

The Changing Scene: Organizational Adaptation and Survival

CHAPTER OBJECTIVES

- Describe the health care environment as it has evolved since the middle to late 1960s.
- Examine megatrends in the health care environment.
- Identify the need for organizational survival as a fundamental goal of organizational effort.
- Identify selected management strategies used to enhance organizational survival.
- Identify the phases of the organizational life cycle that reflect major changes and relate these to the functions of the manager.

THE CHANGING HEALTH CARE SCENE

A great deal is said about change. We are constantly adapting to change, probably to a greater extent than we realize. Although we are aware that nothing stays the same for very long, people who enter contemporary health care careers soon discover that change in health care has for some time been more dramatic and more rapid than in most other dimensions of modern life.

Those who manage health care organizations must, therefore, monitor change so that they can anticipate the points of convergence in trends and effectively meet

the challenges presented. It is helpful—and, in fact, necessary—to be knowledgeable of continuing trends such as the following:

- Changes in client characteristics
- Regulation of the health care industry
- Reimbursement patterns and mandates
- Restructuring of health care organizations through mergers, affiliations, and the virtual enterprise model
- The impact of technology
- Ongoing social and ethical factors

CHANGES IN CLIENT CHARACTERISTICS

The demographic patterns of the overall population have a direct impact on the health care organization. For example, the increase in the number of older persons requires more facilities and personnel specializing in care of this group, such as continuing care communities, skilled care, and home care. Clinical conditions associated with aging also lead to the development of specialty programs such as memory care, cardiac and stroke rehabilitation, and wellness programs to promote healthy aging. At the other end of the age spectrum, attention to neonatal care, healthy growth and development, and preventive care are points of focus.

Diseases and illnesses are, of course, an ever-present consideration. Some diseases seem to have been conquered and eliminated through timely intervention. Some reoccur after long periods of absence. Tuberculosis, polio, smallpox, and pertussis are examples of successes in disease management. Sometimes, however, new strains may develop or compliance with immunization mandates may decrease, so that these types of communicable diseases reappear.

New clinical conditions may also arise within certain age groups, necessitating fresh approaches to their care. By way of example, consider the rise in autism and the increase in childhood obesity.

REGULATION OF THE HEALTH CARE INDUSTRY

Laws and regulations are a major consideration in the delivery of health care. Three current examples stand out: the Health Care Reform Act of 2010 (the Patient Protection and Affordable Care Act), whose massive provisions are

affecting the entire system; the American Recovery and Reinvestment Act (ARRA), which included new provisions regarding health information privacy, security, and access rights; and the electronic health record mandates for 2014. These laws will be augmented in the usual manner—via the promulgation of detailed regulations from governmental departments and agencies.

When an organization provides goods and services central to the common good of the overall population, state and federal governments place strict regulatory requirements on their practices. In government organization terminology, these oversight organizations are called regulatory agencies or independent commissions or corporations. Familiar examples of this model of extensive industry regulation include the Nuclear Regulatory Commission, the National Transportation Safety Board, and the National Railroad Passenger Corporation (Amtrak). Such agencies are created when the government exercises tight control but does not directly render the services or produce the goods.

How closely does the regulation of health care fit the classic model of an officially regulated industry, to the point where health care will fall under a centralized federal regulatory body? Compare the characteristics of the formally regulated agency or commission with the net effect of health care regulations. A federal (or state) regulatory agency generally has these features:

- It is an official unit of the federal or state government.
- It is established by lawmakers to closely regulate a specific industry.
- A distinct regulatory agency promulgates a coordinated set of regulations appropriate to the industry.
- It is governed by a board of regulators, appointed by the president (or governor), and not subject to removal except for cause.

Given the amount of detail in laws and regulations at both the state and federal levels, the health care industry is, at the very least, a quasi-regulated industry. There is not yet one overall regulatory body with the classic board of regulators. However, initiatives to overhaul the health care delivery system include such consideration, making this a trend to be monitored and assessed. The extensive literature (especially in the field of public administration) concerning the pros and cons of the centrally regulated industry provides managers with insights into this process. The position papers developed by major health care associations, political parties, and labor unions are another source of information about this debate. The issue is usually tied to the increasing cost of health care.

REIMBURSEMENT AND PATTERNS OF PAYMENT

Patterns of payment for health care have changed in response to social, political and economic pressures. Hospitals and clinics have deep historical roots in charitable, not-for-profit models. This approach to care was coupled with fee-for-service payment directly to practitioners. Health insurance programs, both nonprofit such as Blue Cross and Blue Shield, and commercial plans, emerged in the 1930s as a partner in the health care field. The 1960s saw the introduction of federally funded care, along with the emergence of the health maintenance organization (HMO). The managed care model became a permanent and common feature in the coordination of and payment for care. The latest trend is toward universal health insurance through the mandates of the 2010 Health Care Reform Act.

Concern for health care costs and efforts to control or reduce these costs have been gathering momentum since the 1960s. Costs clearly took a leap upward immediately following the introduction of Medicare and Medicaid in the mid-1960s; however, Medicare and Medicaid are not the sole cause for the cost escalation. Rather, costs have been driven up by a complex combination of forces that include the aforementioned programs and other government undertakings, private not-for-profit and commercial insurers, changes in medical practice and advancements in technology, proliferation of medical specialties, increases in physician fees, advances in pharmaceuticals, overexpansion of the country's hospital system, economic improvements in the lot of health care workers, and the desires and demands of the public. These and other forces have kept health care costs rising at a rate that has outpaced overall inflation two- or three-fold in some years.

As concern for health care costs has spread, so have attempts to control costs without adversely affecting quality or hindering access. The final two decades of the twentieth century and the beginning of this century have seen some significant dollar-driven phenomena that are dramatically changing the face of health care delivery, specifically:

- The rise of competition among providers in an industry that was long considered essentially devoid of competition
- Changes in the structure of care delivery, such as system shrinkage as hospitals decertify beds; an increase in hospital closures, mergers, and other affiliations that catalyzed the growth of health care systems; and the proliferation of independent specialty practices
- The growth and expansion of managed care to its present level

In one way or another, most modern societal concerns for health care relate directly to cost or, in some instances, to issues of access to health care, which in turn translate directly into concern for cost. Massive change in health care has become a way of life, and dollars are the driver of this change.

THE MANAGED CARE ERA

Driven by Dollars

Technological advances aside, nearly everything that has occurred in recent decades in the organization of health care delivery and payment has been driven by concern for costs. Changes have been inspired primarily by the desire to stem alarming cost increases and in some instances to reduce costs overall. These efforts have been variously focused. Government and insurers have acted upon health care's money supply, essentially forcing providers to operate on less money than they feel they require. Provider organizations have taken steps to adjust expenditures to fall within the income limitations imposed on them—steps that have included closures, downsizing, forming large systems to take advantage of economies of scale, and generally looking for ways to deliver care more economically and efficiently. Evolving in this cost-conscious environment, managed care seemed to offer workable solutions to the problem of providing reasonable access to quality care at an affordable cost.

Managed Care Proliferates

With the advent of managed care, for the first time in the history of American health care, significant restrictions were placed on the use of services. Managed care introduced the concept of the primary care physician as “gatekeeper” to control access to specialists and various other services. Previously, an insured individual could self-refer, going to any specialist at will, and the person's insurance would generally pay for the service. With the gatekeeper in place, however, a subscriber's visits to a specialist are covered only if the subscriber is referred by the primary care physician. Certain ancillary services, such as X-rays or laboratory tests, were ordered by the primary care physician; under managed care, the services of medical specialists were also ordered by the primary care physician. Subscribers who went to specialists without benefit of referral suddenly found themselves being billed for the specialists' entire costs.

By placing limitations on the services that would be paid for and the circumstances under which these services could be accessed, managed care plans reduced

health insurance premium costs for employers and subscribers. In return for lower costs, subscribers had to accept limitations on their choice of physicians, having to choose from among those physicians who agreed to participate in a given plan and accept that plan's payments, accepting limitations on the services that could be accessed, and, in most cases, having to pay certain specified deductibles and copayments.

Managed care organizations and elements of government brought pressure to bear on hospitals as well. Hospitals and physicians were encouraged to reduce the length of hospital stays, cut back on the use of ancillary services, and meet more medical needs on an outpatient basis. Review processes were established such that hospitals were penalized financially if their costs were determined to be too high or their inpatient stays too long. Eventually payment became linked to a standard, or target, length of stay so that any given diagnosis was compensated at a specific amount regardless of how long the patient was hospitalized.

As they grew larger, managed care organizations began to deal directly with hospitals, negotiating the use of their services. As various plans contracted with hospitals that would give the best price breaks for the plan's patients, price competition between and among providers became a factor to be reckoned with.

PROVIDER GROWTH: MERGERS AND AFFILIATIONS

It should be no secret to even the casual observer that the structure of the nation's health care delivery system changed dramatically over the last few decades of the twentieth century, and it continues to change in this new century.

Restructuring through mergers and affiliations and the trend toward the creation of the virtual enterprise characterize these efforts to adapt and survive. Why do health care organizations seek such restructuring? The reasons are several:

- The desire to increase size so as to have greater clout in negotiations with managed care providers who tend to bypass smaller enterprises
- The desire to penetrate new markets to attract additional customers
- The need for improved efficiencies resulting from centralized administrative practices such as financial and health information resource streamlining, or public relations and marketing intensification
- The desire to express an overall value of promoting comprehensive, readily accessible care by shoring up smaller community-based facilities, keeping them from closure

As cost-containment pressure grew, providers—primarily hospitals—initially moved into mergers mostly to secure economies of scale and other operating efficiencies and sometimes for reasons as basic as survival. The growth and expansion of managed care plans provided further incentive to merge among hospitals, which seems to have inspired health plan mergers in return. Each time a significant merger occurs, one side gains more leverage in negotiating contracts. The larger the managed care plan, the greater its clout in negotiating with hospitals and physicians, and vice versa.

Clarification of Terms

The term *merger* is used to describe the blending of two or more corporate entities to create one new organization with one licensure and one provider number for reimbursement purposes. One central board of trustees or directors is created, usually with representation from each of the merged facilities. Debts and assets are consolidated. For example, suppose a university medical center buys a smaller community-based hospital. Ownership and control of the smaller facility is now shifted to the new organization. Sometimes the names of the original facilities are retained as part of public relations and marketing, as when a community group or religious-affiliated group has great loyalty and ties to the organization. Alternatively, a combined name is used, such as Mayfair Hospital of the University Medical System.

An *affiliation* is a formal agreement between or among member facilities to officially coordinate and share one or several activities. Ownership and control of each party remains distinct, but binding agreements, beneficial to all parties, are developed. Shared activities typically include managed care negotiations, group purchasing discounts, staff development and education offerings, and shared management services.

Such restructuring efforts, especially the formal merger, are preceded by mutual due diligence reviews in which operational, financial, and legal issues are assessed. Federal regulations and state licensing regulations must be followed. Details of the impact of the restructuring on operational levels are considered, with each manager providing reports, statistics, contractual information, leases (as of equipment), and staffing arrangements, including independent contractors and outsourced work.

Practical considerations constitute major points of focus, such as redesign of forms, merging the master patient index and record system into one new system, merging finance and billing processes, and the specifics of officially discharging and readmitting patients when the legally binding merger has taken place.

Present-day mergers and affiliations can have a pronounced effect on the health professional entering a management position. Consider the example of the laboratory manager who must now oversee a geographically divided department because a two-hospital merger has left this person responsible for a department with two sites that are miles apart. There is far more to consider in managing a split department than in managing a single-site operation; the manager's job is made all the more difficult. Overall, mergers and affiliations are blessing the professional-as-manager with greatly increased responsibility and accountability and a role of increasing complexity.

THE VIRTUAL ENTERPRISE

In the business community, the concept of the virtual enterprise (or corporation) has emerged as a result of available technology. The virtual enterprise is a relatively temporary partnership of independent companies or individuals, composed of suppliers of certain goods, services, or customers. Two or more organizations temporarily join together into a meta-enterprise to take advantage of rapidly changing technology. The meta-enterprise seeks to capitalize on this technology by making it readily available. These virtual services or products (e.g., one-hour eyeglasses, online prescription processing, clinical decision support information) rapidly adapt to user needs and demands. A key feature of many virtual enterprises is heavy reliance on outsourcing, with only a small, centralized corporate core staff and physical facility. Information exchange is highly dependent on computer networks.

Health care organizations already exhibit some of these characteristics, a trend that is likely to increase.¹ The contemporary health information department reflects some of these trends: outsourcing of the dictation-transcription function and home-based coding are common practices.

IMPACT OF TECHNOLOGY

A survey of any health care discipline would readily provide examples of the impact of technology. New treatment modalities emerge; specialty care is taken to the patient (e.g., bedside anesthesia, mobile van with chemotherapy, portable diagnostic equipment). The need for large, dedicated space within one central facility is reduced; staffing patterns change. Technology has made possible the use of "e-visits" and the "digital doctor," replacing or augmenting face-to-face contact. Another advance is the use of a variety of monitors placed in the patient's home.

These advances require education of the patient about their use as well as the sociological and psychological aspects of this less personal intervention.

Translational medicine is defined as the effort to more effectively and rapidly complete the cycle of bench-to-bedside-to-bench. This trend has also gained impetus through the use of supportive technology for virtual interaction between caregivers and researchers.

Information technology is yet another area with major impact on health care delivery. As organizations merge or affiliate, more freestanding facilities develop, independent practitioners provide services in their own facilities, and patients access e-health information right in their own homes, information sharing becomes all the more vital. Several interrelated concepts are associated with contemporary information technology. These practices incorporate and enhance the more historical methods of the paper record, decentralized indexes and registries, and special studies:

- Data warehousing—centralized depository of data collected from all aspects of the organization (for example, patient demographics, financial/billing transactions, and clinical decision making) gathered into one consistent computerized format. Easy connectivity to national and international databases (e.g., National Library of Medicine) is yet another feature of this process.
- Data mining—analyzing and extracting data to find meaningful facts and trends for “real-time” intervention in clinical decision-making support, studies and oversight review of administrative and clinical practice by designated review groups, budget support, and related data usage. With proper safeguards (e.g., patient confidentiality, data security), data are made more accessible to approved users in the organization.
- Informatics standards and common language—these include standard vocabulary and classification systems, such as the National Library of Medicine’s Unified Medical Language System (UMLS) and the standards developed by the Institute of Electrical and Electronics Engineers (IEEE). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations require the adoption of the American National Standards Institute (ANSI) protocols for electronic transactions. These standards cover both format and content for data capture and transmission.
- Development of a national health care information infrastructure—the development of the infrastructure has the support of key advocates such as the American Health Information Association along with other stakeholders, resulting in the nation-wide implementation of electronic health records.

Other current technologies having an impact on timely data recoding include the handheld personal digital assistant (PDA), portable computer, e-mail communications, and speech recognition technologies. The evolution of improved technology shows no signs of letting up, making this aspect of change one needing constant monitoring. Particular attention is required for the prevention of medical identity theft, which has become a fast-growing area of crime. Technology also influences social and therefore ethical norms, as discussed next.

SOCIAL AND ETHICAL FACTORS

Given the continuing activity in genetic research, ethical questions have intensified in recent years. Consideration of social and ethical norms has always been a part of the health care ethos, but from time to time a more urgent debate is required. As noted here, a technological breakthrough occasions such renewed interest. At another time, a new legislative mandate, such as the Patient Self-Determination Act, brings about fresh consideration of enduring concerns. Increased sensitivity to patient or consumer wishes is yet another source of attentiveness to social and ethical issues; for example, the increased use by patients of alternative therapies and interventions has reopened questions about the proper integration of nontraditional care with the accepted modes. This debate reaches into the question of reimbursement as well; health care plans are increasingly approving some alternative/complementary interventions as reimbursable costs.

Ethical considerations such as the foregoing result in the increased use of the ethics review committee, the institutional review board, and similar clinical and administrative review groups. These issues are further affected by initiatives such as the quality-adjusted remaining-years assessments and the complete-lives concept. Implicit and explicit limits to health care continue to surface anew as a feature of health care reform.

These trends and the ways that health care organizations respond to them typically inspire a discussion of organizational strategies for both survival and growth. A method for analyzing organizational theory and its application to a contemporary health care setting is provided here. The suggested starting point is observation—anchor the concepts in the familiar. Next, study the theory in its development along with its contemporary themes. The groundwork for the theoretical and practical aspects of organizational survival and growth strategies was extensively developed in the 1950s and 1960s. These concepts of bureaucratic imperialism, co-optation, goal expansion, and organizational life cycle continue to have application today in the continuing challenge of responding to change.

INTRODUCING ORGANIZATIONAL SURVIVAL STRATEGIES

Organizational survival and growth are implicit goals requiring the investment of energy and resources. Normally, only higher levels of management need give attention to organizational survival; it may be taken for granted by most employees or members, some of whom may even take actions that threaten the organization's survival (for example, a prolonged strike). There may be an unwillingness to admit the legitimacy of survival as a goal because it seems self-serving; however, managers disregard the concept of organizational survival—whether the whole corporation or just a department or unit—at their own peril.

So fundamental is the goal of organizational survival that it underpins all other goals. Fostering this goal contributes to the satisfaction of the more explicit goals of the group or organization. Bertram Gross described this implicit goal as “the iron law of survival.” The unwritten law of every organization, he said, is that its survival is an absolute prerequisite for its serving any interest whatsoever.²

Survival is articulated as a goal in certain phases of organizational development—for example, when competition threatens. The clientele network includes competitors, rivals, enemies, and opponents that must be faced. Certain threats to organizational survival may be identified:

- Lack of strong, formal leadership after the early charismatic leadership of the founders
- Too-rapid change either within or outside the organization
- Shifting client demand, either with the loss of clients or with the increased exercise of control by clients
- Competition from stronger organizations
- High turnover rate in either the rank and file or the leadership
- Failure to recognize and accept organizational survival as a legitimate, although not the sole, organizational purpose

These factors drain from the organization the energy that should be goal-directed.

An organization ensures its survival through certain strategies and processes, such as bureaucratic imperialism, co-optation, patterns of adaptation, goal multiplication and expansion, use of organizational roles, conflict limitation, and integration of the individual into the organization. Astute managers recognize such patterns of organizational behavior and assess them realistically. A weak organization or unit cannot pull together the money, resources, and power to serve its clients effectively.

BUREAUCRATIC IMPERIALISM

An organization develops to pursue a particular goal, serve a specific client group, or promote the good of a certain group. In effect, an organization stakes out its territory. Thus a professional association seeks to represent the interests of members who have something in common, such as specific academic training and professional practice. A hospital or home health agency seeks to serve a particular area. A union focuses on the needs of one or several categories of workers. A political party attempts to bring in members who hold a particular political philosophy. A government agency seeks to serve a specific constituency.

The classic definition of bureaucratic imperialism reflects the idea that a bureaucratic organization exerts a kind of pressure to develop a particular client group and then to expand it. It becomes imperialistic in the underlying power struggle and competition that ensues when any other group seeks to deal with the same clients, members, or area of jurisdiction. Matthew Holden, Jr., coined the term *bureaucratic imperialism* and defined it in the context of federal government agencies that must consider such factors as clients to be served, political aspects to be assessed, and benefits to be shared among administrative officials and key political clients. According to Holden's definition of the concept, bureaucratic imperialism is "a matter of interagency conflict in which two or more agencies try to assert permanent control over the same jurisdiction, or in which one agency actually seeks to take over another agency as well as the jurisdiction of that agency."³ The idea of agency can be expanded to include any organization, the various components of the clientele network can be substituted for the constituency, and the role of manager can replace that of the administrative politician in those organizations that are not in the formal political setting.

Managers in many organizations can recognize the elements of this competitive mode of interaction among organizations. There may even be such competition among departments and units within an organization. In the health care field, competition may be seen in the areas of professional licensure and practice, accreditation processes for the organizations as a whole, the delineation of clients to be served, and similar areas.

Professional licensure has the effect of annexing specific "territory" as the proper domain of a given professional group, but other groups may seek to carry out the same, or at least similar, activities. For example, there is the question of the role of chiropractors in traditional health care settings. Is the use of radiological techniques the exclusive jurisdiction of physicians and trained radiological technicians or should the law be changed to permit chiropractors greater use of

these techniques? Psychiatrists question the expanding role of others who have entered the field of behavioral health. As each health care profession develops, the question of jurisdiction emerges.

The accreditation process in health care reflects similar struggles for jurisdiction. Which shall be the definitive accreditation process for behavioral care health facilities—that approved by the American Psychiatric Association or that approved by The Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations [JCAHO])? Should all of these processes be set aside, leaving only state governments to exercise such control through the licensure of institutions?

Other examples may be drawn from the health care setting. There has been a jurisdictional dispute over blood banking between the American Red Cross and the American Association of Blood Banks, as well as competition of health maintenance organizations (HMOs) with the more traditional Blue Cross and Blue Shield-type plans and commercial medical insurance companies.

Although the charitable nature of health care has been emphasized traditionally, the elements of competition and underlying conflict must be recognized. With shifts in patient populations and changes in each health care profession, health care managers must assess the effects of bureaucratic imperialism in a realistic manner. The competition engendered by bureaucratic imperialism and the resultant total or partial “colonization” of an organizational unit or client group may be functional. Holden noted that conflict not only forces organizational regrouping by clarifying client loyalty and wishes, but also sharpens support for the agency or unit that “wins.” Furthermore, it disrupts the bureaucratic form from time to time, causing a healthy review of client need, organizational purpose, and structural pattern.

CO-OPTATION

Another method that organizations use to help ensure their survival is *co-optation*, an organizational strategy for adapting and responding to change. Philip Selznick described and labeled this strategy, which is viewed as both cooperative and adaptive. He defined co-optation as “an adaptive response on the part of the organization in response to the social forces in its environment; by this means, the organization averts threats to its stability by absorbing new elements into the leadership of the organization.”⁴ The organization, in effect, shares organizational power by absorbing these new elements. Selznick called it a realistic adjustment to the centers of institutional strength.⁵

Formal Versus Informal Co-optation

In formal co-optation, the symbols of authority and administrative burdens are shared, but no substantial power is transferred. The organization does not permit the co-opted group to interfere with organizational unity of command. Normal bureaucratic processes tend to provide sufficient checks and balances on any co-opted group, just as they tend to restrict the actions of managers. Through formal co-optation, however, the organization seeks to demonstrate its accessibility to its various publics.

In health care, the co-optation process is suggested by the practice of appointing “ordinary” citizens to the board of trustees. Community behavioral care health centers and some neighborhood health centers tend to emphasize consumer or community representation. Health planning agencies include both providers and consumers in planning for health care on a regional or statewide basis. The formalization of nursing home ombudsmen or patient care councils is still another example of this process.

Professional associations in those disciplines that have technical-level practitioners have sought to open their governing processes in response to the growing strength of the technical-level group. Increases in numbers, greater degree of training, further specialization, and a general emphasis on the democratic process and provision of rights for all members have fostered changes in these associations. Open membership, such as that recently adopted by the American Health Information Management Association, is an example of positive co-optation: The rapid developments in the wider field of information technology gave impetus to including the IT specialists in the existing health information arena. Without cooperative adaptation to such internal changes, there is a risk that additional associations will be formed, possibly weakening the parent organization.

When an organization seeks to deal less overtly with shifting centers of power and to maintain the legitimacy of its own power, co-optation may be informal in nature. For example, managers may meet unofficially with informally delegated representatives of clients, employees, or outside groups. Organizational leaders may deal regularly with some groups, but there are no visible changes in the official leadership structures. No new positions are created; committee membership remains intact. Informal co-optation may be more important than formal co-optation because of its emphasis on true power, although each form serves its unique purpose. An organization can blend formal and informal co-optation processes, as they are not mutually exclusive.

Control of Co-opted Groups

Although the co-opted group could gain strength and attempt to consolidate power, this does not happen frequently for several reasons. First, the organization has the means of controlling participation. For example, only limited support may be given to the group; there may be no physical space, money, or staff available to give to the co-opted group, or management could simply withhold support. Another possible course is to assign so much activity to the co-opted group that it cannot succeed easily. With this approach, key leaders of the co-opted group generally retain their regular work assignments but now have in addition projects and tasks relating to their special causes. Co-opted leaders also become the buffer individuals in the organization, because the group has placed its trust in them and looks for results faster than they can be produced. Such leaders may find their base of action eroded and their activity turning into a thankless task.

In a more Machiavellian approach, organizational authorities could schedule meetings at inconvenient hours or control their agenda in such a way that issues of significance to the co-opted group are too far down on the list of discussion items to be dealt with under the time constraints. Absolute insistence on parliamentary procedure may also be used as a weapon of control; a novice in the use of *Robert's Rules of Order* is at a distinct disadvantage when compared with a seasoned expert.

The subtle psychological process that occurs in the co-opted individual who is taken into the formal organization as a distinct outsider acts as another controlling measure. The person suddenly becomes, for this moment, one of the power holders and derives new status. Certain perquisites also are granted. Consumer representatives, for example, may find their way paid, quite legitimately, for special conferences or fact-finding trips to study a problem. The individual, in becoming privy to more data and sometimes to confidential data, may start to “see things” from the organization’s point of view.

Certain subtle social barriers may make the co-opted individual uncomfortable, even though they may not be raised intentionally and may be part of the normal course of action for the group.

Individuals representing pressure groups find that their own time and energies are limited, even if they desire power. Other activities continue to demand their energies. In addition, certain issues lose popularity, and pressure groups may find their power base has eroded. Finally, the agenda items that were causes of conflict may become the recurring business of the organization. The conflict may become a routine, and the structure to deal with it may become a part of the formal

organization. In the collective bargaining process, for example, the union is a part of the organization, and its leaders have built-in protection from factors that erode effective participation. Labor union officials commonly have certain reductions in workload so that they may attend to union business, space may be provided for their offices or meetings, and they may seek meetings with management as often as executives seek sessions with them. Co-optation has occurred in such a case, but without a loss of identity of the co-opted group. In health care organizations, consumer participation has become part of the organizations' continuing activity through the development of a more stable process for consumer input, such as the community governing board models.

HIBERNATION AND ADAPTATION

To maintain its equilibrium, an organization must adapt to changing inputs. This adjustment may take the passive form of *hibernation*, in which the institution enters a phase of retrenchment. Cutting losses may be the sensible option. If efforts to maintain an acceptable census in certain hospital units, such as obstetrics or pediatrics, are unsuccessful, there may be an administrative decision to close those units and concentrate on providing quality patient care in the remaining services. An organization may adjust or adapt to changing inputs more actively by anticipating them. Staff specialists may be brought in, equipment and physical facilities updated, and goals restated. Finally, the overall corporate form may be restructured as a permanent reorganization that formalizes the cumulative effects of changes. A hospital may move from private sponsorship to a state-related affiliated status, or a health care center may become the base service unit for behavioral care programs in the area.

The relationships among the concepts of hibernation, adaptation, and permanent change can be seen in the following case history of a state behavioral care hospital. After the state legislature cut the budget of all such state hospitals, the institution director began to set priorities for services so that the institution could survive. The least productive departments were asked to decrease their staff. The rehabilitation department lost two aide positions. The institution director had to force the organization into a state of hibernation to accomplish some essential conservation of resources.

The director of rehabilitation services revised the department goals to improve the chances of departmental survival. After closing ancillary services, the director concentrated staff on visible areas of the hospital and asked them to make their work particularly praiseworthy. At the same time, the director emphasized the

need to document services so that patients' progress in therapy programs could be demonstrated. The director adapted to the change in the organization.

The program changes proved successful. The director of the rehabilitation department consolidated the changes and modified the department's goals. Instead of offering periodic programs to adolescent, neurological, geriatric, and acute care patients, the staff would concentrate on acutely ill geriatric patients. The staff applied for funds that were available to treat this population. At the same time, the staff determined that the adolescent unit could benefit from their services. Although funds were shrinking, the staff serviced this unit because needs in that area were unmet. The director and the staff decided to apply for private funds to service neurological and acute care cases so that these programs could also continue. By adopting a combined strategy of hibernation and adaptation, with alternate plans for expansion, the department director was able to foster not only departmental survival but, ultimately, departmental growth.

Another example of hibernation as a survival strategy is illustrated by the response of a continuing care or retirement community to several challenges. Planning assumptions, budget projections, short- and long-term investments, and fee structures were based on expectations of a modest to robust profit. Unfortunately, a prolonged economic downturn reduced the rate of return on investments with no concomitant decrease in costs. Credit lines became more difficult to obtain and came with much higher interest rates. An increase in regulatory requirements for the assisted living component of the facility would have required major renovations that were cost prohibitive. As a response to these factors, the assisted living component was eliminated and other expansion plans were put on hold.

GOAL SUCCESSION, MULTIPLICATION, AND EXPANSION

Because an organization that effectively serves multiple client groups can attract money, materials, and personnel more readily than an organization with a more limited constituency, leaders may actively seek to expand the original goals of the organization. In addition to the pressures in the organizational environment that may force the organization to modify its goals as an adaptive response, success in reaching organizational goals may enable managers to focus on expanded or even new goals. The terms *goal succession*, *goal expansion*, and *goal multiplication* are used to describe the process in which goals are modified, usually in a positive manner.

Amatai Etzioni described this tendency of organizations to find new goals when old ones have been realized or cannot be attained.⁶ In goal succession, one goal is reached and is succeeded by a new one. The actions of one group of local merchants reflect this pattern. They formed a cooperative group to coordinate clean-up efforts after catastrophic flooding—a goal that was met. However, a strong cooperative group had been formed; solid administrative structures had been developed; community and regional support was strong. Rather than disband after meeting its original goal, the group took on new goals of fostering economic development and promoting tourism. Sometimes an organization takes on additional goals because the original goals are relatively unattainable. For example, a church may add a variety of social services to attract members when the worship forms and doctrinal substance per se do not increase the church's membership. A missionary group may offer a variety of health care or educational services when its direct evangelical methods cannot be used. The original goal is not abandoned, but it is sought indirectly; more tangible goals of service and outreach succeed this primary goal.

Goal expansion is the process in which the original goal is retained and enlarged with variations. Colleges and universities, for example, may expand their traditional educational goals to include continuing education. An acute care facility may open a rehabilitation or convalescent care hospital as an adjunct to its short-stay services. A medical center may open a specialty division just for the comprehensive care of senior citizens. The Joint Commission continues to focus primarily on inpatient acute care hospital accreditation but has expanded its standards and accreditation process to include home care, outpatient, and emergency care units. A collective bargaining unit negotiates specific benefits for its workers and takes on the administrative processing of certain elements, such as the pension fund; the basic goal of improving the circumstances of the workers is retained and expanded beyond immediate economic benefits. A long-term care (skilled care) facility expands its goals to provide a new service: a memory care or Alzheimer's disease unit. The Easter Seals Association reflects a history of goal expansion, beginning with services for children with disabilities, and currently offering additional services to families affected by autism. In response to the growing number of military service members who are returning from active duty with disabilities, an organization has broadened its client group to serve them. A community pharmacy uses goal expansion by implementing comprehensive medication review for its customers. Another example of goal expansion may be seen in the work of the Red Cross. Originally organized to provide disaster relief

in World War I, it subsequently expanded its work to assist in coordinating relief from all disasters, regardless of cause. In all of these examples, the basic goal is retained and the new ones derived from it; the new goals are closely related and are essentially extensions of the original goal.

Goal multiplication is also a process in which an original goal is retained and new ones added. In this case, however, the new goals reflect the organization's effort to diversify. Goal multiplication is often the natural outgrowth of success. A hospital may offer patient care as its traditional, primary goal. To this it may add the goal of education of physicians, nurses, and other health care professionals. Because excellence in education is frequently related to the adequacy of the institution's research programs, research may subsequently become a goal. The hospital may take on a goal of participating in social reform, seeking to undertake affirmative action hiring plans and to foster employment within its neighborhood. It may offer special training programs for those who are unemployed in its area or for those who are physically or developmentally impaired. It may coordinate extensive social services in an effort to assist patients and their families with both immediate health care problems and the larger social and economic problems they face.

Similar examples can be found in the business sector. A large hotel-motel corporation, with its resources for dealing with temporary living quarters, may go into the nursing home industry or the drug and alcohol treatment facility business by offering food, laundry, and housekeeping services; it may even operate a chain of convalescent or alcohol and drug rehabilitation centers. Several real estate firms might consolidate their efforts in direct sale of homes and then offer mortgage services as an additional program. Organizations take on a variety of goals as a means of diversification; resources are directed toward satisfaction of all the goals. Such multiplication of goals is seen as a positive state of organizational growth.

ORGANIZATIONAL LIFE CYCLE

Organizational change can be monitored through the analysis of an organization's *life cycle*. This concept is drawn from the pattern seen in living organisms. In management and administrative literature, the development of this model stems from the work of Marver Bernstein, who analyzed the stages of evolution and growth of independent federal regulatory commissions.⁷ This model of the life cycle can be applied to advantage by any manager who wishes to analyze a particular management setting.

The organization is assessed not in chronological years but in phases of growth and development. No absolute number of years can be assigned to each phase, and any attempt to do so to predict characteristics would force and possibly distort the model. The value of organizational analysis by means of the life cycle lies in its emphasis on characteristics of the stages rather than the years. For example, the neighborhood health centers established in the 1960s under Office of Economic Opportunity sponsorship had a relatively short life span in comparison with the life span of some large urban hospitals that are approaching a century or more of service. Both types of organizations have experienced the phases of the life cycle, with the former having completed the entire phase through decline and—in its original form—extinction.

The phases of the organizational life cycle usually meld into one another, just as they do in the biological model. Human beings do not suddenly become adolescents, adults, or senior citizens; so, too, organizations normally move from one phase to another at an imperceptible rate with some blurring of boundaries. Finally, not every organization reflects in detail every characteristic of each phase. The emphasis is on the cluster of characteristics that are predominant at a specific time.

Gestation

In this early formative stage, there is a gradual recognition and articulation of need or shared purpose. This stage often predates the formal organization; indeed, a major characteristic of this period is the movement from informal to formal organization. The impetus for organizing is strong, as it is necessary to bring together in an organized way the prime movers of the fledgling organization, its members (workers), and its clients.

Leadership tends to be strong and committed, and members are willing to work hard. Members' identification with organizational goals is strong because the members are in the unique situation of actualizing their internalized goals; in contrast, those who become part of the institution later must subsequently internalize the institution's objectives. Members of the management team find innovation the order of the day. Creative ideas meet with ready acceptance, because there is no precedent to act as a barrier to innovation. If there is a precedent in a parent organization, it may be cast off easily as part of the rejection of the old organization. A self-selection process also occurs, with individuals leaving if they do not agree with the form the organizational entity is taking. This is largely a flexible process, free of the formal resignation and separation procedures that come later.

Youth

The early enthusiasm of the gestational phase carries over into the development of a formal organization. Idealism and high hopes continue to dominate the psychological atmosphere. The creativity of the gestational period is channeled toward developing an organization that will be free of the problems of similar institutions. There is a strong camaraderie among the original group of leaders and members. Organizational patterns exhibit a certain inevitability, however. If a creative new organization is successful, it is likely to experience an increase in clients that will force it to formalize policies and procedures rapidly so as to handle the greater demand for service.

Some crisis may occur that precipitates expansion earlier than planned. A health center may have a plan for gradual neighborhood outreach, for example, but a sudden epidemic of flu may bring an influx of clients before it is staffed adequately. Management must make rapid adjustments in clinic hours and staffing patterns to meet the demand for specific services and, at the same time, to continue its plan for comprehensive health screening. A center for the developmentally challenged may schedule one opening date, but a court order to vacate a large, decaying facility may require the new center to accept the immediate transfer of many patients. Routine, recurring situations are met by increasingly complex procedures and rules. Additional staff is needed, recruited, and brought into the organization, perhaps even in a crash program rather than through the gradual integration of new members.

At this point, a new generation of worker enters the organization. These workers are one phase removed from the era of idealism and deeply shared commitment to the organization's goals. The organizational structure (e.g., work flow, job descriptions, line and staff relationships, and roles and authority) is tested. For the newcomer brought in at the management level, formal position or hierarchical office is the primary base of authority. Other members of the management team, as the pioneers, know one another's strengths and weaknesses intimately, but these managers may need to test the newcomer's personal attributes and technical competence. Sometimes, because the new organization attempts to deal with some problem in an innovative manner, an individual health care practitioner is hired in a nontraditional role; not only the professional and technical competence but also the managerial competence of that individual are tested.

Communication networks are essential in any organization. During an organization's youth, it is necessary to rely on formal communication because the informal patterns are not yet well developed, except within the core group. This lack

of an easy, anonymous, informal communication network forces individuals to communicate mainly along formal lines of authority. The core group may become more and more closed, more and more “in,” relying on well-developed, secure relationships that stem from a shared history in the developing organization, while the newcomers form a distinct “out” group.

The jockeying for power and position may be intense. If managers hold an innovative office, those who oppose such creative organizational patterns may exert significant pressure to acquire jurisdiction or to force a return to traditional ways. Since there may be much innovation in the overall organizational pattern, managers have little or no precedent against which they can measure their actions.

Certain problems center on the implementation of the original plans. The planners may start to experience frustration with managers who enter the organization during this period of formalization. Perhaps the original plans need modification; perhaps the innovative, ideal approach of the original group is not working, largely because of the change in the size of the organization. The line managers find themselves in the difficult situation of seeming to fail at the task on the one hand and being unable to make the original planners change their view on the other hand. The promise of innovation becomes empty, however, if the original planners guard innovation as their prerogative and refuse to accept other ideas.

In the youth phase of an organization, more time must be devoted to orientation and similar formal processes of integrating new individuals into the organization. Certain difficulties may be encountered in recruiting additional supervisors and professional practitioners; for example, there may be no secure retirement funds, only minimal group medical and life insurance, and a lack of benefits that are predicated on long-term investments and large membership. Salary ranges may be modest in comparison with those of more established organizations simply because insufficient time has passed for the development of adequate resources. The strong normative sense of idealism may have a negative effect on potential workers as well as a positive one; a certain dedication to the organization’s cause may be expected, and it may also be assumed that personnel should be willing to work hard without being rewarded monetarily.

Bernstein stressed the increased concern for organizational survival in this youthful stage. The organization may become less innovative because it is not sure of its strength. It may choose to fight only those battles in which victory is certain. In the case of regulatory bodies, which were Bernstein’s major focus, the businesses subject to regulation may be perceived as stronger than the agency itself. In a health care organization, the new unit may be treated as a stepchild of related health care institutions. A new community behavioral health center or a home

care organization, for example, may have to choose between competing with older, traditional units within the parent organization and being completely independent, still competing for resources but with less legitimacy of claim. A struggle not unlike the classic parent–adolescent conflict may emerge. Thus, organizational energy may go into an internal struggle for survival rather than into serving clients and expanding goals.

If the client groups are well defined and no other group or institution is offering the same service, a youthful organization may flourish. A burn unit in a hospital may have an excellent chance of survival as an organization because of the specificity of its clients as compared, for example, with the chance of a general medical clinic's survival. A similar positive climate may foster the development of units for treatment of spinal cord injury or for rehabilitation of the hand as specialized services. In effect, a highly specialized client group may afford a unit or an organization a virtual monopoly, which will tend to place the unit or organization in a position of strength.

A particularly challenging aspect of the transition from gestation to youth is the necessary development of articles of incorporation and related bylaws. The closely knit group of founders must make plans to anticipate difficulties, conflicts, and the possibility of failure. Provision for removal of board members or officers, auditing of business records, succession plans to replace themselves, and the disposition of assets if the venture fails are concepts seemingly at odds with the idealism of this stage.

Middle Age

The multiple constraints on the organization at middle age are compounded by several factors. In addition to the external influences that shape the work of the organization, internal factors must be dealt with, such as the organizational pattern, the growing bureaucratic form, the weight of decision by precedent, and an increasing number of traditions.

However, the organization also reaps many benefits from middle age. Many activities are routine and predictable; roles are clear; and communication, both formal and informal, is relatively reliable. These years are potentially stable and productive. There is a reasonable receptivity to new ideas, but middle age is not usually a time of massive or rapid change and disruption, even the positive disruption resulting from major innovation. The manager in an organization in its middle age performs the basic traditional management processes in a relatively predictable manner.

Periods of rejuvenation are precipitated by a variety of events. A new leader may act as a catalytic agent, bringing new vision to the organization; for example, the president of a corporation may push for goal expansion by introducing a new line of products, or an aggressive hospital administrator may push for the development of an alternative health care service model. Mergers and affiliations with new and developing types of health care institutions, such as community health centers and home care programs, may be the catalyst. Although primarily negative events, the fiscal chaos associated with bankruptcy or the loss of accreditation as a hospital may cause the organization to reassess its goals and restructure its form, thereby giving itself a new lease on life. Sheer competition, coupled with a strong belief in its mission of comprehensive care, might cause a community hospital to add services in specialties such as sports medicine and rehabilitation, cardiac treatment, behavioral health for older adults, and on-site comprehensive imaging and laboratory services.

Some external crisis or change of articulated values in the larger society may make the organization vital once again. The recent emergence of alternative modes of communal living reflects individuals' search for a mode of living that combats the alienation of urban society; organizations that provide alternative modes of living can be revitalized because of this renewed interest in shared living arrangements. The effect of war on the vitality of the military is an obvious example of crisis as a catalytic agent that causes a spurt of new growth for an organization. The growth of consumer and environmental agencies is another organizational response to change or crisis in the larger society.

In health care, family practice has developed as a specialty in response to patients' wishes for a more comprehensive, more personal type of medical care. The hospice concept for the terminally ill has become an alternative to the highly specialized setting of the acute care hospital.

An organization may experience a significant surge of vitality because of some internal activity, such as unionization of workers. During the covert as well as the overt stage of unionization, management may take steps to "get the house in order," including greater emphasis on worker–management cooperation in reaching the fundamental goals of the organization. Service of strong client groups may become more active, both to focus attention on the institution's primary purpose and to mobilize client goodwill in the face of the potential adversary (i.e., the union). Such internal regrouping activities foster rejuvenation in the organization as an offshoot of their primary purpose—that is, avoiding unionization or reducing its impact.

Legislation of massive scope, particularly at the federal level, may have a rejuvenating effect. The infusion of money into the health care system via Medicare and Medicaid is partly responsible for the growth of the long-term care industry, although population trends and sociological patterns for care of the aged outside of the family setting are contributing factors. The passage of the National Health Care Planning and Resource Development Act rejuvenated some of the existing health planning agencies; its gradual phasing out, of course, has had the opposite effect in some instances by forcing a decline in certain planning groups. Changes in state professional licensure laws may bring certain professional groups into a season of new vigor.

The bureaucratic hierarchy protects managers who derive authority from a position that traditionally is well defined by the organization's middle age. Planning and decision making are shared responsibilities, subject to several hierarchical levels of review. The same events that may spur rejuvenation also may hurl the organization into a state of decline, the major characteristic of the final stage: old age.

Old Age

Staid routines, resistance to change, a long history of “how we do things,” little or no innovation, and concern with survival are the obvious characteristics of an organization in decline. There may be feeble attempts to maintain the status quo or to serve clients in a minimal fashion, but the greater organizational energy is directed toward efforts to survive. If the end is inevitable, resources are guarded so that the institution can fulfill its obligations to its contractual suppliers and to its past and present employees (e.g., through vested pension funds, severance pay, and related termination benefits). There may even be a well-organized, overt process of seeking job placement for certain members of the hierarchy; time and resources may be made available to such individuals. Sometimes key individuals from the dying organization attempt to develop a new organization.

Because of its dwindling resources, the organization may no longer serve clients well, and all but the most loyal clients will look for other organizations. The organization in decline cannot attract new clients; the cycle is broken. Without clients, the organization cannot mobilize financial and political resources to maintain its physical facilities, expand services, respond to technological change, or remain in compliance with new licensure or regulatory mandates. The end, which may come swiftly, may be brought about by a decision to close and a specific plan to do so in an orderly way. For example, a department store might announce a liquidation sale

that ends with the closing date. Only the internal details of closing need attention; as far as clients are concerned, the organization has died.

A final closing date may be imposed on an organization. In a bankruptcy, for example, the date may be determined in the course of legal proceedings. Legislation that initially establishes certain programs may include a termination date, although the date is more commonly set when legislation to continue funding the program fails. The changes in medical care evaluation under professional standards review organizations (PSROs) and the Office of Economic Opportunity neighborhood health centers are examples in the health care field of programs that moved into a state of decline or closure when funding was no longer available through federal legislation.

The closing decision may be a more passive one; there may be a gradual diminution of services and selective plant shutdowns and layoffs, as may occur in manufacturing corporations that rely primarily on military or space contracts. Bankruptcy is costly in economic and political terms in some cases, so the decision is implemented slowly. Indeed, it sometimes seems that no one actually makes a decision in some institutions that decline. Because of its unpopularity, the decision to close certain services, such as health care services, may be made in a somewhat passive way; however, the seemingly gradual slipping away of clients and the deterioration or outright closing of urban hospitals may be accompanied by the emergence of competitive forms of health care, such as home care units, neighborhood health centers, and mobile clinics.

Although some organizations cease to exist entirely, others may change form or come under new sponsorship. For example, some of the neighborhood health centers under specialty grant sponsorship were absorbed into other federal government systems of health clinics. Several major railroad divisions were reorganized under Amtrak. Some hospitals that had been owned and controlled by religious orders became community-based, nonprofit institutions. Some organizations seem only to change title and official sponsorship. The various types of agencies for health care planning over a decade or so have included regional medical programs, regional comprehensive health planning programs, Health Systems Agencies (HSAs), and statewide health planning agencies; the organizational structure, not the total mandate, of these agencies has changed or been eliminated.

The managers in the declining organization may find themselves in a caretaker role that involves such difficult activities as allaying the anxiety of workers, monitoring contradictory formal and informal information about closing, and developing a plan for closing while continuing to give a modicum of service to

the remaining clients. Managers must continue to motivate the workers without a traditional reward system, even in its most limited form. Staff may be reduced, and workers may seek to use up all benefits that they may lose if the organization closes (e.g., sick days and vacation days). Line managers may be forced to deal with the hostility of the workers facing job loss. Finally, a personal decision must be made: stay to the end or leave and cut theoretical losses.

Paradoxically, this may be a time of great opportunity for managers. Middle managers may have an opportunity to participate in activities outside their normal scope as the executive team grows thin. This may be the ideal time for middle managers to try their hand at related jobs, because failure may be ascribed to the situation rather than to their inexperience or even incompetence. Valuable experience may be gained because this may also be a time of great creativity as the gestational phase begins for a new organization with its unique opportunities, challenges, and frustrations. The organizational phoenix rises—sometimes.

We now move from general survival of the total organization to the specifics of individual change strategies. Chapter 2 focuses on the manager as change agent.

EXERCISE: BECOMING A SPLIT-DEPARTMENT MANAGER

Imagine that you are the manager of a department, the function of which is to provide service in your chosen profession. In other words, if your career is medical laboratory technology, you are a laboratory manager; if your field is physical therapy, you manage physical therapy or rehabilitation services; and so on. You are employed by a 60-bed rural hospital, an institution sufficiently small that you represent the only level of management within your function (unless your profession is nursing, in which case there will be perhaps two or three levels of management). This means that unless you are a first-line manager in nursing (for example, head nurse), you report directly to administration.

You have been in your position for about two years. Following some stressful early months, you are beginning to feel that you have your job under control most of the time.

A possibility that for years had been talked about and argued throughout the local community, the merger of your hospital with a similar but larger institution (90 beds) about 10 miles away, recently became a reality. One of the initial major changes undertaken by the new corporate entity was realignment of the management structure. In addition to placing the new corporate entity under

a single chief executive officer, the realignment included, for most activities, bringing each function under a single manager. Between the merger date and the present, most department managers have been involved in the unpleasant process of competing against their counterparts for the single manager position.

You are the successful candidate, the survivor. Effective next Monday, you will be running a combined department in two locations consisting of more than twice the number of employees you have been accustomed to supervising.

Instructions

Generate a list of the ways in which you believe your responsibilities and the tasks you perform are likely to change because of the merger and your resulting new role. *Hint:* It may be helpful to make lists of what you imagine to be the circumstances before and after your appointment. For example, two obvious points of comparison involve the number of employees (which implies many necessary tasks) and the travel inherent in the job. See how long a list you are able to generate.

If possible (for example, within a class or discussion group), after individual lists have been generated, bring several people together, combine their lists with yours, and see if a group process can further expand the list.

Also, address the following questions:

1. What does this split-department situation do to your efficiency as a manager, and how can you compensate for this change?
2. On which specific management skill should the newly appointed split-department manager be concentrating?

NOTES

1. William Davidow and Michael Malone, *Virtual Corporation: Structuring and Revitalizing the Corporation for the Twenty-First Century* (New York: Harper-Collins, 1993).
2. Bertram Gross, *Organizations and Their Managing* (New York: Free Press, 1968), 454.
3. Matthew Holden, Jr., "Imperialism in Bureaucracy," *American Political Science Review* (December 1966): 943.
4. Philip Selznick, *TVA and the Grass Roots* (New York: Harper Torchbooks, 1966), 13.
5. *Ibid.*, 13, 260–61.
6. Amatai Etzioni, *Modern Organizations* (Englewood Cliffs, N.J.: Prentice-Hall, 1964), 13–14.
7. Marver Bernstein, *Regulating Business by Independent Commission* (Princeton, N.J.: Princeton University Press, 1955).