient both physically and mentally.

(8) The supervisor is in complete charge of all nursing personnel on her shift, and as such is responsible for their care rendered to the patient.

In addition to the aforementioned duties, all supervisors are responsible for such duties above and beyond those listed, as they may be assigned by the nursing director.

The Ward Books devised for the 3 nursing divisions -- Pediatrics, Obstetrics, and Surgery -- contain the following information, rules, and procedures in common: 1. Admission of Patient -- to the hospital, to the floor; 2. General Rules for Charting; 3. Use of Kardex or Acme Visible Record; 4. General Directions in Nursing Care; 5. Ecclesiastical Rites of a Catholic Confession, Communion, Extreme Unction or Last Rites; 6. Notice -- Rules for Requisitioning of Supplies; 7. Bed Bath Procedure; 8. Administration of Oral Medication; 9. Hypodermic Medications; 10. Oral Oxygen - Nasal Oxygen; 12. Checking Patient Receiving Oxygen; 13. Skin Preparation for Operation; 14. Preparation of Patient for Surgery; 15. Preparation of Patient to Receive Averine Anesthesia, Rectal Anesthesia; and 16. General Preparation.

The Morning Routine is also similar in essential respects in the three divisions: 1. The head (or floor) nurse or her assistant check the supply of narcotics and hypnotics. 2. The morning report (or 3 P.M. or 11 P.M.) is made out after the assignment of duties has been completed. The nurse in charge visits the patients after the report. The 8 A.M. cases going to surgery are to be inspected by a graduate nurse. 3. Temperature, pulse, and respiration readings are taken by the aides and charted by the Ward Secretary. Anything ususual is reported to the R.N. (Temperature high, too low; rapid, intermittent, soft or weak pulse -- any unusual condition of the patient). 4. Breakfast is served by the kitchen aides at 7:30 A.M. to the patients indicated. Ward aides precede the dietary personnel when the trays are to be served and place the bedside stand shelf in the proper postion, place the overbed table in position, and help the patient to a comfortable position during the meal. They follow the dietary personnel when the trays are removed to adjust the bed and pillows and to adjust the

overbed and bedside tables. They also open the windows if the room is too warm and adjust the window shades. 5. Patients who do not take breakfast may have a bath at this time. 6. All patients who get bed baths are done first since they usually are the sickest patients. 7. Those patients who take their own baths or partial baths have their beds made ready for the bath -- a basin with warm water is placed conveniently, towels and face cloth with soap are placed within reach. The aide finishes the bath of those patients taking only part of their own bath and makes the bed. She also straightens the room before leaving. 8. The aide makes the beds of those who take their own baths, puts the room in order, and gets the patient fresh drinking water. 9. The auxiliary volunteers serve refreshments at 10 A.M., 2 P.M., and 8 P.M. 10. The physicians make their rounds after the above has been completed.

TOPICAL OUTLINES OF WARD BOOKS FOR PEDIATRICS AND OBSTETRICS

Pediatrics:

1.,2.,3.	Admission of Patient
4.,5.	General Rules for Charting
6.	Use of Kardex or Acme Visible Record
7.	General Directions in Nursing Care
8.,9.	Ecclesiastical Rites of a Catholic
10.,11.	Notice: Rules for Requisitioning of Supplies
12.,13.	Bed Bath Procedures
14.,15.,16.	Administration of Oral Medication
17.,18.	Hypodermic Medications
19.	Oral Oxygen
20.,21.	Oral Oxygen - Nasal Oxygen
22.	Checking Patient Receiving
23.,24.	Skin Preparation for Operation
25.,26.	Preparation of Patient for Surgery
27.	Preparation of Patient to Receive (Averine Anesthesia) (Rectal Anesthesia)
28	Preparation of Post-Operative Bed
29.,30.,31. 32.	Lavage
33.	The Wheel Chair
34.,35.	Woegenstein
36.,37.,38.	Adult, Hypodermocysis
39.,40.	X-Ray Department -- Routine Preparation of Patient
41.,42.	Blood Transfusion
43.,44.	Infusion - I.V.
45.,46.	Abdominal Dressing
47.,48.	Alcohol Sponge
49.,50.	Insertion of Rectal Tube
51.,52.	Cleansing Enema
53.,54.	Enema -- Using Pitcher and Runnel
55.,56.	Types of Enemas
57.,58.	Enema Solutions
59.,60.	Transfer of Patient
61.	Dressed Stretcher and In Use
62.,63.	Sitz Bath
64.,65.	Catheterization
66.,67.	Bladder Irrigation
68.,69.	Paracentisis
70.,71.,72.	Thoracentisis
73.,74.	Perineal Compresses
75.,76.	Vaginal Douche
77.	Assisting with a Rectal Examination
78.,79.	Terminal Care of Bedside Unit
80.,81.,82.	Cervical Smears and Cultures
83.,84.	Steam Inhalation
85.,86.,87.	Abdominal Stupes
88.,89.	Treatment of Pediculosis Capitis
90.	Care of Body after Death

Obstetrics:

1.	General Rules for Obstetrical Floor
2.,3.	General Directions on Labor and Delivery Floor
4.,5.	General Directions in Nursing Care O.B.
6.,7.	General Rules for Charting O.B.
8.,9.	Admission of O.B. Patients
10.,11.	Admission of Patients to Labor Room
12.,13.	Cleansing Enema O.B.
14.,15.	Enema Using Pitcher and Runnel O.B.
16.	Labor Room Examining and Perineal Chart
17.	O.B. Preparation Tray
18.,19.	Care of Patient in Labor
20.,21.	Vaginal Examination
22.	Delivery Hand Scrub
23.	Gown and Glove Techniques
24.,25.	Perineal Preparation in Delivery Room
26.-31.	Assisting with a Delivery
32.,33.	Terminal Care of Labor Unit
34.,35.	Venous Pressure and Circulation Time O.B.
36.,37.,38.	Initial Postpartum Perineal Care
39.,40.	Catheterization O.B.
41.,42.	Bladder Irrigation O.B.
43.,44.	Care of the Ambulatory Postpartum Patient O.B.
45.	Perineal Compresses O.B.
46.	Care of Third Degree Lacerations O.B.
47.-50.	Assist with a Bag Induction
51.	Removal of Perineal Sutures O.B.
52.	Heat Lamp

AIDE'S INDIVIDUAL RECORD

Code: D -- Observed Demonstration
RD -- Gave return demonstration
T -- Passed performance test

Name:

	D	RD	T		D	RD	T
Patient's signal				Shower & tub bath			
Arranging Unit				Cleaning equipment			
Care of Flowers				Water sterilizer			
Empty Beds				Pick-up forceps			
Ether Beds				Utility room care			
Fluid intake				Cleaning empty unit			
Giving Fresh Water				Care of linen			
Meal trays				Using Rubber Ring			
Feeding patients				Cotton rings			
Extra nourishments				Bed Cradle			
Bedpan and urinal				Side rails			
Measuring outputs				Isolation technique Mask			
Urine specimens				Gown			
Feces specimens				A.M. Care			
Moving pt. in bed				Vaginal & Rectal Exam			
Wheelchair				Discharging patient			
Patient to stretcher				Cleansing enema			
Cast & Traction				Hot H_2O Bottle			
Admitting patient				Hot soaks			
Physical exam				Hot compresses			
Care of teeth				Ice bag & collar			
Changing gown				Cold compresses			
Back rub				Wet dressings			
Combing hair				Temperature			
Occupied Bed				Pulse			
Bed Bath				Respiration			

TO THE EMPLOYEE:

May I take this opportunity to welcome you to this institution. You are working in a rapidly growing hospital with persons who are dedicated to the service of humanity.

It is my sincere hope that you will enjoy working in this hospital.

The hospital family is one of many skills, services, and professions. Our responsibility gives our work its special character for our first aim must always be service to the patient.

This handbook has been written for you, in the hope that it will aid all employees, old and new, in knowing about your hospital.

Sincerely yours,

Administrator

YOUR PAY

The pay of each hospital employee is based on either an hourly, a daily, or a monthly rate of pay. Your base rate of pay -- hourly, daily, or monthly -- determines your payroll classification. Your classification has a bearing on the benefits and privileges described in this handbook.

POLICY

It is the hospital's policy to pay wages that are equal to and prevailing in this community and surrounding communities for similar work, requiring similar skill, experience, and responsibility. Your pay will be determined by the hospital's basic scale for your job,

PLUS

HOW WELL YOU DO YOUR JOB.

TIME CARD

ALL employees are required to punch a time card. Your time card will be used by the Payroll department to compute your pay. Each slot in the time card rack is numbered. The card in the slot bearing the number you have been assigned is your time card. You will find a new card in your slot after each pay period.

FORGETTING TO PUNCH: If you should forget to punch your time card, be sure to report the fact before the end of your shift to your department head for authorization. If your department head is not on duty, get in touch with the Comptroller and have that person authorize the card for you.

YOUR PAY CHECK

WHEN YOU GET IT:

Regardless of your payroll classification, you will get your check twice each month. Pay day is on the 5th day and the 20th day of each month. The check issued on the 5th covers from the 16th of the previous month, to the end of that month. The check issued on the 20th covers from the 1st of the month through the 15th of that month.

WHERE YOU GET IT:

Pay checks may be picked up and signed for in the office of the Comptroller on the 5th and 20th days of each month.

TO GET IT:

To get your pay check you must sign your time card. In case of illness on pay day you may name an authorized person to pick up your check or it will be held until you return to work.

IF YOU HAVE QUESTIONS

QUESTIONS REGARDING THE AMOUNT OF YOUR PAY CHECK SHOULD BE TAKEN UP WITH YOUR DEPARTMENT HEAD. Questions about payroll deductions should be

taken up with the Comptroller. NO CHECKS WILL BE ISSUED BEFORE PAY DAY EXCEPT IN CASES OF EMERGENCY OR TERMINAL PAY, in which case you need approval of your department head.

CASHING YOUR CHECK

The hospital's accounting system makes it impossible to cash payroll checks at the hospital, unless it is to make payment on an account. Personal checks will be cashed only in payment on an account.

OVERTIME PAY

The hospital considers it inadvisable for employees to work more than your regularly assigned working hours. Overtime should be avoided except in cases of emergency.

IN CASE OF EMERGENCY, authorization for overtime work will be given by your department head, or the Administrator. Those who work overtime are required to take an equal amount of time off. Should this be impossible, compensation will be made as follows:

Hourly and Day Rate Employees: straight time

Salaried Employees: the monthly rate divided by 30 (days in mo.) to set daily rate, if full days are involved, or daily rate divided by 8 to set hourly rate, if pay for a few hours is desired.

Department Heads: Unless authorized by the Administrator, department heads are not to receive compensation for overtime-work.

TARDINESS

Tardiness in a hospital is a very serious matter. It may subject you to penalty deductions from your pay. Consistent or excessive tardiness is regarded as cause for dismissal.

ILLNESS

After six consecutive monthly employment, salaried full-time (40 hr.) employees are entitled to 7 work days of sick leave per year. Part-time employees are not compensated for sick time.

LEAVE OF ABSENCE WITHOUT PAY

Employees wishing to take a leave of absence without pay must apply to their department head for permission. Decision to grant leave of absence will be based on merits of the case and the work load of the department.

LUNCH TIME

Every employee is allowed thirty minutes for lunch. This may be purchased in the hospital dining room at the rate of 50¢ per meal, if desired. Coffee is free, and the use of the dining room is encouraged, for those who desire to bring their lunch.

COFFEE BREAK

The services of the hospital dining room are available to you for a 15 minute coffee break each morning between 9:00 and 11:00. BREAKFAST IS NOT SERVED TO EMPLOYEES. Please do not take coffee breaks before the above mentioned hours. Coffee breaks are also permitted between 2:00 and 4:30 p.m. COFFEE IS SERVED WITHOUT CHARGE TO EMPLOYEES AND GUESTS.

SMOKING

Smoking is permitted in the Nurses Lounge, Hospital Dining Room, and in the hospital basement. SMOKING IS NOT ALLOWED ON THE FLOORS.

VACATIONS

Each full-time salaried employee who has been in the employ of the hospital for 12 consecutive months is entitled to a two-week vacation with pay. (10 paid days) This applies to hourly and daily full-time employees also.

Vacations are not cumulative. They cannot be postponed until the following year.

Split-vacations are discouraged. However, department heads are permitted to make exceptions if warranted by any special circumstances.

No special allowances are made for sickness during one's vacation.

An employee leaving the hospital is entitled to his earned vacation. But the earned vacation must be taken prior to the official termination of employment.

HOLIDAYS

The hospital observes six holidays per year. All full-time employees are entitled to these paid holidays: NEW YEARS DAY, FOURTH OF JULY, LABOR DAY, MEMORIAL DAY, THANKSGIVING DAY, AND CHRISTMAS DAY.

WORK ON HOLIDAYS

Salaried employees: Salaried employees working any of the six holidays will be given compensating time off at another time approved by their department heads.

Hourly and Day Rate Employees: Hourly and day rate employees required to work on a holiday which happens to be one of their regularly scheduled work days, will be given compensating time off. If it is not possible to take the compensating time off, the employee will receive an additional day's pay for this holiday, at straight time.

HOLIDAYS THAT FALL ON DAYS OFF

Should a holiday fall on a Saturday or Sunday, the Employees will be given compensatory time off according to schedules determined by the department.

HOLIDAYS DURING VACATION

Should any of the six recognized holidays fall within a vacation period, the employee will be compensated with an additional day off.

BLUE CROSS - BLUE SHIELD

WHO MAY JOIN - All hourly, day and monthly rate full-time employees are eligible for enrollment in the hospital's BLUE CROSS - BLUE SHIELD Group, which provides both surgical and hospital benefits.

WHEN TO JOIN - To join Blue Cross - Blue Shield, each new employee must file a written application with the Comptroller within 30 days after date of hire. Failure to do so within the first thirty days will make it necessary for the new employee to wait until the regular re-enrollment period for the Group, which is in the fall of the year.

ADDING DEPENDENTS - In the event of marriage, any Blue Cross - Blue Shield subscriber may add the spouse as a dependent by making an application to that effect, with the Comptroller before the 8th of the month following the event. Birth of children must be reported the same way within 15 days. Change of home address should also be reported to the office.

RE-ENROLLMENT PERIOD - During the regular re-enrollment period of the hospital group, eligible employees who have not joined Blue Cross will be able to join. Those who are already enrolled will be able to make changes in their contracts, such as adding a spouse or children as dependents, or change for ward or semi-private or vice versa.

PAYROLL DEDUCTIONS - Your Blue Cross - Blue Shield monthly payment will be deducted from the pay period ending prior to the eighth of each month. Each deduction pays up your Blue Cross - Blue Shield for the 30 day period up to the first pay period of the following month.

EMPLOYEE DISCOUNTS

Employees not covered by Blue Cross or commercial hospitalization insurance will receive a 20% discount on all hospital services in the event of illness requiring hospitalization.

Employees covered by Blue Cross or commercial insurance will receive a 20% discount on that portion of their bill not covered by their Blue Cross

benefits or their insurance policy. BALANCES ON ALL ACCOUNTS ARE PAYABLE UPON DISCHARGE.

Pharmaceuticals from the hospital's pharmacy are not available for employee purchase.

SICK TIME BENEFITS - Salaried full-time employees, daily and hourly full-time employees, after six months consecutive employment, are entitled to 7 days of sick leave with pay within each calendar year. Sick leave is renewed on the first of each year. It cannot be accumulated from year to year. To be eligible for sick leave pay, you must notify your immediate supervisor at once about your inability to report for work. Your illness must be sufficiently serious to require your confinement to home.

Illness during your vacation cannot be charged to your sick leave time.

COMPENSATION FOR INJURIES ON THE JOB

Any employee sustaining an injury on the job must be treated immediately by the Emergency Room and must report the accident to the department head. All medical bills for such compensable injuries must be turned over to the Administrator.

SOCIAL SECURITY

All new employees come under the Social Security Act.

UNEMPLOYMENT COMPENSATION

Because the hospital is a charitable, non-profit institution, it does not come under the provisions of the unemployment compensation law.

DEATH IN THE FAMILY

In the event of the death of a member of an employee's family, the employee is entitled to a day's leave at full pay. A member of the immediate family will be a parent, sister, brother, spouse, son or daughter.

EMPLOYEE SERVICES

Dining Room

For the benefit of its employees the hospital operates the dining room in which the food is served at cost. Meals are served at the following times.

Lunch	11:45 to 1:15
Dinner	5:00 to 6:15

Meals may be purchased for 50¢ in this dining room. To purchase meals, the employee may purchase a meal ticket from the Business Office at the rate of $5.00 for 10 meals. Or, the employee may pay 50¢ at the

Business Office before 9:00 a.m. for lunch or 3:00 p.m. for supper. The receipt of payment given by the Business Office, will be the admission ticket to the dining room.

For employees who desire to bring the lunch, or dinner, the dining room is available, and the coffee is free to those employees.

Parking

All employees are urged to park their cars behind the west wing of the hospital (OPERATING ROOM). PLEASE do not park along the sidewalk. Cars parked along the south wing of the hospital will be removed.

Vending Machines

Vending machines are offering candy, and cigarettes, and are placed in the main corridor. The Auxiliary gift bar carries items such as stationery, childrens apparel, and personal hygiene items.

Lost and Found

The Housekeeping department operates a lost and found service. All articles found on the premises of the hospital should be taken to this department. All articles lost by employees, patients, and visitors should be reported without delay to the housekeepers.

Bulletin Boards

You will find bulletin boards near the time clock, in the nurses lounge, and in the nurses station, these boards are for posting announcements and information of value to all employees.

Hospital Bulletin

The Hospital Bulletin is published once per month for employees. You will find it an interesting monthly summary of news from various departments.

HOSPITAL POLICIES

Promotions

This hospital believes firmly in the policy of promoting from within the ranks of the permanent employees. Your chances of promotion depend, therefore, on the ability and dependability you demonstrate in your present job.

Transfers

All inter-departmental transfers require FIRST, approval of the department head from which the employee wishes to transfer, SECONDLY,

approval of the head of the department to which employee wishes to transfer, and THIRDLY, the approval of the Administrator.

Absence

If you are unable to report for work, you must notify your department head as soon as possible, giving the cause of your absence and stating how long you think you will be away. Absence for three days without such notification is cause for dismissal. If you know in advance that you will be absent, notify your department head accordingly. Illness and accidents are always conditions requiring urgent attention. It is essential that all jobs in the hospital be covered at all times.

Address and Telephone and Name Change

It is imperative that your department head have at all times your correct address and telephone number. There is no way of telling when a serious situation may make it necessary for him to get in touch with you. Report to him or her immediately, any change in your address or telephone number, or a change in your name bacause of marriage or court action. Also notify the payroll office of any changes.

Telephone Messages

Communication plays a critically important part in the services a hospital provides. It is unthinkable, as you can understand, that the Business Office be bogged down with personal calls by employees, particularly since such a condition could not only be dangerous, but the cost of so many phone calls would have to be charged to the patients. Therefore, please tell your friends not to call you during working hours, except in the case of an emergency. There is a public phone in the hospital lobby from which you can make your personal calls during lunch hours, and coffee breaks.

Gift Collections

It is customary in this hospital to present fellow employees with flowers, and gifts on some special occasions. Collections are made for funds to purchase these gifts. For those who wish to participate, 25¢ per month can be paid to the Comptroller, and this fund is used for such occasions.

DISCHARGES

Discharging an employee is considered a very serious matter by this institution. The problem is carefully weighed and the employee is given every consideration. An employee will be warned by the department head and given a probationary period before final action is taken, except for the following offenses:

1. Absence for three consecutive days without notice

2. Dishonesty

3. Insubordination, including willful negligence or refusal to do work in the manner assigned

4. Misconduct of a serious nature

5. Discourteous treatment of patients or the public

This hospital expects its employees to conduct themselves in a manner becoming men or women engaged in work that calls for conduct and discipline of the highest order.

An employee's department head or supervisor and the director are the only persons authorized to discharge a person.

A discharged employee is eligible for earned vacation. He must take this vacation prior to the date of discharge.

An employee discharged by one department head cannot be rehired by another department without the permission of the Administrator.

RESIGNATIONS

Employees who decide to resign are expected to give two weeks notice. Department heads are required to give one month's notice. Earned pay may be received on the day that employment is terminated, if authorized by the Administrator.

An employee who has voluntarily resigned will be treated as a new employee, if rehired, as far as all benefits are concerned.

An employee resigning from his job, if eligible for earned vacation time must take this vacation prior to official termination of employment.

IN GENERAL -- ALL OF THESE POLICIES ARE SUBJECT TO REVISION FROM TIME TO TIME. WE WELCOME CONSTRUCTIVE CRITICISM THAT YOU MAY CARE TO OFFER. IT IS OUR SINCERE HOPE THAT YOU WILL LIKE YOUR WORK HERE AT THE MILLS SPRINGS COMMUNITY HOSPITAL.

RULES FOR HANDLING NEWS ABOUT PATIENTS

Information Requiring Consent

Since actual hospital and medical records are universally held as confidential, the hospital may not legally release such information without the written consent of the patient and the attending physician.

PHYSICIAN'S NAMES:
In consideration of personal ethics the name of the attending physician should not be released without obtaining his permission.

PHOTOGRAPHS:
The hospital should not permit photographers to take pictures of patients without the written consent of the patient and the attending doctor.

Information Not Requiring Consent

Hospitals can cooperate with the press by providing the following information WITHOUT THE PATIENT'S CONSENT in accident and police cases which are a matter of police record.

IDENTIFICATION:
Name and address (verify for accuracy)
Sex
Marital status
Occupation
Time and admittance to hospital or emergency service
Employer
Name of parents (in case of birth)
Name of next-of-kin (cases of death)
Name of mortician (case of death)

NATURE OF ACCIDENT:
If a patient is allegedly injured by automobile, explosion, hunting, shooting, etc., for example, the hospital may state that the patient was injured by a knife or sharp instrument, or that there was a penetrating wound, but may NOT say whether it was a situation of assault, accident or self-inflicted. Explain to reporters that this information must come from police, medical examiner, or coroner.

DESCRIPTION OF INJURIES:
Only general information regarding injuries may be made.

INJURIES OF THE HEAD:
A simple statement may be made that injuries are the "head." The word fracture should not be used unless confirmed by the attending physician.

FRACTURES:
If it appears a fracture may be involved, do not describe it in any way except to state the member involved, such as leg, arm and so on.

INTERNAL INJURIES:
It may be stated that there are possible internal injuries, but do not specify the location. If very serious, a statment may be made to that effect.

UNCONSCIOUSNESS:
If the patient appears unconscious when brought to the hospital, a statement may be made to that effect. However, the cause of unconsciousness may not be given. This again is information which the reporters should obtain from the police.

BURNS:
A statement may be made that the patient is burned and the member of the body affected. A statement as to the degree of the burn and cause can be made only when the facts are known. No prognosis should be given.

PATIENT'S CONDITION:
A statement may be made as to the general condidion of the patient using the following classifications: minor injuries, good, fair, serious or critical.

DEATH:
A death of a patient is presumed to be public property, and such information may be released to the press.

Information That May Not Be Given

Because of a difficulty in diagnosis, the time involved in making a diagnosis, and the possibility of repercussion in the form of damage suits, details involving the following types of accident cases the hospital should refer inquiries it is not permitted to answer to the medical examiner, coroner or to the police.

INTOXICATION:
No statement may be made as to whether the patient is intoxicated or that the accident was due to intoxication, or otherwise.

SHOOTING OR STABBING:
No statement may be made as to how the accident occurred, or whether it was an accident, suicidal, homicidal, or in a brawl, nor may the environment be given under which the accident occurred.

SUICIDE OR ATTEMPTED SUICIDE:
No statement may be made that there was a suicide or an attempted suicide.

POISONING:
No statement may be made that the patient is poisoned. No statement concerning motive, suicide or accidental, may be given and the name of the poisonous substance may not be used.

DRUG ADDICTION:
No statement may be made that the patient is a suspected or confirmed drug addict or that the accident was the result of drugs. In all cases where moral turpitude is involved, the hospital again should refer inquiries to the police, medical examiner, or coroner.

FOOTNOTES

Chapter I

[1]Funds from the National Institutes of Health, United States Public Health Service, supported the "Hospital-Community Relationships" project undertaken by members of the then Department of Sociology and Anthropology (late 1950s) and the Social Research Service at Michigan State University.

[2]A. J. Muntean, Community Change and Hospital Development: A Case Study of Community Power Structure, Masters Thesis (East Lansing: Michigan State University, 1959).

[3]G. C. Homans, The Human Group (New York: Harcourt Brace Jovanovich, 1950): C. P. Loomis, and J. A. Beegle, Rural Sociology: The Strategy of Change (Englewood Cliffs, New Jersey: Prentice-Hall, 1950).

[4]W. L. Thomas, Jr. (Ed.), Current Anthropology (Chicago: The University of Chicago Press, 1950), pp. 3-25.

[5]Ibid., p. 3.

[6]See P. A. Sorokin, Sociological Theories of Today (New York: Harper and Row, 1966) for one of the recent and most trenchant treatments of this problem.

[7]These conceptual distinctions are made by D. Bidney, Theoretical Anthropology (New York: Columbia University Press, 1953).

[8]Ibid., p. 10.

Chapter II

[1]R. L. Warren, The Community in America (Chicago: Rand McNally and Co., 1963), 2nd Edition, 1973.

[2]Examples that come easily to mind are the Middle Town studies of the Lynds, West's Plainville and MacIver's emphasis, as well as that of many anthropologists doing ethnographic work.

[3]Warren, Ibid.

[4]C. M. Arensberg and S. T. Kimball, Culture and Community (New York: Harcourt, Brace and World, 1965).

[5]W. H. Form and D. C. Miller, Industry, Labor and Community (New York: Harper and Brothers, 1960).

[6]Warren, Ibid., pp. 9-11.

[7]Ibid., p. 13.

[8]Ibid., p. 53.

[9]P. H. Rossi, "Community Decision Making," Administrative Science Quarterly I, 415-443.

[10]Ibid., p. 417.

[11]R. M. Williams, Jr., American Society (New York: A. A. Knopf, 1960), 2nd Edition.

[12]Warren, Ibid., pp. 229-232.

[13]Consult Footnote 3, Chapter I and Bibliography of books and articles.

[14]G. C. Homans, The Human Group (New York: Harcourt Brace Jovanovich, 1950).

[15]See articles in bibliography on decision-making.

[16]Rossi, Ibid., pp. 422-424.

[17]M. Aiken and P. E. Mott (Eds.), The Structure of Community Power (New York: Random House, 1970), pp. 193-200.

[18]Warren, Ibid., pp. 213-216.

[19]Ibid., pp. 217-220; 228-229.

[20]Ibid., pp. 230-232.

[21]Ibid., pp. 220-227.

[22]Ibid.

[23]R. Linton, The Study of Man (New York: D. Appleton-Century Company, Inc., 1936), p. 272.

[24]Ibid., p. 273.

[25]A. W. Gouldner, "Cosmopolitans and Locals: Toward an Analysis of Latent Social Roles, I & II," Administrative Science Quarterly 2 (December 1957-March 1958): 281-306; 444-480.

[26]See books Bibliography for works by these authors on community power.

[27]Form and Miller, Ibid.

[28]Ibid., pp. 433-452.

[29]Ibid.

[30]J. C. Coleman, Community Conflict (Glencoe, Illinois: The Free Press, 1957).

Chapter III

[1]See the Bibliography of books and articles for an impressive output of work in this area.

[2]Caplow's magnum opus in this area is Principles of Organization (New York: Harcourt, Brace and World, Inc., 1964).

[3]J. E. Haas and T. E. Drabek, Complex Organizations: A Sociological Perspective (New York: MacMillan, 1973).

[4]See Chapter I above, pp. 14-16.

[5]A. Etzioni (Ed.), Complex Organizations: A Sociological Reader (New York: Holt, Rinehart and Winston, 1961), p. VII.

[6]A. Etzioni, A Comparative Analysis of Complex Organizations (Glencoe, Illinois: The Free Press, 1961), p. 79.

[7]A. Etzioni, Modern Organizations (Englewood Cliffs, New Jersey: Prentice-Hall, 1969), p. 3.

[8]Ibid., pp. 3-4.

[9]Caplow, ibid.

[10]Ibid., pp. 6-9.

[11]J. G. March and H. A. Simon, Organizations (New York: John Wiley and Sons, 1958), p. 4.

[12]H. A. Simon, Administrative Behavior (New York: MacMillan, 1950), p. 220.

[13]P. Selznick, T.V.A. and the Grass Roots (New York: Harper and Row, 1966).

[14]C. I. Barnard, The Functions of the Executive (Cambridge, Mass.: Harvard University Press, 1938).

[15]See the Bibliography under M. Weber and J. Freund.

[16]T. Parsons, "Suggestions for a Sociological Approach to the Theory of Organizations," Administrative Science Quarterly I: 63-85; II: 225-239.

[17]E. W. Bakke, Organizational Structure and Dynamics: A Framework for Theory (New Haven, Connecticut: Yale University Press, Labor and Management Center, 1954).

[18]Etzioni.

[19]A. Etzioni, "Two Approaches to Organizational Analysis: A Critique and a Suggestion," Administrative Science Quarterly 5: 257-278.

[20]A. Etzioni, Modern Organizations (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1964), pp. 5-19.

[21]J. D. Thompson, "Organizational Management of Conflict," Administrative Science Quarterly 4: 389-409.

[22]Caplow, Ibid.

[23]March and Simon, Ibid.

[24]Ibid.

[25]Weber, ibid.

[26]Etzioni, Ibid., pp. 50-57.

[27]A. Etzioni, A Comparative Analysis of Complex Organizations (Glencoe, Illinois: The Free Press, 1961), pp. 4-8; 256-281.

[28]Ibid., pp. 17-20.

[29]Haas and Drabek, Ibid.

[30]See Chapter I above, pp. 14-16.

[31]Ibid.

[32]W. Buckley, Modern Systems Research for the Behavioral Sciences (Chicago: Aldine Publishing Company, 1968).

[33]J. J. Zugich, Master of Public Health, Yale University, 1951.

[34]H. L. Smith, The Sociological Study of Hospitals, Doctoral Dissertation (Chicago: University of Chicago, 1949).

[35]L. G. Jackson, Hospital and Community (New York: MacMillan Co., 1964).

[36]See the Bibliography for these book references.

[37]Smith, Ibid.

[38]Barnard, Ibid.

Chapter IV

[1]G. W. Bachman & Associates, Health Resources in the United States (Washington, D.C.: Brookings Institute, 1952).

[2]A. Flexner, Medical Education in the U.S. and Canada (New York: Carnegie Foundation for the Advancement of Teaching, Bulletin #4, 1910).

[3]See Appendix I.

[4]See Bibliography for complete citation.

[5]See Appendix J.

[6]R. L. Coser, Life in the Ward (East Lansing, Michigan: Michigan State University, 1962).

Chapter V

[1]See revised and enlarged edition of A Comparative Analysis of Complex Organizations, 1975.

[2]See Chapter II above.

BIBLIOGRAPHY

Books:

Adams, R. N., & Preiss, J. J. (Eds.). Human Organization Research: Field Relations and Techniques. Homewood, Illinois: Dorsey Press, 1960.

Adrian, C. R. (Ed.). Social Science and Community Action. East Lansing, Michigan: Michigan State University, Board of Trustees, 1960.

Aiffa, H. R. Decision Analysis. Reading, Massachusetts: Addison-Wesley Publishing Co., 1968.

Aiken, M., & Mott, P. E. (Eds.). The Structure of Community Power. New York: Random House, 1970.

Allport, F. H. Theories of Perception and the Concept of Structure. New York: John Wiley & Sons, Inc., 1955.

American Hospital Association. Establishing a New Hospital. Chicago: American Hospital Association, 1952.

American Hospital Association. The Individual Hospital. Chicago: American Hospital Association, 1945.

Apple, Dorrian (Ed.). Sociological Studies of Health and Sickness. New York: McGraw-Hill, 1961.

Arensberg, C. M., & Kimball, S. T. Culture and Community. New York: Harcourt, Brace & World, 1965.

Argyris, C. Diagnosing Human Relations in Organizations: A Case Study of a Hospital. New Haven: Yale University Press, 1956.

Argyris, C. The Impact of Budgets on People. Ithaca, New York: Cornell University Press, 1952.

Argyris, C. Understanding Organizational Behavior. Homewood, Illinois: Dorsey Press, 1960.

Bachman, G. W. & Associates. Health Resources in the United States. Washington, D.C.: Brookings Institute, 1952.

Bachmeyer, A. C., & Hartman, G. (Eds.). Hospital Trends and Developments: 1940-46. Cambridge, Massachusetts: Harvard University Press, 1948.

Bachmeyer, A. C., & Hartman, G. (Eds.). The Hospital in Modern Society. New York: The Commonwealth Fund, 1943.

Bakke, E. W. Organizational Structure and Dynamics: A Framework for Theory. New Haven: Yale University Press, 1954.

Baldridge, J. V. Power and Conflict in the University. New York: John Wiley & Sons, Inc., 1971.

Bales, R. F. Interaction Process Analysis. Cambridge, Massachusetts: Addison-Wesley, 1950.

Bales, R. F. Personality and Interpersonal Behavior. New York: Holt, Rinehart and Winston, 1970.

Barnard, C. I. The Functions of the Executive. Cambridge, Massachusetts: Harvard University Press, 1938.

Becker, H. S., et al. Boys in White. Chicago: University of Chicago Press, 1961.

Belknap, I. Human Problems of a State Mental Hospital. New York: McGraw-Hill, 1956.

Belknap, I., & Steinle, J. G. The Community and Its Hospitals. Syracuse, New York: Syracuse University Press, 1963.

Bell, G. D. (Ed.). Organizations and Human Behavior. Englewood Cliffs, New Jersey: Prentice-Hall, 1967.

Bernard, J. American Community Behavior (Revised Edition). New York: Holt, Rinehart and Winston, 1962.

Berrien, F. K., General and Social Systems, New Brunswick, New Jersey: Rutgers University Press, 1968.

Bertalanffy, L. General System Theory. New York: George Braziller, 1964.

Bidney, D. Theoretical Anthropology. New York: Columbia University Press, 1953.

Binger, C. A. L. The Doctor's Job. New York: W. W. Norton & Company, 1945.

Blau, P. M. Exchange and Power in Social Life. New York: John Wiley and Sons, 1964.

Blau, P. M. & Meyer, M. W. Bureaucracy in Modern Society (2nd edition). New York: Random House, 1971.

Blau, P. M. & Schoenherr, R. A. The Structure of Organizations. New York: Basic Books, 1971.

Blau, P. M. & Scott, W. R. Formal Organizations. San Francisco: Chandler Publishing Company, 1962.

Block, L. Hospital Trends. Chicago: Hospital Topics, 1956.

Bloom, S. W. Power and Dissent in the Medical School. New York: The Free Press, 1973.

Bloom, S. W. The Doctor and His Patient. New York: The Free Press, 1965.

Blumenthal, L. H. How to Work With Your Board and Committees. New York: A.H.A. Press, 1954.

Brown, E. Nursing for the Future. New York: Russell Sage Foundation, 1948.

Bullock, R. P. What Nurses Think of Their Profession. Columbus, Ohio: Ohio State University Press, 1954.

Burling, T., Lentz, E. M. & Wilson, R. N. The Give and Take in Hospitals. New York: G. P. Putnam's Sons, 1956.

Caplow, T. Principles of Organization. New York: Harcourt, Brace & World, Inc., 1964.

Caudill, W. The Psychiatric Hospital as a Small Society. Cambridge, Massachusetts: Harvard University Press, 1958.

Cole, S. The Sociological Method. Chicago: Rand McNally, 1956.

Corwin, E. H. L. The American Hospital. New York: The Commonwealth Fund, 1946.

Davis, M. M. Medical Care for Tomorrow. New York: Harper & Bros, 1955.

Deutscher, J. Public Images of the Nurse. Kansas City, Missouri: Community Studies Inc., 1955.

Dunham, W. and Weinberg, S.K. The Culture of the State Mental Hospital. Detroit: Wayne State University Press, 1960.

Ehrenreich, B. and J. The American Health Empire: Power, Profits and Politics. New York: Vintage Books, 1971.

Etzioni, A. A Comparative Analysis of Complex Organizations. Glencoe, Illinois: The Free Press, 1961. Revised & enlarged edition 1975.

Etzioni, A. (Ed.). Complex Organizations: A Sociological Reader. New York: Holt, Rinehart and Winston, 1961. Revised edition, A Sociological Reader on Complex Organizations, 1969.

Etzioni, A. Modern Organizations. Englewood Cliffs, New Jersey: Prentice-Hall, 1964.

Etzioni, A. (Ed.). Readings on Modern Organizations. Englewood Cliffs, New Jersey: Prentice-Hall, 1969.

Etzioni, A. The Semi-Professions and Their Organization. New York: The Free Press, 1969.

Faxon, N. W. The Hospital in Contemporary Life. Cambridge, Massachusetts: Harvard University Press, 1949.

Fenton, J. The Medical Staff in the Hospital. Chicago: The Physician's Record Company, 1953.

Filstead, W. J. (Ed.). Qualitative Methodology. Chicago: Markham, 1970.

Form, W. H. and Miller, D. C. Industry, Labor and Community. New York: Harper & Bros., 1960.

Francis, R. G. and Stone, R. C. Service and Procedure in Bureaucracy. Minneapolis: University of Minnesota Press, 1956.

Freidson, E. (Ed.). The Hospital in Modern Society. Glencoe, Illinois: The Free Press, 1963.

Freund, J. The Sociology of Max Weber. New York: Pantheon Books, 1968.

Georgopoulos, B. and Mann, F. C. The Community General Hospital. New York: MacMillan, 1962.

Gilmer, S. O., Jr. (Ed.). Elements of Hospital Operation, Washington, D.C.: Public Health Service, 1950.

Ginzberg, E. A. A Pattern for Hospital Care: Final Report of the New York State Hospital Study. New York: Columbia University Press, 1949.

Glaser, B. G. and Strauss, A. L. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Publishing Company, 1967.

Goldwater, S. S. On Hospitals. New York: MacMillan, 1947.

Gouldner, A. W. Patterns of Industrial Bureaucracy. Glencoe, Illinois: The Free Press, 1954.

Greenblatt, M., Levinson, D. J. and Williams, R. H. The Patient and the Mental Hospital. Glencoe, Illinois: The Free Press, 1957.

Gross, N., Mason, W. S., & MacEachern, A. W. Explorations in Role Analysis. New York: John Wiley & Sons, Inc., 1959.

Gulick, L., & Urwick, L. F. (Eds.). Papers on the Science of Administration. New York: Columbia University Press, 1937.

Haas, J. E., & Drabek, T. E. Complex Organizations: A Sociological Perspective. New York: MacMillan, 1973.

Hage, J., & Aiken, M. Social Change in Complex Organizations. New York: Random House, 1970.

Haire, Mason (Ed.). Modern Organization Theory. New York: John Wiley & Sons, Inc., 1959.

Hall, O. The Informal Organization of Medical Practice in an American City. Doctoral Dissertation, University of Chicago, 1944.

Harkness, J. W. Hospital Organization in Transition. Doctoral Dissertation, Michigan State University, 1961.

Health Information Foundation. Trends in the Use of General Hospitals. Progress in Health Services, VIII, No. 8, October, 1959.

Holloway, R. G. Systemic Linkage, Influence and Control in a Hospital Decision-Making Structure. Doctoral Dissertation, Michigan State University, 1962.

Homans, G. C. The Human Group. New York: Harcourt Brace Jovanovich, 1950.

Homans, G. C. Social Behavior: Its Elementary Forms. New York: Harcourt Brace Jovanovich, 1961.

Hunter, F. Community Power Structure: A Study of Decision-Makers. Chapel Hill, North Carolina: The University of North Carolina Press, 1953.

Hunter, F., Schaffer, R. D., & Sheps, C. G. Community Organizations, Action and Inaction. Chapel Hill, North Carolina: University of North Carolina Press, 1956.

Jackson, L. G. (ed.). Hospital and Community. New York: MacMillan, 1964.

Jaco, E. G. (Ed.). Patients, Physicians and Illness. Glencoe, Illinois: The Free Press, 1958.

Joint Commission of A.H.A. and the American College of Hospital Administrators. Code of Hospital Ethics. Chicago: A.H.A., 1942.

Kahn, R. L., & Boulding, E. (Eds.). Power and Conflict in Organizations. New York: Basic Books, 1964.

Krupp, S. Pattern in Organizational Analysis. New York: Holt, Rinehart and Winston, 1961.

Lawrence, P. R. and Lorsch, J. W. Organization and Environment. Homewood, Illinois: Richard D. Irwin, 1969.

Lentz, E. M. The American Voluntary Hospital as an Example of Institutional Change. Doctoral Dissertation, Cornell University, 1956.

Likert, R. New Patterns of Management. New York: McGraw Hill, 1961.

Loomis, C. P. and Beegle, J. A. Rural Sociology: The Strategy of Change. Englewood Cliffs, New Jersey: Prentice-Hall, 1950.

Lutes, J. D. The Hospital Governing Board. Augusta, Georgia: Tidwell Printing Supply Company, 1949.

MacEachern, M. T. Hospital Organization and Management. Chicago: Physician's Record Company, 1946.

Mann, F.C. and Hoffman, L. R. Automation and the Worker: A Study of Social Change in Power Plants. New York: Holt, 1960.

March, J. G. (Ed.). Handbook of Organizations. Chicago: Rand McNally and Company, 1965.

March, J. G. and Simon, H. A. Organizations. New York: John Wiley & Sons, 1958.

Matthews, B. P. A Study of the Effects of Administrative Climate on the Nurse's Psychological Orientation Toward Hospital Patients. Doctoral Dissertation, University of California, 1960.

McGibony, J. R. Principles of Hospital Administration. New York: G. P. Putnam & Sons, 1952.

Mechanic, D. Medical Sociology. New York: The Free Press, 1968.

Merton, R. K. Social Theory and Social Structure. Glencoe, Illinois: The Free Press, 1957.

Merton, R. K., Gray, A. P., Hockey, B. and Selvin, H.C. (Eds.). Reader in Bureaucracy. Glencoe, Illinois: The Free Press, 1952.

Merton, R. K., Reeder, G. G. and Kendall, P. The Student Physician. Cambridge, Massachusetts: Harvard University Press, 1957.

Miller, P. A. Community Health Action. East Lansing, Michigan: Michigan State College Press, 1953.

Mills, C. W. The Power Elite. New York: Oxford University Press, 1957.

Mills, C. W. The Sociological Imagination. New York: Oxford University Press, 1959.

Morse, N. C. Satisfaction in the White Collar Job. Ann Arbor, Michigan: Institute for Social Research, 1953.

Muntean, A.J. Community Change and Hospital Development: A Case Study of Community Power Structure. Master's Thesis, Michigan State University, 1959.

Perrow, C. Complex Organizations: A Critical Essay. New York: Scott, Foresman and Company, 1972.

Ponton, T. R. The Medical Staff in the Hospital. Chicago: Physicians Record Company, 1953.

Press, C. Main Street Politics: Policy-Making at the Local Level. Board of Trustees, Michigan State University, 1962.

Presthus, R. The Organizational Society. New York: A.A. Knopf, 1962.

Price, J. L. Organizational Effectiveness: An Inventory of Propositions. Homewood, Illinois: Richard D. Irwin, 1968.

Reissman, L. and Rohrer, J. H. Change and Dilemma in the Nursing Profession. New York: G. P. Putnam & Sons, 1957.

Richardson, H. B. Patients Have Families. New York: The Commonwealth Fund, 1945.

Roberts, M.M. American Nursing: History and Interpretation. New York: MacMillan, 1954.

Seashore, S. E. Group Cohesiveness in the Industrial Work Group. Ann Arbor, Michigan: Institute for Social Research, 1955.

Simmons, L. W. and Wolff, H. G. Social Science in Medicine. New York: Russell Sage Foundation, 1954.

Simon, H. A. Administrative Behavior. New York: MacMillan, 1950. Revised edition, 1958.

Smith. H. L. The Sociological Study of Hospitals. Doctoral Dissertation, University of Chicago, 1949.

Sorokin, P. A. Sociological Theories of Today. New York: Harper and Row, 1966.

Southmayd, H. J. and Smith, G. Small Community Hospitals. New York: The Commonwealth Fund, 1944.

Staff of the Administrative Science Center, University of Pittsburgh, Comparative Studies in Administration, Pittsburgh: University of Pittsburgh Press, 1959.

Stanton, A. H. and Schwartz, M. S. The Mental Hospital. New York: Basic Books, 1954.

Tannenbaum, A. S. Control in Organizations. New York: McGraw Hill, 1968.

Taylor, F. W. Scientific Management. New York: Harper & Row, 1947.

Thomas, W. L., Jr. (Ed.). Current Anthropology. Chicago: The University of Chicago Press, 1956.

Thompson, J. D. (Ed.). Approaches to Organizational Design. Pittsburgh, Pennsylvania: University of Pittsburgh Press, 1966.

Thompson, J. D. Organizations in Action. New York: McGraw Hill, 1967.

Vroom, V. H. (Ed.). Methods of Organizational Research. Pittsburgh, Pennsylvania: University of Pittsburgh Press, 1967.

Warren, R. L. (Ed.). Perspectives on the American Community. Chicago: Rand McNally and Company, 1966. 2nd edition, 1973.

Warren, R. L. The Community in America. Chicago: Rand McNally and Company, 1963. 2nd edition, 1973.

Weber, M. (Gerth, H.H. and Mills, C. W., translators and editors), From Max Weber: Essays in Sociology. New York: Oxford University Press, 1946.

Weber, M. The Theory of Social and Economic Organization. New York: Oxford University Press, 1947.

Weiss, R. S. Processes of Organization. Ann Arbor, Michigan: Institute for Social Research, 1956.

Wessen, A. F. The Social Structure of a Modern Hospital. Doctoral Dissertation, Yale University, 1951.

Williams, R. M., Jr. American Society. New York: A. A. Knopf, 1960, (2nd edition).

Wilson, R. N. The Sociology of Health. New York: Random House, 1970.

Woodward, J. Industrial Organization: Theory and Practice. London, Oxford University Press, 1965.

Zald, M. N. Organizational Change: The Political Economy of the Y.M.C.A. Chicago: The University of Chicago Press, 1970.

Zugich, J. J. Influences on Interpersonal Relations in the Hopsital Organization. Master of Public Health, Yale University, 1951.

Zwerman, W. L. New Perspectives on Organizational Theory. Westport, Connecticut: Greenwood Press, 1970.

Articles:

Adams, S. "Trends in the Occupational Origins of Physicians." American Sociological Review, 18, 404-410.

Agger, R. E. "Power Attributions in the Local Community: Theoretical and Research Consideration." Social Forces, 34, 322-331.

_____, & Ostrom, V. "The Political Structure of a Small Community." Public Opinion Quarterly, 20.

Aldrich, H. E. "Organizational Boundaries and Interorganizational Conflict." Human Relations, 24, 279-282.

Allen, W. H. "Hospital Efficiency." American Journal of Sociology, XII, 298-318.

Amsden, J. P. "Community Representatives Interpret Hospital to Public and Public to Hospital." Modern Hospital, 82, 89-90.

Anderson, T. R., & Warkov, S. "Organizational Size and Functional Complexity: A Study of Administration in Hospitals." American Sociological Review, 26, 23-28.

Andrews, C. N. "Community Relations Can Be Improved if Blue Cross and Hospitals Work Together." Modern Hospital, 75, 71-72.

Argyris, C. "Some Problems in Conceptualizing Organizational Climate: A Case Study of a Bank." Administrative Science Quarterly, 2, 501-520.

_____. "The Individual and Organization, Some Problems of Mutual Adjustment." Administrative Science Quarterly, 2, 2-24.

Arnold, D. O. "Dimensional Sampling: An Approach for Studying a Small Number of Cases." The American Sociologist, 5, 147-150.

Babcock, K. B. "Accreditation." Hospitals, 34, 43.

Banfield, E. C. "The Decision-Making Schema." Public Administration Review, 17, 278-285.

Barnard, C. "Functions and Pathology of Status Systems in Formal Organizations." In Industry and Society, W. F. Whyte (Ed.) New York: McGraw-Hill Book Company, 1946.

Barth, E. A. T., & Johnson, S. D. "Community Power and a Typology of Social Issues." Social Forces, 38, 29-32.

Bendix, R. "Bureaucracy and the Problem of Power." Public Administration Review, V, 194-209.

_____. "Bureaucracy: The Problem and Its Setting." American Sociological Review, 12, 493-507.

Blau, P. M. "A Formal Theory of Differentiation in Organizations." American Sociological Review, 35, 201-218.

_____. "Co-operation and Competition in a Bureaucracy." American Journal of Sociology, LIX, 530-535.

Bunzel, J. H. "The General Ideology of American Small Business." Political Science Quarterly, LXV, 87-102.

Cressey, D. R. "Contradictory Directives in Complex Organizations: The Case of the Prison." Administrative Science Quarterly, 4, 1-19.

Dahl, R. A. "A Critique of the Ruling Elite Model." American Political Science Review, 52, 463-469.

_____. "The Concept of Power." Behavioral Science, 2, 201-215.

deGrazia, S. "What Authority is Not." American Political Science Review, LIII, 321-331.

Denzin, N. K. "Symbolic Interactionism and Ethnomethodology: A Proposed Synthesis." American Sociological Review, 34, 922-934.

Devereauz, G., & Winter, F. R. "The Occupational Status of Nurses." American Sociological Review, 15, 628-634.

Diesing, P. "Noneconomic Decision-Making." Ethics, LXVI, 18-35.

Dill, W. R. "Environment as an Influence on Managerial Autonomy." Administrative Science Quarterly, 2, 409-423.

Dimock, M. E. "What it Means to be an Administrator." Hospital Administration, 2, 5-21.

Etzioni, A. "Dual Leadership in Complex Organizations." American Sociological Review, 30, 688-698.

_____. "Two Approaches to Organizational Analysis: A Critique and a Suggestion." Administrative Science Quarterly, 5, 257-278.

Freidson, E. "Client Control and Medical Practice." American Journal of Sociology, LXV, 374-382.

Garceau, O. "Organized Medicine Enforces its 'Party Line.'" Public Opinion Quarterly, 4, 408-428.

Goldhamer, H., & Shils, E. A. "Types of Power and Status." American Journal of Sociology, XLV, 171-182.

Gore, W. J., & Silander, F. S. "A Bibliographical Essay on Decision Making." Administrative Science Quarterly, 4, 97-121.

Groner, F. S. "Essentials of Administrator-Board Relationships." Trustee, 7, 14-17.

Gusfield, J. R. "The Problem of Generations in an Organizational Structure." Social Forces, 35, 323-330.

Hall, O. "The Informal Organization of the Medical Profession." Canadian Journal of Economics and Political Science, 12, 30-44.

_____. "The Stages of a Medical Career." American Journal of Sociology, LII, 327-336.

Hawley, P. R. "The Responsibility of the Hospital to the Community." Hospital Administration, 2, 5-14.

Homans, G. "Bringing Men Back In." American Sociological Review, 29, 809-818.

Hughes, E. C. "Institutional Office and the Person." American Journal of Sociology, XLIII, 404-413.

Kaufman, H., & Jones, V. "The Mystery of Power." Public Administration Review, XIV, 205-212.

Kinzer, D. M. "The Only Team that Pilots -- and Doctors Recognize is Their Own." Modern Hospital, 92, 59-63.

Lieberman, S. "The Effects of Changes in Roles on the Attitudes of Role Occupants." Human Relations, 9, 385-402.

Long, N. E. "Power and Administration." Public Administration, 9, 257-264.

_____. "The Local Community as an Ecology of Games." American Journal of Sociology, LXIV, 251-261.

McKinley, C. "Some 'Principles' of Organization." Public Administration Review, 12, 157-165.

Miller, D. C. "Decision-Making Cliques in Community Power Structures." American Journal of Sociology, LXIV, 299-310.

Miller, P. A. "The Process of Decision Making Within the Context of Community Organization." Rural Sociology, 17, 143-161.

Naegele, K. D. "The Social Content of Communication." Hospital Administration, 2, 32-43.

Parsons, T. "Suggestions for a Sociological Approach to the Theory of Organizations I." Administrative Science Quarterly, 1, 63-85; II, 225-239.

Pelz, D. C. "Some Social Factors Related to Performance in a Research Organization." Administrative Science Quarterly, 1, 310-325.

Perrow, C. "The Analysis of Goals in Complex Organizations." American Sociological Review, 26, 854-866.

Perrucci, R., & Pilisuk, M. "Leaders and Ruling Elites: The Inter-organizational Bases of Community Power." American Sociological Review, 35, 1040-1057.

Polsby, N. W. "The Sociology of Community Power: A Reassessment." Social Forces, 37, 232-236.

Presthus, R. V. "Toward a Theory of Organizational Behavior." Administrative Science Quarterly, 3, 48-72.

Ransonhoff, P. A. "The Administrator and Management Development." Hospital Administration, 3, 21-32.

Rossi, P. H. "Community Decision Making." Administrative Science Quarterly, 1, 415-443.

Schulze, R. O. "The Role of Economic Dominants in Community Power Structure." American Sociological Review, 23, 3-9.

Simon, H. A. "Decision-Making and Administrative Organization." Public Administration Review, IV, 16-30.

_____. "On the Concept of Organizational Goal." Administrative Science Quarterly, 9, 1-22.

_____. "The Administrator as Decision-Maker." Hospital Administration, 3, 26-41.

_____. "The Decision-Making Schema: A Reply." Public Administration Review, 18, 60-63.

_____. "Theories of Decision-Making in Economics and Behavioral Science." The American Economic Review, XLII, 253-283.

Simpson, R. L. "Vertical and Horizontal Communication in Formal Organizations." Administrative Science Quarterly, 4, 188-196.

Smith, H. L. "Two Lines of Authority, One Too Many." Modern Hospital, 84, 59-64.

Sofer, C. "Reactions to Administrative Changes." Human Relations, 8, 291-316.

Thompson, J. D. "Organizational Management of Conflict." Administrative Science Quarterly, 4, 389-409.

_____, & McEwen, W. J. "Organizational Goals and Environment: Goal-Setting as an Interaction Process." American Sociological Review, 23, 23-31.

Thompson, V. A. "Hierarchy, Specialization and Organizational Conflict." Administrative Science Quarterly, 5, 485-521.

Viguers, R. T. "The Politics of Power in a Hospital." Modern Hospital, 96, 89-94.

Waldo, D. "Organizational Theory: An Elephantine Problem." Public Administration Review, XXI, 210-225.

Winick, C. "Hospitals as a Social System." New York Society of Nurses, 26, 9-11.