USE OF PATIENT CARE STATISTICS IN THE COMMUNITY HOSPITAL:
A STUDY IN ORGANIZATIONAL CHANGE

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A general theory of organizational change is difficult to develop for two major reasons. First, there is a large number of issues to be dealt with in any one systematic treatment. And second, it is not convenient, or perhaps possible, to cast what is thought or what is known from a variety of perspectives or cultural frameworks into a common language or frame of reference. For the purposes of the present study it is necessary thus to borrow hypotheses from a variety of areas in the literature. These will be outlined in turn.

A first hypothesis may be referred to as the Crisis Hypothesis. It holds organizational change to be most likely in a situation of crisis or disruption. The social worker thus may be most able to assist a family or a community organization when these are embroiled in controversy or conflict with the rest of the environment. Similarly, the community or organizational leader may be better able to make changes when the community or organization is faced with some rather disruptive and threatening problem. Lewin's concept of unfreezing (See Lewin, 1947) describes one way of viewing the crisis role in change. The hypothesis focuses on the conditions of readiness for change.

A second hypothesis may be referred to as the Feedback Hypothesis. It holds organizational change to be most effectively accomplished when the organization can see and perhaps measure the effects of its efforts to change. Likert (1961) and Mann (1957), for example, focus on this variable as one of the important means by which the organization can plan and execute changes effectively. This hypothesis makes use of a system or structural concept in describing an organizational feature or facility which may stimulate change or guide it successfully to the desired goal.

A third hypothesis may be referred to as the Environmental Hypothesis. It holds organizational change to occur when the situation or forces of the environment change. General systems theorists and Parsons seem to be able to account for change only on this basis (See Cancian, 1960, for a discussion of this problem). That is, only when the environment changes will the system change. Examples or organizational change as a consequence of environmental influence include the growth of school systems, industries, or hospitals as a function of community growth. Other examples of environmentally induced change include that which occurs in an organization as a consequence of the legislative bodies of a community or larger governing body or that which occurs as a consequence of the support or non-support of various funding agencies of the community. This hypothesis refers generally to the variety of environmental influences or forces which may create or direct organizational change.
A fourth hypothesis may be referred to here as the Human Relations Leadership Hypothesis. This hypothesis holds organizational change to be most productively accomplished by means of democratic or supportive modes of management and the exercise of human relations skills by the change agent. The stance is illustrated by Coch and French (1948) in their study of overcoming resistance to change. It is developed into a more elaborate system for the administration of change by Bennis (1956). This hypothesis was studied in the often cited study of Morse and Reimer (1956) which, incidentally, found one measure of productivity to increase significantly more in hierarchically (less democratically) controlled programs of change. This hypothesis focuses on the style of intervention of the change agent and of the continuing leadership in an organization.

A fifth hypothesis may be referred to as the Inherent Conflict Hypothesis. This hypothesis holds organizational change to be the consequence of inherent struggle between individual inside the organization. For example, the participants may be competing for dominance, for resources, or may be in conflict for more idiosyncratic reasons. As one regime tires or is overthrown a new one rises and redirects the organization. This hypothesis is perhaps most explicitly expressed in Dahrendorf (1959) who posits conflict and change as inherent in all social relationships. The view is expressed at the societal level in Marxist's descriptions of inherent class struggle and consequences of this struggle for societal change. This hypothesis of organizational change focuses on internal dynamics and the interaction between subunits which generate the forces and direction of change.

A sixth hypothesis may be referred to as the Technological Hypothesis. It holds organizational change to be the consequence of the development of new technologies or new inventions. At the societal level Ogburn and Nimkoff (1958) have described technological development as a major factor in social change. At the organizational level one may think of the industrial organization which develops an improved production machine or method, the educational system which invents new teaching methods, or the hospital which finds an improved care procedure. Sometimes, of course, the technology may represent an input from the environment in which case the Environmental Hypothesis would also be involved. The organization which acquires a computer, duplicating machine, or carefully engineered building provides an example. It should be noted that while the technological development represents a change in itself, the Technological Hypothesis is concerned with the organizational changes which are consequences of this development. Thus, it is the organization which reorganizes its staff or increases its productivity as a consequence of the Technological Development which is of interest. The Technological Hypothesis focuses on one kind of internal change which leads to subsequent organizational change.

A seventh hypothesis may be referred to as the Power Hypothesis. This hypothesis holds organizational change to be the consequence of the exercise of one or another of a variety of forms of social power. Following Weber (1947), for example, one might attribute organizational change to traditional, charismatic, or legal direction. Or following Lasswell...
(1950), one might attribute organizational change to the use of rewards, coercion, or the influence of legitimate, attractive, or expert individuals. Power may be used to refer to a wide variety of activities and attributes of specific individuals or groups in organizations. When the form of social power is exercised indirectly through influence from the environment, feedback, human relations skills, or technological change, other hypotheses may also be related to the process of organizational change. It is helpful to note, however, that the Power Hypothesis has a special emphasis on the activities and attributes of the individual or group which wants or effects power.

As noted below, more than one hypothesis may be relevant to the study of any particular instance of organization change. One strategy in the study of organizational change is to find specific instances of such change and to try out the various hypotheses with respect to the extent to which they are supported by or appear relevant to the phenomenon studied. The present study adopts this strategy in the study of change in the community general hospital. Two case studies are presented and a first approximation of testing the several hypotheses is attempted.

Method

The setting for the present study of organizational change was that of the community general hospital. The change involved the development of uses of patient care statistics. Specifically, these were the statistics of the Professional Activities Study (PAS) and Medical Audit Plan (MAP) provided by the Commission on Professional and Hospital Activities (CPHA), Ann Arbor, Michigan.

The Commission nominated seventeen hospitals for which it had information that PAS materials were likely to be used. The nomination list included, by design, hospitals of various sizes located in a variety of areas in the United States. Nominations were based on the impressions of Commission staff members resulting from the number of special reports requested by the hospital, enthusiasm evidenced by hospital staff members in tutorial sessions conducted by the Commission and recollections of utilization of patient-care statistics.

Thirteen of the hospitals nominated were visited for half-day sessions with hospital staff members participating first in a general introductory session and then in individual conferences for approximately three quarters of an hour. Typically these interviews were conducted with the Chief of Staff, the Director of Medical Education, the Hospital Administrator, the Medical Record Librarian, PAS liaison physician, and other staff members potentially involved in the PAS use process. The purpose of these half-day interviews was to enable the selection of two hospitals which gave the clearest evidence that change had actually occurred in these hospitals with respect to the use of PAS materials. In making these choices, at least the following criteria were kept in mind:
a) innovative quality of the programs of hospital management.
b) evidences of hospital effectiveness in taking steps to improve patient care.
c) willingness of the hospital staff to provide the information needed for a further qualitative study.
d) potential utilitarian nature of the findings for application in other hospitals.
e) usefulness of the data for discussion in a proposed working conference on medical staff development.

Subsequently, the two hospitals selected were visited for two days of intensive interviewing of hospital staff members regarding the nature of the change in the use of PAS materials and the factors which played a role in this change. An interview schedule was followed which included both forced choice ratings of the features of the change process and also open ended questions regarding the elements which were crucial to the change.

The material gathered in the two hospitals was compiled as source data from which the present study draws information relevant to three questions:

1. What specifically changed?
2. What were critical events in the change process?
3. Who were critical performers in the change?

These questions are answered with respect to the two selected hospitals for comparative purposes. The analytical approach of the present study focuses then on the comparison of the process in the two hospitals.

The Case Studies

Hospital A

Hospital A is located in the New England Area and has from 7,000 to 10,000 annual discharges. It is not a teaching hospital.

The changes which have occurred in the hospital since 1963 may be summarized:

1) The hospital now prepares and distributes, on a monthly basis, a comparative report using nearest 12 month totals based on PAS data. This is a two page report of age-stay analysis prepared by total patient as well as by medical, surgical, and specialty categories. It also provides comparative figures for total patient, medical, and surgical categories by source of payment.
Color highlighting (yellow for increases, pink for decreases) enables the physicians to see general trends at a glance.

(2) The hospital reports a systematic decrease in patient stay since the introduction of the special monthly report (and the related efforts to draw patient stay to the attention of the staff).

(3) An active utilization committee systematically reviews the PAS reports and has developed statistical summaries based on PAS reports regarding hospital practices. This committee has made presentations before the staff regarding the utilization of PAS report data (e.g., "studies of the efficacy of one unit blood transfusions" and diagnostic categories in which either admission rates or average stay varied markedly from CPHA data).

(4) At least one staff member reports himself a convert to PAS, although formerly he was opposed to its introduction in the hospital.

The critical events which led to the present use of PAS in the hospital may also be summarized:

(1) The State Medical Society after discussion in the Medical Economics Council (composed of an equal number of representatives from: the Society; the Hospital Association; Blue Cross-Blue Shield) recommended the establishment of special Utilization Committees in state hospitals. (The Hospital Administrator is very active in the Medical Economics Council.) This proposal in Hospital A was unsuccessfully opposed on legal grounds by some staff members. (September, 1960.)

(2) Dr. Slee of CPHA and Dr. Myers, Associate Director, American College of Surgeons were invited in September, 1961, to address the staff with representatives from other state and nearby state hospitals in attendance. One of the guest hospitals subscribed to PAS immediately, but Hospital A delayed, rejected a motion to join PAS in November, but with the leadership of the hospital administrator and Chief of Staff, reconsidered and subscribed in January of 1962. The program, however, was not implemented because of illness of the Record Librarian who resigned in June. Her replacement began duties March, 1963, and the PAS program was implemented on October 1st.

(3) The long-range survey report made by a hospital consultant in April 1962 contained the following recommendations: "Include, as a function of your Joint Conference Committee, a close study and scrutiny of the hospital's:

A. Higher than average admission rate;

B. Longer than average length of stay."
Request a Utilization Committee for your medical staff to provide the Board of Trustees with a monthly report of hospital activity, including the above two factors and recognizing and correlating your experience with:

A. Professional Activity Study;

B. Comparable experience of other state hospitals."

(It may be noted that the hospital consultant could obtain for comparison purposes with other state hospitals only gross data on overall admission and stay rates for medical and surgical patients grouped.)

(4) The original Utilization Committee determined that it could not survey hospital use effectively unless and until satisfactory review methodology could be developed and hence lent its support to the invitation of CPHA officials to visit the hospital - paragraph (2) above. However, after this visit tension continued between the staff and the committee to such an extent that a member resigned (May 1962) and the chairman refused to call meetings until the staff resolved the status of the committee, which at this point was only a temporary committee.

In August 1962, the staff, acting upon the urging of a member who was a representative of the Society to the Medical Economics Council, established the committee as a standing committee, with explicit purposes and functions, by means of bylaws amendment. However, feelings still ran high and the committee met briefly in October 1962 - in response to a call by one of its members - and declared its function to be that merely of circulation review of long-stay inquiries received from the Medical Economics Council. This position was taken on the grounds that data retrieval methodology had not been instituted at that date. No further meetings were held until 1964.

(5) Blue Cross for some time had been critical of the length of stay at the hospital and, upon the invitation of the hospital administrator, its chief executive met with the Executive Committee of the Board of Trustees in December 1963. Comparisons were made with other member hospitals which showed its overall average stay to be substantially higher. The Blue Cross official also called the attention of the trustees to a considerable number of cases who stayed in the hospital until the final day of benefit coverage.

(6) A member of the original Utilization Committee was persuaded (by the administrator?) to accept chairmanship of the committee when annual staff committee appointments were made in January 1964. He was relatively invulnerable in regard to his practice,
(general practitioner) was large and forceful in manner, but capable also of being tactful and diplomatic. Under his leadership the committee began biweekly meetings in March 1964, when the first three months PAS data had been accumulated.

PAS data from two other state hospitals was obtained for comparative purposes and later expanded into depth studies comparing all six state PAS hospitals by the hospital administrator. Presentations of this data were made to Staff and Joint Conference Committee meetings. Later presentations were made to all state hospitals in the state capitol at the invitation of the Medical Economics Council in December 1964. These studies indicated that when evaluation was made concerning variables of patient populations (e.g., age mix, diagnoses, procedures performed) among the six hospitals, that the hospital's adjusted average length of stay approximated the median for the hospitals compared.

The first full twelve months comparison of patient stay as of December 1965, showed overall stay reduced by .5 day, affecting all age groups and most service categories, especially for surgical patients. Subsequent reports continue to show decreases.

Hospital enrolled in Medical Audit Program of CPHA. (March, 1966.)

A CPHA computer study of average stay, for a two year period ended December 1965, indicated through the use of matched patient data that the hospital's stay was bettered by only one hospital for the last six months among the six state hospitals compared. The results of this study were discussed and distributed at a regional hospital meeting in March 1966, and later published in the state Society's journal. Further review of the survey at a series of meetings sponsored by the Medical Economics Council resulted in the enrollment of all of the state's general hospitals in PAS-MAP.

Hospital subscribes to Length of Stay Package of CPHA (June 1966).

The key participants in the change process at Hospital A included:

(1) The Hospital Administrator who was influential in promoting a utilization committee, confrontation of the length of stay problem, and subscription to PAS. The Administrator consistently developed his role in the State Medical Economics Council and other influential bodies and made internal use of his contacts with the Blue Cross, CPHA, and hospital consultants. It is appropriate to note that during the process of the present study the Administrator was developing liaison with a state newspaper writer, a Governor's Commission, and resources of the project staff of the present study to help his work both
in the hospital and the state's hospital associations. It is the Hospital Administrator who, having had professional training in accounting, at the time of this study, prepares the monthly reports on age-stay analysis.

(2) The Chairman of the Utilization Committee who displayed qualities for the management of a difficult role. His general practice is relatively invulnerable to the influence of the rest of the hospital staff. He is a large man and is described by other hospital staff members in such terms as Buddha-like, tough when necessary, strictly impersonal in his treatment of cases before the committee.

(3) The past two chiefs of staff and three staff members who supplied support at critical moments for supporting the establishment of the utilization committee and subscription to PAS. Some of the men command considerable respect from more reluctant and opposed staff members and thus played critical roles in developing staff commitment to new courses of action.

(4) Members of the Board of Trustees who were prepared to approve of subscription to PAS before the hospital staff was ready and have provided the Hospital Administrator with latitude to work in a variety of external settings as opportunities to help the hospital internally as well as to work for the state's hospitals as a whole. It is appropriate to note that one of these at least was surprisingly knowledgeable about PAS reports and their use in the hospital.

**Hospital B**

Hospital B is located in the Southwest United States and has from 15,000 to 20,000 patient discharges annually. It is not a university hospital although teaching is being done.

The change which has occurred in Hospital B with respect to PAS use since 1959 may be summarized:

(1) The hospital has created a special position for a Director of Data Retrieval and Analysis. This position is presently held by a former Medical Record Librarian who has been a teacher of Medical Record Librarians. This Director is to be responsible for care statistics and reports concerning these. She is an active participant in committees concerned with PAS statistics.

(2) The hospital has sent a large number of participants to attend PAS tutorials in Ann Arbor. Those sent include not only senior medical staff members and administrative personnel,
but also paramedical specialists such as those from pharmacy, physical therapy, and industrial engineering.

(3) An elaborate committee structure in the hospital reviews PAS information, screens it, and communicates relevant material to other sections in the medical review and audit process. Nursing, physical therapy, and other paramedical personnel review some reports in addition to four subsidiary audit committees and the main Medical Audit Committee.

The significant events which led to this change in the hospital include:

(1) The death of the former administrator amid the problems of an overbedded community and both a medical and management audit. In this situation the new administrator was determined to develop an image of excellence for the hospital and began to cultivate resources for promoting standards of excellence. A major task was the reorganization of the hospital's governing structure. (1959.)

(2) A Director was obtained for the Medical Record Librarian School conducted by the hospital. The former Medical Record Librarian resigned and the director of the school acquired responsibility for both roles. (1960.)

(3) PAS and MAP data were seen by the administrator as means by which the hospital could obtain some purchase on the problems of review and improvement and these were adopted by the hospital. (1963.)

(4) The position of Director of Data Retrieval and Analysis was created with committee status and responsibilities. A new Medical Record Librarian and Director of the School now permitted the former occupant of these positions to perform this new role full time. (1966.)

The participants in the change process include:

(1) The Hospital Administrator who became interested in PAS and MAP as tools for improving the hospital and was influential in promoting them as well as sending a sizable number of participants to CPHA tutorials.

(2) The Director of Data Retrieval and Analysis who prepares reports, gives assistance in interpreting the PAS-MAP materials, presents information in staff committees and at formal presentations, and actively participates in committee functions. It is appropriate to note that during the course of the present study she and the Hospital Administrator were faculty resource persons at a national conference. Their presentation concerned the use of PAS.
(3) The medical staff members of the hospital who have given the Hospital Administrator and the Director of Data Retrieval and Analysis support first in obtaining PAS-MAP services, second in sending staff members to be trained in their use, and third in the development of a special role of Director of Data Retrieval and Analysis.

**Analysis**

Several similarities emerged in the comparison of the two case studies presented. These serve to illustrate some basic factors in the effective implementation of organizational change.

First, in both hospitals there were circumstances which might be called a "pain situation." In Hospital A patient days seemed out of line and the hospital was subjected to strong criticism on this account. The pain situation in Hospital B was, if anything, more serious. The hospital braced for lost revenue because of the sudden over expansion of hospital beds in the community. In addition to a management audit, the hospital was simultaneously embroiled in the bitter controversy of a medical audit which resulted in the dismissal of staff members. During these difficulties the Assistant Hospital Administrator replaced the former administrator who died of a coronary. In short, in both organizations there was a clear and pressing situation which threatened the hospital. Two implications may be appropriate. The person interested in obtaining change may wish to attempt to make the threat to the organization more apparent and pressing. Or the person interested in obtaining change may need to assess the readiness of the system for change in terms of the pain or threat which it experiences.

Second, in both hospitals there was a relatively clear objective of change which resulted from the pain situation. In Hospital A this objective was to reduce criticism of patient stay. In Hospital B the objectives were to adapt to reduced income and to restore community confidence in the quality of service provided by the hospital. These represented pressing needs to which responsible members of the hospital would of necessity be obligated to respond. Simultaneously, these objectives served to mark the degree of progress in the development of solutions. Thus in Hospital A the reduction in patient days marked hospital progress. In Hospital B the ability to project hospital needs and to focus on quality of care reviews marked progress in pursuing its objectives. (Hospital B projects future admissions from its own source of data by section of town and type of patient for purposes of responding to competition from new hospitals in the city.) Again two implications may be appropriate for the individual interested in applying principles illustrated in these two instances. A specific goal of change, especially a measurable one, marks progress or the lack of it and thereby serves to stimulate or encourage those involved in the change process.
Third, in both hospitals special resource people appear to have played a crucial role. In Hospital A a physician was needed who would be somewhat invulnerable to other staff members and who had the diplomatic but forceful skills to conduct an effective utilization committee. The hospital administrator was able to enlist such a person. In Hospital B a data retrieval specialist was needed who could make the PAS-MAP materials understandable to staff members and who could obtain confidence and respect as a staff member in a committee role. The Hospital Administrator was able to obtain and develop such a person. In short, both hospital administrators were able to secure the help of a staff person suited by special skills or attributes to perform critical roles in the development of use of PAS and MAP materials. The implication which might be drawn would seem straightforward. The individual interested in developing change in an organization should devote careful attention and appropriate effort to the task of obtaining allies in the change process who have the special skills indicated by the roles to be performed.

Fourth, in both hospitals a similar strategy was employed with respect to use of environmental forces to accomplish internal objectives. In Hospital A this was an elaborately developed program in which the Hospital Administrator used resource people from the state and other states to alert his hospital staff to its problems and opportunities. A selected list of such external resources would include the State Medical Economic Council, the State Blue Cross, CPHA, the governor’s staff and commission, a state newspaper, a regional hospital association, and the leaders in the community in which the hospital is located. In Hospital B the administrator has made extensive use primarily of the resources of the PAS tutorials conducted by CPHA by investing heavily in sending his staff to these tutorials. It is appropriate to note, as well, that during the process of the present study the administrator was actively involved in the development of community planning with respect to medical facilities—work which could have saved the hospital much pain in the past several years and should help to save it such pain in the future. Both hospitals, it should be noted, made use of consultation in diagnosing the problem. The individual interested in change should be well advised to attend to the environmental or external resources and forces which impinge upon the organization and should attempt to utilize these to help solve internal problems or promote internal objectives.

Fifth, in both hospitals the change process encountered resistance which had to be confronted. In both cases, for example, a new Medical Record Librarian had to be obtained who was knowledgeable about the PAS system and committed to it. Similarly, in both hospitals some staff members were opposed to the use of PAS and MAP materials particularly in the form of review of practice. These men had to be persuaded or firmly opposed in their resistance. This process could not be without its conflict and animosity at some level. The individual interested in developing change in a system should be prepared to face resistance and conflict and should be able to manage the conflict effectively.
Sixth, in both hospitals the change process was advanced at critical points through the support of key influential and respected staff members who supported appropriate resolutions and measures. In Hospital A this was staff support for beginning PAS and for developing the Utilization Committee. In Hospital B this was staff support on beginning PAS-MAP, for reorganization of the governing structure in a way to facilitate the developmental process, and for sending staff members to PAS tutorials. The individual interested in organizational change should assess the potential support of influential staff members and should be able to enlist this support at critical moments in the management of the change process.

One difference between the two settings is also noteworthy with respect to its possible implications for principles of planned change.

The two hospitals appear to manifest some degree of difference in the style of administration and use of PAS materials. In Hospital A the focus on patient days was initiated by the Hospital Administrator who personally maintains monthly reports of age-stay analysis. Similarly, the Chairman of the Utilization Committee appears to be something of a strong man in leading the Committee to perform its functions. In Hospital B, while the Hospital Administrator appears reluctantly to have had a very strong role in the reorganization of the staff, his prominence in the review process seems less apparent. Nor is the stance of the Director of Data Retrieval Analysis a very directive one. The responsibility or at least the interest and enthusiasm for the overall program, in short, seems more broadly shared in Hospital B. It is important to note, in this respect of course, that Hospital A may simply represent an undeveloped form of leadership displayed now in Hospital B. This suggests that, in subsequent stages of development, Hospital A may arrive at a stage more like the one presently evidenced in Hospital B. Nevertheless, it is significant to note that both styles of administration have been somewhat effective for the purposes of developing the changes indicated. This view, it would be pointed out, is not an accepted one in some of the literature on organizational management. Specifically, one implication might be that the style of administration is of relatively less significance than other factors in the change process. Alternatively, for given objectives and in certain stages of growth, more directive forms of administration may be as effective as less directive forms. Needless to say, only future events can confirm that the change in Hospital A is as effectively institutionalized as that in Hospital B.

Discussion

The present study was conducted as a case study in organizational change. A comparison has been made between the process of change in two organizational settings. This comparison provides the data for considering several hypotheses of organizational change.
The Crisis Hypothesis of organizational change would indicate the likelihood that hospitals which evidence change would experience crisis situations at the beginning of the change process. This expectation seems clearly born out in Hospital B which experienced a very serious crisis. The pain situation in Hospital A was serious but perhaps does not warrant the "crisis" description.

The Feedback Hypothesis of organizational change would lead to the expectation that hospitals which evidence change will use some means for marking progress in change. The monthly report on age-stay analysis in Hospital A serves as a clear example. The indications for marking progress in Hospital B are unclear and were perhaps more subtle.

The Environmental Hypothesis would lead to the expectation that hospitals which evidence change will make use of or be exposed to environmental resources or pressures. Both Hospital A and B confirm this expectation. In Hospital A a variety of environmental forces played critical roles. In Hospital B the PAS tutorials played an important role.

The Human Relations Leadership Hypothesis would lead to the expectation that hospitals in which change is most productively accomplished will display a pattern of administration or leadership which is democratic, supportive, or sensitive to the feelings of others. This hypothesis does not draw clear support from the present study. Rather the two hospitals differed with respect to the degree of forceful and directive leadership and involved much assertive effort by single individuals in both instances. It could be, of course, that the directive leadership was more apparent than real in either or both cases. It would be useful to trace in time the persistency of the changes and also relate the degree of effectiveness of the new PAS and MAP utilization systems with the extent to which the leadership was seen to be supportive.

The Inherent Conflict Hypothesis would lead to the expectation that hospitals which evidence change will experience a struggle for influence or control prior to the change process. From the case study material here it is not clear that the personnel of either hospital participated in a struggle prior to the change process. There are clear indications, of course, that struggle and conflict marked the change process itself. In short, conflict did play a role if not a determining one in the process of change.

The Technological Hypothesis would lead to the expectation that hospitals which evidence change will have developed some new method or technique prior to the change process. In Hospital A the use of color highlighting in indicating trends for patient day data provides an example. In one sense the creation of a role for data retrieval and analysis in Hospital B also represents an "organizational invention." This may or may not be more properly considered as an exercise of organizational power.
The Power Hypothesis would lead to a variety of alternative expectations regarding hospitals which evidence change. For one, it is likely that such change will involve the use of power figures to support the process of change. In both hospitals, by way of support, respected senior staff men were involved at critical points in taking steps to advance the change process in the hospital.

In general, thus, the hospitals conform to these several expectations derived from the several hypotheses of organizational change. The possible exception is the Human Relations Leadership Hypothesis. It may be, of course, that the support or lack of support of the various hypotheses may reflect idiosyncracies of the case studies or problems of comprehensive data collection. The limitations of the present study in these respects indicate the direction of more rigorous testing of the hypotheses of organizational change.
References


