PART I
The Setting

CHAPTER 1

The Evolving Supervisory Role

Nothing in progression can rest on its original plan. We might as well think of rocking a grown man in the cradle of an infant.

— **Edmund Burke**

CHAPTER OBJECTIVES

- Identify the dimensions in which the healthcare manager's work environment is changing most significantly and develop an awareness of the major factors contributing to the evolution of the supervisory role.
- Review the principal paradigm shifts that are contributing to major change in the management and delivery of health care.
- Review the changes in the managerial role that have occurred in recent years and suggest how future changes may affect managers' work.
- Highlight the importance of flexibility and adaptability as significant determinants of managerial success.
- Examine management in health care and "industry" for similarities and differences.
- Provide criteria for describing or "typing" organizations according to functional differences rather than by product or service.
- Identify several key departmental characteristics that serve as determinants of individual "management style."

KEY TERMS

- Flattened organization—a term describing organizational structure following the removal of layers of management.
- Paradigm shift—a major conceptual or methodological change in the theory or practice of a particular science or discipline; a change in your world as you believed it to be.
- Reengineering—the systematic redesign of a business's core processes, starting with desired outcomes and establishing the most efficient possible processes to achieve those outcomes.

▶ For Consideration: Reinventing the Healthcare Organization

You work for a healthcare organization or are at least somewhat familiar with how some healthcare providers work. Assume also that your organization is a community hospital and that you have been asked to participate in an activity intended to produce suggestions for redesigning the ways in which your hospital delivers care. For your purposes consider the desired outcome of the hospital's processes to be the preservation of life and the restoration of health through medical and surgical interventions in both inpatient and outpatient settings.

Instructions

In either words or diagrams, or in combination of both, develop an organizational structure for accomplishing the foregoing objective, designating the functions you believe will have to be performed. You can do this individually, but this activity may be more fruitful when undertaken by small groups (perhaps three or four people). Spend 10 minutes or so identifying functions for your redesigned hospital, and then consider the following three questions as you proceed through this chapter:

1. Did you find yourself using the names of so-called "traditional" hospital activities (emergency, housekeeping, admitting, etc.) to describe the functions of your redesigned hospital? Why might you have done so?
2. Why do you suppose you can experience considerable difficulty trying to envision new ways of achieving a hospital's desired outcomes?
3. Desired outcomes were previously described as including "preservation of life and restoration of health." In what ways might we hear this phrase challenged in describing the apparent purposes of the healthcare system of today?

▶ The (Whirl) Winds of Change

As a working healthcare supervisor, it seems as though you have more work facing you than ever before. Hospital occupancy has been declining steadily but outpatient volume has been increasing on all fronts. You have probably lost some of your more effective employees and have tried to replace them. However, because of periodic hiring freezes and other delays that remain frustratingly beyond your control, your department has been chronically understaffed for months. On your last attempt to obtain approval for replacement hiring you were told that your open positions would most likely be eliminated. As if that were not enough, you just learned that the middle manager you have reported to for several years is leaving and that the position is being eliminated.

Does the foregoing scenario describe your present working circumstances in some respects? Or does it reflect any of what you might have gone through in recent years or that you have reason to believe might await you and your organization just around the corner? If so, you are far from alone. First-line managers, those who supervise the people who do the hands-on work, are caught up in a continuing period of bewildering change that some, whether by choice or involuntarily, will not survive. It is a period during which the supervisor's role is being transformed in ways that most of today's working managers could never have anticipated when they entered the healthcare workforce.

▶ The Broadest Shifting Paradigms: The Only Constant Is Change

As far as the world of work is concerned, the paradigms of the generations of workers who entered the American workforce during the middle decades of the 20th century have come under severe attack and in some instances have crumbled altogether. To these generations, specialized higher education or employment in certain kinds of settings were principal requisites of job—and thus income—security.

One message that young people were bombarded with for decades concerned the value of higher education: for a secure job with a good income, get a college education. There is, of course, still much truth in that advice; in the long run, the well-educated fare better than those who are not as well educated. However, in recent years it has become apparent that a college education is not nearly as effective as it once was in ensuring employment that is both well paid and stable.

For a while it was also a widely held belief that securing a job with a large corporation would usually lead to employment security. For years it was assumed that getting a job with one of the major manufacturing firms could secure one's income for 20 or 30 or more years and lead to a reasonable retirement. This was true for many who entered the manufacturing workforce as early as the middle to late 1930s or during or shortly after World War II. A significant number of these people put in 30 or so years and retired comfortably during a time when all were being encouraged to aspire to retirement at younger and younger ages. Many retired by age 60, and those who followed were primed to expect the retirement age to drop to 55 in time for them to take advantage of it.

Take a close look at the overall status of college graduates in today's job market, and look as well at the numbers indicating how far employment has fallen in manufacturing.

With the exception of those trained in certain occupational and professional specialties, many college graduates have been out beating the bushes for employment rather than being recruited on campuses as they were in earlier decades. A great many of the people presently seeking jobs in manufacturing count themselves lucky to find steady work—"steady" meaning that it might last a few years—and are overjoyed should they also be able to obtain benefits such as health insurance.

In brief, to a generation or two of Americans the control was perceived to be in the hands of the individual: Get into a good company, follow the rules and be loyal, and you were set for life. However, the paradigms of these past generations have crumbled significantly. Products and even entire technologies come and go, companies come and go, and when economics and the need for survival prevail, the rules mean less than they once meant; loyalty, both personal and organizational, comes in a far second to the bottom line.

▶ Organizational Priority Number One: The Bottom Line

It is a common contention of many healthcare workers today that top management cares only about the bottom line. The critics point accusingly at even the most prestigious of the not-for-profit, supposedly humanely motivated, healthcare organizations and charge that patient care has taken a back seat to financial viability. They also can and do point at the government and other major third-party payers and accuse them of compromising healthcare quality by cutting back on reimbursements and by applying other pressures to reduce costs. Changes in many organizations have prompted some to claim that the concern for money has grown all out of proportion to concern for the public's health.

There is really no question that healthcare costs, the growth of which has at times far outpaced so-called normal inflation, need to be brought under control. As a solution, however, outright resistance to all cost-control pressure is neither practical nor sustainable. For long-run viability a healthcare organization—or for that matter, any business organization—must balance bottom-line concerns with human concerns. An organization that pays no heed to fiscal concerns will not survive long. An organization that focuses mostly on the bottom line may last longer, but a constant, all-fiscal focus leads to morale problems, increased turnover, and decreasing productivity, all of which can take the organization toward failure as business goes to others. Failure via this route is more gradual but fully as certain. Without balance between financial and human concerns, any organization is headed for problems.

Mergers, acquisitions, affiliations, and other combinations have frequently created an organizational distance in which layers of structure separate profitability issues from people concerns. This condition ensures that some of the more exploitative employers will exercise the upper hand in work relationships. The management attitude frequently suggests that if you are unhappy with the way the place is being run, there are others out there willing to do your job. This exclusive bottom-line focus uses up people.

▶ Then Came Reengineering

In many organizations "reengineering" is misunderstood. Other labels such as "repositioning," "downsizing," "rightsizing," or simply "reorganizing" are thrown around as synonymous with reengineering. True reengineering, however, includes much more than appears in these other-named processes. Reengineering may be defined as *the systematic redesign of a business's core processes, starting with desired outcomes and establishing the most efficient possible processes to achieve those outcomes.*

There has been much talk of reengineering, and there have been a considerable number of exercises that have borne that label. Many of these, however, have been little more than cursory exercises in reorganizing as a few functions are combined or some are eliminated, and a number of positions are done away with. In some instances, there are actual layoffs; in others, sufficient planning and thought have gone into the process to allow the decision makers to manage normal attrition over a period of time and thereby reduce the workforce without involuntary separations. In either case, however, it sometimes appears as though the only constant in all such efforts is inevitable reduction of the workforce.

True reengineering, beginning with a clear focus on the desired outcome and working backward to determine how best to achieve that outcome, consumes large amounts of time and energy. It also frequently requires considerable amounts of money in the form of consultant costs and other expenses. But more often than not it is embarked upon when financial circumstances are poor and there is an anxiously perceived need to do something quickly to stave off disaster.

As numerous management consultants have discovered, rarely has there arisen a need that makes outside consultants' services as valuable as does reengineering. It is not, however, any special wisdom or experience that makes the outsider important in reengineering. Rather, it is perspective; the outsider can see what the insider cannot see. The person inside of the organization is hampered by the internal perspective and is frequently unable to see much beyond the processes of which he or she is an integral part and in which he or she has a significant personal stake that can be as basic as continued employment.

There is also a lurking dread in the supervisor's knowledge that "reengineering is

coming." This is the fear that one's own position is going to be eliminated, a fear often borne out as reengineering proceeds. Can one expect a supervisor to plunge willingly into a reengineering effort when it might mean the loss of his or her job? How many people will honestly and enthusiastically work themselves out of their jobs?

Faced with the reality of reengineering, today's healthcare managers are hampered in three significant dimensions: (1) they are at risk in the process, and this manifests itself as fear and uncertainty; (2) they are internal to the organization and cannot step back and objectively view what so intimately involves them; and (3) they are affected far more than they might ever be able to acknowledge by some long-held paradigms that are presently under concentrated—and largely successful—attack.

▶ Can We "Reinvent" the Hospital?

What you have been encouraged to recognize and to think about in "For Consideration: Reinventing the Healthcare Organization" is the difficulty involved in true reengineering. Most who ponder this exercise will discover that they cannot avoid using names of a number of so-called traditional activities to describe the redesigned organization. Although true reengineering calls on us to begin with the desired outcome and find the apparently most efficient path to that outcome, we are swayed by our familiarity with the path that already exists. It is as though our present knowledge and understanding form walls around us—walls we cannot readily see beyond. We are virtually in a box, giving rise to the often-heard admonition of the need to "think outside of the box." Yet thinking outside the box can be difficult because we so often fall victim to the implicit assumption that "the box" represents the limits of our world. We do not readily see

a new path to our desired outcome because of the existence of the path already used.

Certainly the "preservation of life and restoration of health" may presently be challenged in a number of ways. Although it must remain a primary outcome of the system as a whole and of most individual organizations, it is seen by some as secondary to, or at best equivalent to, a financial purpose that may be as basic as organizational survival. Like it or not, finances are a major driving force in health care. There are those who will say, not completely without justification, that patient care concerns are secondary to financial considerations, and this feeling will prevail as long as limits exist on resources available for health care. For-profit healthcare providers cannot be expected to provide care if there is no profit in doing so, and even not-for-profit providers, comprising the majority of hospitals and a significant percentage of long-term-care facilities, need to stay financially solvent to continue serving their purpose in achieving their desired outcomes.

▶ Healthcare Paradigms and Their Effects

In terms of how an individual handles incoming information, as a set of rules or beliefs or expectations a paradigm can be both a clarifier and an obstacle. Incoming information that fits within our paradigms is seen clearly because it confirms our expectations. Information that is inconsistent with our paradigms, however, cannot be seen nearly as readily and, in some instances, can hardly be seen at all. The inconsistencies disturb our equilibrium with our environment, and our reactions include fear, uncertainty, frustration, resistance, and the inability to imagine any good resulting from the pressures we are experiencing.

Today's healthcare managers are caught up in some dramatic paradigm shifts. Consider

just a few of the long-held beliefs that are crumbling under present-day pressures:

- The acute care hospital will always be the heart of the healthcare system (clearly no longer true).
- The way we presently deliver care is the best, most cost-effective way available (only to those who cannot see another way).
- We work in an essential industry; times might get tough, but we will never be allowed to disappear (tell that to the former employees of all the hospitals that have merged, downsized, or closed).
- All people have a right to the latest and best that medicine has to offer (contradicted by the steady increase in the rationing of services forced by economics).
- Free choice must always prevail, so managed care—health maintenance organizations and such—can go only so far (contradicted by the growth of managed care options).
- Physicians will (and should) always control the use of the healthcare system (but they too are being swept along by the same changes affecting everyone else).
- "But we can't reduce cost without adversely affecting quality" is a reflection of what is perhaps the strongest paradigm of all, and certainly it is the one causing the most frustration on the part of persons subject to the pressures of change.

In true reengineering it is necessary to begin with the determination of necessary outcomes and work backward to determine what should be put in place to achieve those outcomes. In any organization—in this respect health care is no different from any other business—the people within its systems are limited in their ability to see the possibilities because their paradigms are products of their individual experiences and beliefs.

In working backward from desired outcomes to appropriate processes, at times it is necessary to force our thinking along different paths, to deliberately turn away from what we know and follow a line of thought that feels wrong and that causes discomfort. Assistance from outside the organization, whether from professional consultants or others, can be helpful in forcing us to get out into the uncomfortable territory where the creative solutions are to be found.

Managers working in health care can best ensure their futures by becoming paradigm breakers and by refusing to remain committed to the status quo. We have heard repeatedly that necessity is the mother of invention. Perhaps so at times, although if this were strictly true we would be seeing the world's greatest advances coming out of the areas of most dire need, and this certainly is not happening. Perhaps instead the principal parent of invention, or at least of innovation, is dissatisfaction. Dissatisfaction with the status quo appears to be the strongest force available for breaking out of our paradigms.

▸ The Evolving Role of the Healthcare Manager

Changes in Healthcare Management Lead the Way

One could argue at great length whether management skills in and of themselves are most important in managing in health care or whether one should have a solid grounding in one of the various healthcare disciplines. It is the age-old and generally irresolvable controversy: Who makes the better manager, the functional specialist or the management generalist?

The specialist-versus-generalist argument has probably been more prevalent in health care than in other arenas, although for many years the external view of health care did not especially recognize that conflict. Rather,

much of the external view of health care held that almost anyone could manage there and that the "real" managers managed in "industry," primarily in manufacturing but certainly in the for-profit sector.

Of course there is nothing new about this tendency to look down on other fields as somehow lesser than one's own. Thus, for-profit looks down on not-for-profit; within for-profit, manufacturing looks down on banking, whereas banking looks down on insurance and real estate; within for-profit and not-for-profit, almost everyone looks down on the public sector (government); and so on. What is significant, however, is how past general perceptions of health care as a "lesser" field have led some people to assume an expertise they never possessed. Perhaps because they best remember the days of health care of some decades ago, health care before about 1970 when people of greatly varying backgrounds and qualifications managed healthcare organizations, countless displaced managers with no healthcare expertise whatsoever offered themselves to health care with the attitude that anyone can do it. ("I managed in XYZ Corporation for years, so I'm obviously qualified to manage a hospital or one of its departments.")

The perception external to health care has long tended to lag the internal reality. The years when "industry dropouts" could gravitate to health care's management ranks are decades past. In fact, in recent decades a cycle of sorts has been experienced. Specialized graduate-level training in health administration grew and expanded, which furnished many managers with master's degrees who were trained specifically for health organizations. Such programs proliferated to a point where colleges were turning out many more master's-prepared, would-be managers than the system could absorb. Yet healthcare organizations continue to receive applications from new master's degree holders who are attempting to enter at general administrative levels but are finding that opportunities

are dwindling while the competition is intensifying; they find themselves competing with an increasing number of experienced—and unemployed—healthcare managers.

For the foreseeable future, the best preparation and background for the new manager within health care will include training and experience in one of the various healthcare specialties, or at least in one of the few nonhealth specialties regularly applied within health organizations (e.g., finance) plus graduate-level education in health administration. The days when a newly graduated master of hospital administration (MHA) could count on entering directly into an administrative position are largely gone. Rather, one should expect to spend some time in the ranks and in management at the department level. Because of the current healthcare climate and the dramatically increased competition for administrative positions, a pure health administration education (without benefit of prior, specialized education and experience) is no longer as valuable as it once was.

The Flattened Organization

Today's healthcare managers are working in a period in which one of the most prominent indicators of change is the elimination of layers of management in their organizations. This reduction can be difficult for many to deal with because it is a change that occurs abruptly when compared with the growth of the condition it is correcting.

The management hierarchy usually develops gradually over a period of time. This growth always occurs for what are apparently good reasons: in times of success or at least financial stability, top managers react to what seem to be valid needs and positions are created to serve certain purposes. Each position created becomes interrelated and, to some extent, interdependent with others in the hierarchy. Some tasks accrue to the new position from other positions in the hierarchy; some develop solely as functions of the new position.

There is always some useful purpose served by a newly created management position. However, the process of establishing multiple layers of management has some negative and sometimes extremely damaging effects. The multiple layers breed duplication of effort as the same problems and issues are addressed at succeeding levels. Responsibility is diluted and diffused as additional levels become involved. Communication needs—not to mention the potential for communication breakdowns—expand and intensify as levels proliferate.

The presence of multiple levels of management tends to push decision making up the chain of command. This is in direct contradiction with one of the tenets of total quality management (TQM) and with today's prevailing management belief in general that decisions are most effectively made at the lowest possible organizational level. The manager who makes few real decisions because of the presence of two or three higher levels of management can hardly be described as capable of feeling ownership of the job.

For years many healthcare managers had the benefit of job titles and position perks without having to worry a great deal about accountability. They simply "played supervisor" to the extent that they were visible members of management who could count on their superiors to relieve them of the responsibility of making difficult decisions or dealing with troublesome issues. Now, however, this condition is changing. First-line managers are assuming—and will continue to assume—increased responsibility as layers of management are removed and the organization is flattened (a term that is best appreciated when one views organization charts of the same structure in "before" and "after" circumstances).

A frequent victim of reorganization is the middle manager, the occupant of that intervening layer of management between the supervisor and the top. In reengineering or reorganizing, middle managers sometimes disappear from the organization as their positions are eliminated. Sometimes they remain within the structure but at a lower level, becoming first-line managers.

Middle management might have multiple layers. For example, consider the nursing department run by a vice president, four directors, two dozen nurse managers (head nurses), and a number of assistant nurse managers, not to mention staff who, on occasion, are assigned as charge nurses. Or middle management might be a single layer, as in the case of the billing supervisor (first-line) reporting to the business office manager (middle) who in turn reports to the director of finance.

Middle management is frequently the last level to be created in the hierarchy, evolving from apparent necessity as the spans of supervisory control broaden to seemingly intolerable dimensions. As middle-management positions are cut, a few duties flow upward, but the bulk of what remains—that is, the essential part of what remains—flows downward to the first-line managers. At first, it would seem that the span of first-line control is again increasing as middle management thins out, but what is primarily happening today—or at least should be happening in organizations that have reengineered sensibly—is that the properly empowered supervisors (always considering the term supervisor as synonymous with first-line manager) are empowering their employees and spreading authority and responsibility across the work group.

In any case, a flatter organization means a broader scope of responsibility for the individual supervisor and often also means more employees to manage.

Some Constants to Hang On To

Although this discussion deals primarily with ways in which the supervisory role is changing, it is necessary to point out some fundamentals that should never change in the relationship between supervisor and employees.

Visibility and Availability

It will always be important for the supervisor to be visible and available to the employees of the department. The people doing the hands-on work need to be able to get to the supervisor in a reasonable length of time when questions arise or advice is needed. Even in the absence of immediate problems or needs, workers take some comfort in knowing that the supervisor is readily accessible. Employees need to know that their primary source of job guidance and organizational communication is available when needed and not forever attending meetings or visiting other departments.

Vertical Orientation

Closely related to visibility and availability is the matter of the manager's vertical orientation within the organization: Does this person face upward or face downward? The temptations to face upward, that is, to orient oneself in the direction from which recognition and rewards are perceived as coming, are numerous. However, the upward-facing supervisor is likely to be perceived as aloof and unapproachable. It is the downward-facing supervisor, the one who identifies with the work team and behaves as part of the team, who will be most successful in moving the group in productive directions.

A True Open Door

The supervisor must be a practitioner of a true open-door policy. We know that there hardly exists a manager at any level who has not said, "My door is always open." This is, however, more readily said than accomplished. The open door is largely an attitude, once again related to visibility and availability. Too often the door may be physically open but the supervisor's attitude suggests that one had better make an appointment before approaching. The supervisor who is not readily reachable by direct-reporting staff for at least a few minutes now and then is sending a message of self-importance, saying through behavior that he or she is more important than the staff.

Team Membership

The supervisor should accept a role as a key team member and resist the temptation to behave as though he or she is the most important person in the group. Terms that accurately describe the effective first-line supervisor include the likes of "coach" and "counselor." In fact, the term coach suggests a strong similarity between the coach-and-team relationship and the supervisor-and-group relationship. A team can play without a coach; it would likely play raggedly and without unified purpose or direction, but it can nevertheless play. But a coach cannot coach without a team. Thus a team without a coach is still a team, but a coach without a team is without a job. Similarly, a counselor with no one to counsel is unneeded.

Value

If the supervisor is no more important overall than the team members as far as performing work and serving customers or patients are concerned, then why is this person paid more than the employees are paid? The answer to this lies in the amount of *responsibility* borne. Regardless of how far staff empowerment progresses and how much decision making is done in the ranks, the person who directly supervises the staff remains responsible for what is done and for instructing, coaching, and leading the staff in getting it done. A leader should never set himself or herself above the employees except in one critical dimension—the bearing of responsibility.

Self-Motivation and the First-Line Supervisor

Because of the ways in which the supervisory role is changing and because of the dramatic changes in health care that are causing the alteration of that role, the individual is caught in a classic motivational crunch. Many hospitals are cutting back their staffs and thinning out the ranks of management. Attendant to

this, employee morale is worsening in some places; this is bound to occur during times of heightened uncertainty. This contributes to declining productivity; employees can hardly be expected to give their undivided attention to high-quality output at a time when they fear for their employment. All of this—declining morale and decreasing productivity—tends to occur at precisely the time when productivity should be expected to increase for the sake of organizational survival.

The supervisor occupies a difficult place in today's healthcare organization because he or she is susceptible to the same negative pressures on morale as the nonsupervisory staff. Yet he or she is expected to be sufficiently self-motivated to help lift the employees' level of motivation. As a key team member and the one most responsible for the output of the group, the supervisor can have a significant effect on the group's outlook and effort. It is important that the supervisor do everything possible to be "up" when the group members are "down." This leader must be a cheerleader at a time when the employees might feel there is nothing to cheer about.

Surely this seems like one is expected to put up a false front for the employees. Why, one might ask, should the supervisor not feel the same frustration and lack of confidence in the future that the employees feel? Simply stated, trying to be optimistic is necessary for all concerned: If the supervisor's behavior reflects only the doom and gloom the staff members feel, you can guarantee that this will adversely affect employees' behavior.

Morale and motivation are, of course, complex considerations that at any time can depend on a variety of factors. It is fairly safe to say, however, that the attitude and approach of the leader can have significant effects on the attitude and approach of the group. It is part of the leader's overall responsibility to recognize that the group can be influenced in either positive or negative directions by the attitude brought to the job every day. This is easily said, but not so easily accomplished. You can readily say, "Cheer up!" but if you are gloomy it is no easy task to force a reversal of your mood. So much of what is related to the supervisor's ability to self-motivate will depend on that individual's personal relationship with the elements of the job. If you genuinely like the work, and if you can find satisfaction and fulfillment in the tasks you must perform, then you have a running start on successfully motivating yourself and serving as a positive example for the group members. However, when someone has been lured into the role of supervisor primarily by title, status, pay, and perks, in all probability this person will not rise to the challenges of the shrinking organization and the flattening management structure.

Some Honest Empowerment

In management circles and in the literature there is always a great deal of attention paid to the "flavor of the month." Since the TQM movement arose, one of the principal "in" terms has been "empowerment." In all that we do concerning reengineering and total quality management—somewhat curiously, because these are concepts that frequently work against each other—we speak of appropriately empowering employees.

In terms of a supervisor empowering employees, empowerment is no more than that old standby delegation—but delegation *performed properly*. The problem has been that most of what we have called delegation was not delegation performed properly, so delegation as both a term and an observed management practice has acquired a tarnish that no amount of polishing can remove. However, it is pointless to engage in controversy over what such a term might mean. What is important is that any group's leader must truly be empowering in relationships with employees by delegating properly to the fullest extent of his or her capacities.

In these days when management structures are becoming leaner, empowerment is essential. Empowerment stands as the only

practical way to expand and extend the leader's effectiveness and to pursue the constant improvement that is expected in the present environment. When it comes to seriously improving the ways the group's work is accomplished, empowerment acknowledges the fact that no one knows the details of the work better than the people who perform it every day. The leader needs all the help that can be gotten from the group because chances are the group will be larger than in the past. Leaner management structures will mean more employees within a supervisor's scope of responsibility, thereby automatically increasing the potential for employee problems and expanding the supervisor's involvement in personnel management issues. More time on such matters means less time to devote to other concerns.

New concerns and involvements are arising. In the emerging environment, the supervisor may be called on to undertake tasks that were never before part of the role, such as actively participating in a reduction-in-force and actually designating individuals for layoff.

For the most part, first-line supervisors have traditionally been seen as doers, the working leaders of groups of people whose concentration is on getting today's tasks accomplished. In the leaner, flatter organization, especially the organization that has eliminated middle-management positions, the first-line supervisor will take on much more of a planning role than previously experienced. This provides even more reason for the supervisor truly to be empowering staff: while the employees look after today, the leader will spend more time preparing for tomorrow.

▶ Job Security in the New Environment

As pointed out earlier in this chapter, the old paradigms of job security involved education, loyalty, and stability. These paradigms have

shifted; education does not guarantee employment, loyalty has lost its meaning in terms of organizational attachment, and it is impossible to pursue a stable career and employment relationship when entire technologies and occupations can come and go within a few years and organizations can vanish almost overnight.

In today's steadily changing environment, it is the expansion of personal capabilities that will provide the most likely path to relative job security. Job security—at best a relative commodity, if it exists at all in any absolute sense—no longer lies in constancy and predictability. Rather, job security today lies in one's flexibility and adaptability. The manager who can continually learn and grow and change is most likely to survive to work in the new environment.

It has been said repeatedly that the primary thrust of TQM involves the determination to always do the right things and always do them right the first time. This is a highly appropriate belief for both the individual and corporate entity. After all, whether for an individual or an organization, the best security for continuing success lies in performance.

▶ Health Care Versus "Industry"

The Controversy

Consider the opposing sides of a very old argument:

> It doesn't matter how well it worked in a factory, it won't work here—this is a hospital (or nursing home, urgent care center, or whatever).
> versus
> Good management is good management no matter where it's practiced. What worked elsewhere will work in a healthcare organization as well.

Because this chapter addresses management in the healthcare organization, it would seem sensible to decide first which side of this frequently encountered argument, if either, is the determining consideration and should thus govern the approach to supervising people in the healthcare environment. Should we focus on management and in doing so agree that "good management is good management no matter where it's practiced," or should we give the most weight to the environment, agreeing that health care is sufficiently different to warrant a completely different approach to management?

Healthcare managers are often divided on the fundamental issue of process versus setting. Listen carefully to the comments you are likely to hear regarding the introduction of certain techniques into the healthcare organization by people in fields other than health care. Often all organizational considerations are split into two distinct categories, which are then assumed to be inconsistent with each other. These considerations can be condensed to health care versus "industry," with the latter category including manufacturing, commercial, financial, retail, and all other organizations not specifically devoted to the delivery of health care. Further, in this simplistic comparison, "industry" frequently becomes something of a dirty word. ("After all, *we* deal in human life.")

The Nature of the Healthcare Organization

It is not at all surprising that the process-versus-setting argument exists when one considers the evolution and character of the healthcare organization. The function of the hospital as we know it today is largely a product of the 20th century. Many of the healthcare institutions in existence before, say, 1900 or thereabouts, provided only custodial care; they were places where the sick, usually the poor and the disadvantaged, were housed and cared for until they died. Physicians practiced very little in hospitals, and most persons fortunate enough to be able to afford proper care were tended to at home or in private clinics.

In the hospital of the past there was but one medical profession: nursing. The mission of the organization was nursing care, and essentially the only management was the management of nursing care. Also, most healthcare institutions were charitable organizations operated by churches or social welfare groups, and little thought was given to operating a healthcare institution "like a business."

The modern healthcare organization is vastly different from its counterpart of a century or more ago. What used to be the major purpose of a hospital—maintaining sick people in some degree of comfort until they died—is now the primary mission of only a relatively few healthcare organizations created for the care of the terminally ill (e.g., hospices and certain other specialized institutions). The role of the hospital evolved into that of an organization dedicated to restoring health and preserving life with an increasing emphasis on the prevention of illness.

The hospital of the past had a unique mission that it fulfilled in a simple, one-dimensional manner that had no parallel in other kinds of organizations. The only similarity to the activities of other organizations was the direct supervision of the nurses who delivered care: the basic process of getting work done through people. However, the modern healthcare organization is far from one dimensional. There are many functions to be performed, and numerous complex and sophisticated specialized skills are involved. Also, a number of "business" functions, not specifically part of health care but which are critical to the delivery of health care, are present in the healthcare organization. We find that in many respects the healthcare organization of today very much resembles a business. In fact, in recent years the proliferation and growth of for-profit hospital corporations, health maintenance organizations, and other healthcare

chains demonstrate that health care is indeed a business—and one of significant proportions.

The Dividing Lines

It should initially be conceded that many healthcare organizations are coming to more closely resemble business organizations of other kinds. This is evident in two dimensions: marketing and competition. In the not-too-distant past, marketing and even modest advertising were virtually unheard of in health care—at least in the not-for-profit arena (the largest healthcare provider component). Now, however, health care, up to and including the services of high-level professionals, is advertised and marketed like any other product or service. This activity, of course, relates to the intensifying levels of competition that are evident in health care as provider organizations vie with each other for a share of the market.

However, even the growth of competition and marketing does not essentially make management in health care appreciably different from what it has long been. The traditional views—from inside health care looking out or outside health care looking in—have not changed. Those inside of health care are more likely to claim uniqueness of management; those outside of health care are more likely to cite universality of management.

The argument of health care versus industry is frequently organized along functional lines, with the healthcare professional leaning toward the uniqueness of the field and the so-called outsider inclining toward generic management. Indeed, it may seem natural that polarization of outlook might take place along medical and nonmedical lines.

Many employees in nonmedical activities in health care were originally trained in other kinds of organizations or educated in schools where they were concerned with some general field. These people, essential to the operation of the healthcare institution, include accountants, personnel specialists, building engineers, food service specialists, computer specialists, and others. While acquiring their skills in school and perhaps later practicing them in other settings, these individuals may have no idea of applying these skills in health care until they have an opportunity to do so. They see their functions as cutting horizontally across organizational lines and applying to health care, manufacturing, or any other field.

Healthcare professionals, however, come into their fields by somewhat different routes and with different goals in mind. A healthcare discipline will ordinarily be pursued with the intention of applying that discipline in a healthcare setting; for instance, a student of nursing will become a working nurse. However, a student who pursues accounting may do so with no idea that he or she eventually may be applying this skill in a healthcare organization.

Part of the process-versus-setting argument seems to stem from the background and experience of medical and nonmedical personnel as well as the horizontal-versus-vertical view of organizations. Nonmedical employees may have applied their education and training in other lines of work before entering health care; this reinforces the horizontal view of organizations and encourages the belief that basic skills are transportable across industry lines. However, the healthcare professional's education and training lie almost exclusively in the healthcare setting, and most healthcare professionals who work in other kinds of organizations usually do so in entirely different capacities. Consider, for instance, the person who leaves a job as a bank teller to go to nursing school and eventually takes a position in a hospital. The path followed into nursing and eventually to the hospital strongly reinforces a vertical view of organizations because the skills involved are specific to that kind of organization and are not readily transportable across industry lines.

Certainly there are some fundamental differences between management in healthcare organizations and management in other organizations. However, in claiming the existence

of such differences we may perhaps oversimplify the problem and make the mistake of attempting to classify organizations according to product, output, or basic activity. There are some important differences found in health care, but these differences are not based simply on the contrast of "health care" with "industry," with health care being set apart because of its uniquely humane mission.

Identifying the Real Differences
A Matter of Need

Organizations are created to fill certain needs. Business organizations of all kinds—including healthcare organizations—continue to exist because they provide something that people want or need. Hospitals exist because people need acute care, and nursing homes exist because of the need for long-term health care. In the same manner, food wholesalers and grocery stores exist because people need food.

It should follow that if a set of human needs can be fulfilled in a number of different ways, the organizations that do the best job of responding to those needs will be the ones most likely to continue to exist. It has long been true in manufacturing and in retailing, where competition is ordinarily keen, that the organization that can meet customers' needs with the best products at the most attractive prices will stand the best chance of success. Now that competition in health care is largely a fact of business life, healthcare providers are vying with each other to serve the same customers. This suggests that in one critical respect all business organizations are alike: to continue to exist, they must meet people's needs.

"Typing" Organizations

The basic error in considering healthcare organizations as different is the classification of organizations by mentally assigning them to categories based on what they do such as

health care, manufacturing, retail, commercial, financial, and so on. Such classification is simply not sufficient to allow one to judge the applicability of supervisory practices across organizational lines. Rather, we need to examine organizations for the degree to which certain kinds of activities are present.

Disregard organizational labels and look at the processes applied within organizations and the kinds of activities required to manage these processes. Look not at what business we do, but rather look at how we do business.

Two Theoretical Extremes

In one of the timeless classics of management literature, *New Patterns of Management*, Rensis Likert developed a view of organizations based on how they do the things they do.[1] He expressed much of his work in the form of a "scale of organizations" running from one extreme type to another.

At one end of Likert's scale is the *job organization system*. This system evolved in and applies to industries in which repetitive work is dominant, such as manufacturing industries complete with conveyor belts, assembly lines, and automatic and semiautomatic processes. This system is characterized by an advanced and detailed approach to management. Jobs lend themselves to a high degree of organization, and the entire system can be controlled fairly closely. If you are involved in assembly line manufacturing, it is possible for you to break down most activity into specifically described jobs and define these jobs in great detail. You can schedule output, deciding to make so many units per day and gearing the input speed of all your resources accordingly. A great amount of structure and control is possible. All this calls for a certain style of management, a style suited to the circumstances.

At the other end of Likert's scale is the *cooperative motivation system*. This approach evolved in work environments where variable work dominates most organizational activity.

Management itself is considerably less refined in this system. Jobs are not readily definable in detail, and specific controls over organizational activity are not possible to any great extent. For instance, in a hospital, although we can make reasonable estimates based on experience, it remains difficult to schedule output. Within the cooperative motivation system there is much less opportunity for close control than there is in the job organization system.

What makes these differing organizational systems work? Likert contends that the job organization system depends largely on economic motives to keep the wheels turning. That is, everything is so controlled that the only remaining requirement is for people to perform the prescribed steps. Therefore, what keeps the wheels turning are the people who show up for work primarily because they are paid to do so. These people are not expected to exhibit a great deal of judgment; they need only follow instructions.

In the cooperative motivation system, however, there are no rigid controls on activities. Jobs cannot be defined down to the last detail, activities and outputs cannot be accurately predicted or scheduled, and the nature of the work coming into the system cannot be depended upon to conform to a formula. In the cooperative motivation system it is not sufficient that employees simply show up because they are being paid. This system depends to a much larger extent on individual enthusiasm and motivation to keep the wheels turning.

Examined in their extremes, therefore, the job organization system and the cooperative motivation system are seen to differ in several important ways. The most important difference, however, lies in the role of the human element—the parts that people play in each system. Under the conditions of the job organization system, the system controls the people and essentially drags them along; under the cooperative motivation system, however, the people control the system and keep it moving. A summary comparison of the job organization system and the cooperative motivation system appears in **EXHIBIT 1-1**.

Regardless of an organization's unit of output—whether automobiles, toasters, or patients—one must look at the amount of structure that is both required and possible and at the variability of the work itself. There are few, if any, pure organizational types. As

EXHIBIT 1-1 Comparison of the Job Organization System and the Cooperative Motivation System

Job Organization System		Cooperative Motivation System
Repetitive tasks	Nature of work	Varied and variable tasks
Advanced, predictable	Management system	Loose, unpredictable
Well organized	Job structure	Loosely organized
Rigid or strict control	System controls	Open; tight control not possible
Economic motives	System drivers	Enthusiasm and motivation

already suggested, an example of a pure job organization system would be the automated manufacturing plant in which every employee is a servant of a mechanized assembly line. At the other end of the scale, an example of the cooperative motivation system at work would be the jack-of-all-trades, odd-job service in which any type of task may come up at any time. Within health care, the office of a physician in general practice may be very much a cooperative motivation system, with patients of widely varying needs entering the system in unpredictable order.

The Real World: Parts of Both Systems

Most organizations possess elements of both the job organization system and the cooperative motivation system. For instance, the automated manufacturing plant could have a research and development department describable by the elements of the cooperative motivation system.

The organization of the modern healthcare institution leans considerably toward the cooperative motivation system. There are, however, internal exceptions and differences related to size and degree of structure. A small hospital, for instance, may be very much the cooperative motivation system. A large hospital will include some departments structured along job organization system lines. For example, the housekeeping function of a hospital is highly procedural—there is a specific method prescribed for cleaning a room, and the same people repeat the same pattern room after room, day after day. Food service in a large healthcare institution usually includes conveyor belt tray assembly, the principles of which are essentially the same as those for product assembly lines in manufacturing. A large hospital laundry will include repetitive tasks that are highly procedural, and repetitive functions may be found as well in some business offices, clinical laboratories, and other functions directly supporting the delivery of health care.

Management Style and the Setting

A given technique borrowed from the non-healthcare environment may not apply in health care at all. If this is the case, however, it is not because "this is health care," but rather because of the effects of variability, controllability, and structure.

The concept of Likert's job organization system tends considerably toward production-centered management; the essential interest lies in getting the work done, and the people who do the work are more or less swept along with the system. This system is rigid, and the people who keep the system going need only show up for work. On the other hand, the concept of the cooperative motivation system suggests people-centered management. People are needed to do the work, and more is required of them than simply showing up. They have to take initiative, perhaps make individual decisions and render judgments, and in general must accept a measure of responsibility for keeping the system moving.

It is perhaps unfortunate that businesses that evolved along the lines of the job organization system sometimes tend to overemphasize production while paying less attention to people. Under the cooperative motivation system, however, it is not so easy to ignore people, even by default, because the organization may function poorly or, in the extreme, not function at all if people are not cooperative.

Decision making can be vastly different in the job organization system as opposed to the cooperative motivation system. In the former, it is more likely to be procedural, with many decisions being made "by the book." In the latter, specific procedures often do not exist (and cannot exist because of the variability of the work), so it becomes necessary to rely heavily on individual judgment.

▶ Where Does Your Department Fit?

Decide for yourself what kind of department you work in. Does it look like a job organization system or does it approach the cooperative motivation system? How your department measures up in terms of certain essential characteristics will have a strong influence on the style of supervision necessary to assure proper functioning. Examine the following characteristics:

■ *Variability of work.* The more the work is varied in terms of the different tasks to be encountered, the length of time they take, and the procedures by which they are performed, then the more difficult it is to schedule and control. Tasks that are unvarying and repetitive require supervisory emphasis on scheduling inputs and resources; work that is variable requires supervisory emphasis on guiding the activities of the people who do the work.

■ *Mobility of employees.* If all of a department's employees work in the same limited area and usually remain within the supervisor's sight, the supervisor need not be concerned with certain control activities. However, as employees become more mobile and move about in larger areas, there is a need for the supervisor to pay more attention to people who are out of sight much of the time.

■ *Degree of professionalism.* There can be a vast difference in supervisory style depending on whether the majority of employees supervised are unskilled, semiskilled, or skilled. Many departments in a healthcare institution are staffed with educated professionals who are able, and expected, to exercise independent judgment. Managing the activities of professionals is considerably different from managing the activities of unskilled workers whose primary responsibility lies in following specific instructions.

■ *Definability of tasks.* The more structure possible in work roles, the more rigid the style of supervision may be. For instance, the job of a sorter in a large laundry may be defined in every last detail in a few specific steps on a job description. Because the job is completely definable, the supervisor need only ensure that a well-trained worker is assigned and then follow up to see that the work is accomplished. However, as any nursing supervisor who has attempted to write a job description for a staff nurse is aware, because of task variability, the need for independent judgment, and other factors, the job description for the nurse is not written nearly as easily as that of the laundry sorter. The job of the staff nurse is considerably less definable, so there is likely to be more need for the supervisor to provide case-by-case guidance when necessary and also more need to rely on the individual professional's independent judgment.

In general, the organization of the modern healthcare facility leans well toward Likert's cooperative motivation system, because the activity of a healthcare organization is mostly variable and centered around people. However, elements of the job organization system must be recognized as being present. This suggests that within any particular institution there may be the need for different supervisory approaches according to the nature of the functions being supervised.

▶ A Word About Quality

There is always room in a discussion such as this for consideration of quality. Considering again the belief that all organizations exist to serve people's needs, it follows that quality should always be a primary consideration regardless of the form of the organization's output. Businesses basically organized along

the lines of the job organization system tend to have frequent built-in quality checks at points in the process. As many manufacturers have discovered, however, quality must be built into a product—it cannot be inspected into it.

Organizations tending toward the cooperative motivation system also have their quality checks, but these are less numerous and less specific. In the kind of organization that relies heavily on individual enthusiasm and motivation, there is considerably more reliance on the individual employee to produce acceptable quality.

▸ To Embark on a Successful Supervisory Career[2]

Do not be misled by what you might see as differences between types of organizations. Healthcare organizations are indeed unique in terms of the output they produce, but they are not necessarily unique in terms of the management processes employed. Your approach should be determined not by the fact that "this is a hospital, not a factory" but rather by the kinds of employees you supervise and the nature of their job responsibilities.

To provide yourself with the best possible chance of succeeding as a supervisor in a healthcare organization:

- Know all of the requirements of your job description; overall, know what is expected of you.
- Hold regular one-on-one meetings with all of your employees. Although you will have group meetings individual employees deserve your undivided attention from time to time—not just when criticism is necessary.
- Build relationships with peers and others; establish a personal network.
- As you accrue experience, learn to trust your intuition.

- Be available to help others; become an effective listener.
- Maintain high ethical and moral standards, always mindful that you are (whether you wish it so or not) a role model for employees.
- Know your limitations; be willing to ask questions and ask for help when needed.
- Become active in professional organizations serving your field.
- Be active in self-education; the supervisor who does not continue to learn will steadily fall behind.
- Identify good performance, and acknowledge and reward it.
- Remain calm under stress.
- Display self-confidence at all times.
- Keep all of you relationships free from favoritism and discrimination.
- Defend your employees from unwelcome or unwarranted criticism or intrusion.
- Be courageous; be willing to make unpopular decisions when necessary and see them through.

Questions for Review and Discussion

1. How does true "reengineering" differ from "reorganizing," "downsizing," and other concepts of organizational restructuring?
2. What is the significance of a supervisor's visibility and availability?
3. What is meant by the claim that job security now resides in flexibility, adaptability, and performance?
4. What are the forces encouraging a supervisor to "face upward"?
5. Define "paradigm."
6. How do you believe "empowerment" is differentiated from "delegation," if at all?
7. Why has "marketing" become so prominent in health care today?

8. In reengineering, what is the primary purpose of working backward from desired outcomes to establish new processes?

9. What is the impact of employee mobility on supervisory style?

10. What primarily keeps the organization working toward its goals within Likert's Job Organization System?

11. Why may supervisory style vary with the degree of professionalism present in the work group?

12. Why does the Cooperative Motivation System depend largely on individual enthusiasm and motivation?

13. How is health care different from manufacturing in immediacy of service to customers?

14. What is the principal difference between Likert's Job Organization System and his Cooperative Motivation System?

15. What is the likely effect of the variability of work on a supervisor's management style?

Exercise: Where Does Your Department Fit?

Take a few minutes to "rate" your department according to the four characteristics discussed in the chapter: (1) variability of work, (2) mobility of employees, (3) degree of professionalism, and (4) definability of tasks. Although this assessment will necessarily be crude, it may nevertheless suggest which end of the "scale of organizations" your department tends toward.

Rate each characteristic on a continuous scale from 0 to 10. The following guides provide the ends and the approximate middle of the scale for each characteristic:

Variability of Work

0 = No variability. Work can be scheduled and output predicted with complete accuracy.

5 = Average condition. Workload predictability is reasonable. Advance task schedules remain at least 50% valid.

10 = Each task is different from all others. Workload is unpredictable, and task scheduling is not possible.

Mobility of Employees

0 = No mobility. All employees remain in sight in the same physical area during all hours of work.

5 = Average condition. Most employees work within or near the same general area or can be located within minutes.

10 = Full mobility. All employees continually move about the facility as part of normal job performance.

Degree of Professionalism

0 = No professionals are employed in the department.

5 = About half of the employees are professionals by virtue of degree, licensure, certification, or some combination of these.

10 = All of the employees are professionals.

Definability of Tasks

0 = All jobs are completely definable in complete job descriptions and written procedures.

5 = Average condition. There is about 50% definability of jobs through job descriptions and procedures.

10 = No specific definability. No task procedures can be provided, and job descriptions must be limited to general statements.

Take the average of your "ratings." This may give you a rough idea of whether your

department leans toward the job organization system (an average below 5) or the cooperative motivation system (an average above 5).

Exercise Question

1. Assuming that your "ratings" of the four characteristics are reasonable indications of the nature of your department, what can you say about your supervisory approach relative to each characteristic?

Suggestion for Additional Activity

Try this exercise with a small group of supervisors (perhaps three or four) who are familiar with your department's operations. Try to arrive at a group rating for each characteristic.

Notes

1. R. Likert, *New Patterns of Management* (New York: McGraw-Hill, 1961).
2. Adapted from C.R. McConnell, *Umiker's Management Skills for the New Health Care Supervisor*, Chapter 1, "Do You Really Want to Be a Supervisor?," pp. 14–15.