Health Care: How is it Different from "Industry"?

The end product of all business is people.
—Rensis Likert

CHAPTER OBJECTIVES

☞ Examine management in health care and in "industry" for similarities and differences.

☞ Provide criteria for describing or "typing" organizations according to genuine differences rather than by product or service.

☞ Identify the various settings in which present-day health care is delivered.

☞ Establish an appropriate overall perspective of the organization of the healthcare institution.

☞ Identify several key departmental characteristics that serve as determinants of individual "management style."

SITUATION: THE CASE OF THE STUBBORN EMPLOYEE, OR, "IT ISN'T IN THE JOB DESCRIPTION"

George Morton, manager of the maintenance department, was experiencing increasing frustration with mechanic Jeff Thompson. Morton considered Thompson a good mechanic, and this opinion was usually reinforced by the consistently high quality of Thompson's preventive maintenance work and by his success in accomplishing difficult repair jobs. Morton's frustration centered about Thompson's apparent lack of motivation. Thompson always had to be told what to do next after completing each job. If he were not so instructed, he would take a prolonged break until Morton sought him out and gave him a specific assignment.

Morton's frustration peaked one day when a small plumbing problem got out of hand and suddenly became a large problem. He knew that Thompson had to have seen the leaking valve because it was right beside the pump that Thompson had been servicing. However, when Morton asked Thompson why he had done nothing about the valve, Thompson said, "Plumbing isn't part of my job."

"You could at least have reported the problem," Morton said.

Thompson shrugged and said, "There's nothing in my job description about reporting anything. I do what I'm paid to do, and I stick to my job description."

"You certainly do," said Morton. "Jeff, you're one of the better mechanics I've seen. But you never extend yourself in any way, never reach out and take care of something without being told."

"I'm not paid to reach out or extend myself. You're the boss, and I do what you tell me to do. And I do it right."

"I know you do it right," Morton agreed. "But I also know that you some-times stretch out the work. I know you're capable of giving a lot more to the job, but for some reason you seem unwilling to work up to your capabilities."

Again Thompson shrugged. "I stick to my job description and do what I'm told."

Instructions

Initially, imagine yourself in George Morton's position and think about how you might wish to address employee Thompson's attitude. Then consider the following questions as elements of appropriate responses are developed throughout this chapter:

1. What are the characteristics of a position like Jeff Thompson's that should influence the group manager's style and approach?
2. Should Morton's management approach focus primarily on the task to be done (production centered) or the person assigned to the task (people centered)?
3. Do you basically agree or disagree with Thompson's literal adherence to his job description? Why?
4. Again imagining yourself in Morton's position, describe one or two ways in which you might go about getting this employee to perform more in line with his capabilities.

PROCESS VERSUS ENVIRONMENT

The Controversy

To begin consideration of the healthcare environment, we briefly examine the opposing sides of an age-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].

<div align="center">versus</div>

> Good management is good management no matter where it's prac-ticed. What worked elsewhere will work in a healthcare organization as well.

Since it is intended for this book to address management in the healthcare organization in some detail, it would seem sensible to decide first which side of this frequently encountered argument, if either, is the determining consid-eration and should thus govern the approach to supervising people in the health care environment. Should we focus on management and thus 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 environment. 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-environment 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 past century. Many of the healthcare institutions of the past century 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 (for example, 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, which 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 is a large variety of functions to be performed, and numerous complex and sophisticated specialized skills are involved. Also, a number of "business" functions, which are 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 which 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 the healthcare environment; 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-environment argument seems to stem from the background and experience of medical and nonmedical personnel as well as the vertical-versus-horizontal 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 environment, and most healthcare professionals who

work in other kinds of organizations 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 best 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 type, that is, by mentally assigning organizations to categories 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 a type he called the job organization system. This system evolved in and applies to industries in which repetitive work is dominant, such as the many 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 system 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 can be seen to differ in several important ways. The most important difference, however, lies in the role of the human element—the part that people play in each kind of 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.

Regardless of an organization's unit of output—whether automobiles, toasters, or patients—we need to 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 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. On the other hand, a large hospital will include some departments organized 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.

HEALTHCARE SETTINGS

Earlier in this chapter it was suggested that at one time there were few healthcare organizations, except for hospitals, that were little more than places where the terminally ill, mostly poor or disadvantaged, were maintained until they died. At that time there were but two or three other kinds of healthcare organizations. There were private clinics—mostly small and usually associated with the practices of one or more physicians and available to persons who could afford to pay for their care. There were institutions known primarily as asylums, publicly or religiously operated, that did little more for the mentally ill and seriously impaired than keep them contained—often in fairly grim circumstances. And there were other organizations, again publicly or religiously operated, whose mission was the housing and supervision of older persons and the infirm. These were usually known as homes of various kinds (rest home, county home, church home, etc.).

Many of the examples used throughout this book are drawn from the hospital setting, but other settings are referred to as well. The modern acute care hospital uses the broadest range of healthcare occupations of any healthcare setting. Hospitals continue to employ the greatest percentage of healthcare workers of most occupations, but this percentage has been shrinking steadily as healthcare workers are able to find employment in a growing number of other settings. In addition to both general and specialty hospitals, largely not-for-profit but some for-profit, privately, governmentally, or religiously operated organizations, we find healthcare workers today employed in the following:

- Long-term care facilities, including nursing homes, and a range of designations generally indicating the levels of care provided or the kinds of populations served
- Rehabilitation facilities, sometimes free-standing (for example, a physical therapy practice) as well as often part of acute care or long-term care organizations (for example, a hospital's cardiac rehabilitation program)
- Medical and dental practices, ranging from solo practices to large groups that may be either generalized (family practice, internal medicine, etc.) or specialized (obstetrics/gynecology, prosthodontics, etc.)
- Free-standing surgical centers, where an increasing number of surgical procedures are being accomplished without hospitalization
- Walk-in clinics, urgent care centers, and other designations, essentially free-standing medical practices that patients utilize without appointments
- Health centers, collections of medical practices and ancillary services sharing location and clientele
- Home health agencies, both privately and governmentally operated, using an increasing number of nursing and rehabilitation personnel as home-based healthcare services proliferate
- Free-standing clinical laboratories, including commercial, governmental, and shared not-for-profit entities
- Hospice programs, caring specifically for the terminally ill, both as free-standing and palliative care units of larger entities
- Insurance companies, managed care plans, professional medical review organizations, and government agencies (health departments and other regulatory bodies), all of which employ some health professionals
- Suppliers to healthcare providers and their patients, including pharmacies, pharmaceutical manufacturers, equipment manufacturers, medical transportation companies, and numerous others that provide the materials and services that keep health care functioning

The style of management one might employ may well differ from one setting to another depending on the nature, size, and how a particular function happens to be organized. However, it should be clear at this point that most of health care tends strongly toward Likert's cooperative motivation system, and that most healthcare management will necessarily be people-centered rather than production-centered.

IMPLICATIONS FOR MANAGEMENT

Environment and Management Style

A given technique borrowed from the nonhealthcare 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—the employees—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 largely ignoring people. Under the cooperative motivation system, however, it is not so easy to ignore people—even by default—since 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 controlling 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. Since the job is completely definable, the supervisor need only assure 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, since 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.

RETURNING TO "THE STUBBORN EMPLOYEE"

Concerning the "Situation" described at the beginning of the chapter, the characteristics of Thompson's job that should influence manager Morton's style and approach are:

- Variability, because Thompson's tasks, although all mechanical repairs, can differ greatly from one to the next
- Mobility, because the mechanic's tasks take him everywhere in the facility and he is out of sight most of the time

Thompson's tasks may be only broadly definable because there are so many different kinds of repairs possible that they can never all be detailed in a job description. But most of Morton's frustrations probably concern professionalism, specifically an apparent lack thereof. Morton may believe he has every reason to consider Thompson, an apparently skilled tradesperson, to be capable of the professional behavior desired of someone who must work as independently as Thompson.

Morton's approach to Thompson should, of course, be primarily a people-centered approach. Fortunately, quality of output is not a problem. The problems are amount and timeliness of output, factors that are entirely employee-controlled.

George Morton might look into revising the job description, adding a line calling for the reporting of other maintenance needs encountered, and perhaps adding a standing instruction concerning what to do when a job is finished (such as pursue certain preventive maintenance tasks). Most managers will basically disagree with an employee's rigid adherence to the letter of a job description, preferring to see a certain amount of flexibility and initiative. However, job description changes are not always easy; in a union shop, for instance, it often takes a significant change in equipment or procedures to enable the manager to revise a job description.

Beyond consideration of the job description, the manager also might want to check for weaknesses in the department's work order scheduling practices. Conscientious scheduling might cut down on the opportunity for prolonged breaks, and a work order control system that captures elapsed time, material costs, and other information for each job might reveal whether Thompson is taking more time than is reasonably required for a given job.

All of the foregoing add up to the need for Morton to provide closer supervision of the employee, especially since much of the problem can be seen as residing in the employee's attitude. One can only guess at the reasons behind Thompson's attitude, but the manager does have at least one strong positive factor to build on—the employee's confidence in his own ability to do the job.

Overall, manager Morton should consider the following actions:

- Strengthening the job description and improving scheduling and control procedures
- Supervising Thompson more closely
- Stressing the employee's positive efforts and good results
- Getting to know the employee on a one-to-one basis, expressing an interest in the employee as a whole person as well as a producer

The rest is up to the employee. At worst, Thompson's productivity may improve, even if no attitude change occurs, because of closer supervision. At best, his attitude will improve over time as he is drawn into a relationship in which he sees that he and his skills are respected.

A WORD ABOUT QUALITY

There is always room in a discussion such as this for the consideration of quality. Considering again the contention 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.

EXTERNAL PRESSURE: AN AREA OF CONTINUING CONCERN

The "health-care-is-different, period" argument generally does not succeed in differentiating health care from other lines of endeavor. However, there are some legitimate differences that have made themselves felt in health care more than in other fields. These differences have come in the form of pressure from sources outside of the healthcare organization.

This is not to claim that health care has a monopoly on external pressure. Every work organization that serves people in any way experiences pressure from outside, even if that pressure is as basic as competition from others in the same business. We will not even claim for health care the burden of maximum external regulation. Although health care, or at least health care's hospital sector, may well be the most strictly regulated business in the country, other businesses such as insurance, banking, and public utilities are highly regulated as well. However, very few businesses overall are as highly regulated as those just mentioned, and factors in addition to regulation conspire to make health care quite different in some ways.

Growing regulatory intrusion, increasing financial constraints, and mounting public attention to healthcare costs have combined to create a unique, frequently high-pressure work environment for the supervisor. A product of recent decades, this high-pressure environment will likely prevail into the distant future.

The healthcare organization understandably has a strong interest in maintaining the level of income necessary to provide its services and remain solvent. However, healthcare costs continue to increase at a rate exceeding the overall inflation rate. In recent years, nonhealth businesses' major concern with health care has been with ways of slowing the growth in the amount paid for health insurance coverage. Thus healthcare management has been caught in a rather elemental squeeze between external limitations on income and the need to pay open-market prices for the products and labor needed to continue delivering service.

Some undeniable forces have entered the healthcare system and are reshaping the way that supervisors do their jobs:

- Healthcare costs are being capped in several ways in a continuing effort to prevent them from growing unchecked.
- Competition, once a negligible factor in health care, has become a way of life.
- Continued high-quality health care will be demanded despite constant pressure to contain or reduce costs.

Again, no particular form of external pressure is the province of health care alone. However, virtually every form of external regulation and intrusion is present in health care, making health care one of the country's most regulated

activities. This places pressure on the manager to continually strive to produce more with less, and since the healthcare organization tends toward Likert's cooperative motivation system with its dependence on individual employees to keep the work progressing, it means that the manager must inspire the employees to willingly work under increasing pressure while conserving scarce resources.

Some have claimed that a preponderance of rules and regulations should make management easier; one has only to follow what is prescribed. To the contrary, burgeoning rules and regulations have made healthcare management considerably more difficult, because they mean that health care's desired outcomes—quality service with fiscal viability—come only through creatively finding a way through the obstacles.

YOUR SUPERVISORY APPROACH

We should not be misled by what we 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. Again, examine your own department—how it is put together and especially the variability of the work and the degree of structure required. Your approach will 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.

QUESTIONS FOR REVIEW AND DISCUSSION

1. What is the impact of employee mobility on supervisory style?
2. What primarily keeps the organization working toward its goals within Likert's Job Organization System?
3. Why may supervisory style vary with the degree of professionalism present in the work group?
4. Why does the Cooperative Motivation System depend largely on individual enthusiasm and motivation?
5. How is health care different from manufacturing in immediacy of service to customers?
6. What is the principal difference between Likert's Job Organization System and his Cooperative Motivation System?
7. See how many of this chapter's "Healthcare Settings" you can list—without referring to that section of the chapter.
8. What is the likely effect of the variability of work on a supervisor's management style?
9. What do you believe will be the principal determinants of the style you take with you into a supervisory position in your chosen field?
10. How are external factors affecting what goes on within the healthcare organization?

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 percent 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 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 percent 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.

NOTE

1. R. Likert, New Patterns of Management (New York: McGraw-Hill, 1961).